An interpretative phenomenological enquiry into imposter syndrome and transition shock in clinical educators

Marion Jane Khan

Submitted in accordance with the requirements for the degree of

Professional Doctorate Education

York St John University

School of Education, Language and Psychology

November 2025

The candidate confirms that the work submitted is their own and that appropriate credit has been given where reference has been made to the work of others.

Acknowledgements

I would like to express my deepest gratitude to my Supervisors, Dr Joan Walton and Dr Chris Boyes, whose expertise, guidance and encouragement have been invaluable throughout my research journey. Their thoughtful feedback and patient support helped me to shape my thesis into its final form, and I am immensely grateful for their time and wisdom.

I am also indebted to York St John University and the staff of the Postgraduate Research School; the Library; and Digital Training who provided immense practical support and created an environment where my research could flourish.

My sincere thanks go to the participants who shared their imposter syndrome experiences with me so openly. This research would not have been possible without their willingness to engage with honesty and reflection.

I am extremely grateful to my fellow doctoral researchers, the EdDmins, whose conversations, encouragement, and camaraderie made the challenges of this journey so much lighter, and the successes more meaningful.

I owe a profound debt of gratitude to my family and friends for their unwavering love and support. To our children, Rebecca and Matthew, our five grandchildren, and my husband, Daniel, thank you for your understanding and steadfast belief in me, even when I doubted myself. Your support upheld me more than words can say.

But over everything I acknowledge and am thankful for the sustaining gift of my Christian faith, and the wisdom, perseverance, and inspiration it brought to my doctoral journey.

This thesis is dedicated to all clinicians who embrace the challenge of becoming educators,
who work to inspire the next generation,
and who strive to ensure that knowledge, compassion, and expertise
shape the care given by our future healthcare professionals

Abstract

This thesis is comprised of two studies, and explores the imposter syndrome experiences of clinical educators transitioning from professional healthcare disciplines into teaching roles. Imposter syndrome is characterised as persistent self-doubt, fear of being exposed as a fraud, and difficulty internalising success, and was examined through the lens of Interpretative Phenomenological Analysis in Study 1. Semi-structured interviews explored the experiences of clinical educators who believed they had imposter syndrome. Themes identified in the data analysis unexpectedly revealed the possibility that what participants may have experienced during role transition was transition shock, rather than imposter syndrome, and an hypothesis was formulated to that effect.

Study 2 tested this hypothesis through semi-structured interviews with most of the same participant group. Deductive phenomenological analysis examined their reflections on the role transition experience and whether it was imposter syndrome, or the concept of transition shock, which offered a more accurate framing for their feelings.

The hypothesis was neither accepted nor rejected in full because results were mixed. This led to the development of an overarching theory that in the role transition experience of clinical educators there may be confusion between longer duration imposter syndrome, and shorter duration transition shock. Awareness of this confusion was identified as helpful to clinical educators in that transition shock feelings would not continue indefinitely.

The thesis concluded with recommendations for organisational support such as discussions in clinical educator induction programmes on imposter syndrome and transition shock, and proposals for post-doctoral research.

This thesis contributes to the growing discourse on the complexities of role transition in clinical educators, and highlights the need for organisations to recognise, and respond to, the challenges faced during this role transition experience.

Table of Contents

List of Tables

List of Figures

Abbreviations

ACP	Advanced Care Practitioner
ALS	Advanced Life Support
APA	American Psychiatric Association
APLS	Advanced Paediatric Life Support
ATLS	Advanced Trauma Life Support
BCU	Birthing Centre Unit
CIPS	Clance Imposter Phenomenon Scale
CP	Clinical Psychologist
CTF	Clinical Teaching Fellow
DSM	Statistical Manual of Mental Disorders
ED	Emergency Department
EdD	Doctor of Education
GET	Group Experiential Theme
GETs	Group Experiential Themes
GPVTS	General Practice Vocational Training Scheme
HCA	Health Care Assistant
HIPS	Harvey Imposter Phenomenon Scale
ICU	Intensive Care Unit
IP	Imposter Phenomenon
IS	Imposter Syndrome
IPA	Interpretative Phenomenological Analysis
IRAS	Integrated Research Application System
NETT	Nurse Education Transition Theory
NMC	Nursing & Midwifery Council
PET	Personal Experiential Theme
PETs	Personal Experiential Themes
PGCAP	Post Graduate Certificate in Academic Practice
PGCE	Post Graduate Certificate in Education
PhD	Doctor of Philosophy
WHO	World Health Organization

Chapter 1 Introduction

1.1 Introduction

The successful recruitment and retention of nursing and other healthcare professionals into educator roles is essential to maintain the training and development of the clinical workforce. Feelings of imposter syndrome in the educator role, however, may create job dissatisfaction and negative work experiences, resulting in personal or emotional difficulties and job retention challenges. The research aim of this thesis was to advance understanding of the experience of clinical educators who believed they had feelings of imposter syndrome, and to identify the perceived significance and source of those feelings. Through this research it was hoped a better understanding of the nature of imposter syndrome experiences would be established, and its outcomes contribute to development and support strategies for clinical educators in the workplace.

1.2 Research Question and Aim

The question which guided this research was:

- How do clinical educators make sense of the lived experience they believe to be imposter syndrome?

The aim of this research project was:

- To advance understanding of the lived experience of clinical educators who believed they had imposter syndrome.

The two sub-questions framed to address the aim were:

- What do participants perceive as significant to their feelings of imposter syndrome in the role of clinical educator?
- How do participants describe the source of their feelings of imposter syndrome?

1.3 Background

As lead nurse of the clinical education team, I was surprised to receive a resignation letter from Ruth (anonymised), a valued team member. Formerly an ICU Deputy Sister, Ruth had joined us as a clinical educator to teach clinical skills to nurses, allied health professionals, and medical students. She was highly experienced, knowledgeable, and respected by colleagues and students alike.

In discussing her resignation, Ruth revealed overwhelming self-doubt about her teaching abilities. Despite feeling valued, she constantly feared being exposed as a fraud. While she thrived in the high-pressure of ICU, she struggled with anxiety in her educator role and this had affected both her work and personal life. Walking into work filled her with dread, and writing her resignation letter had brought immediate feelings of relief. She was certain returning to frontline nursing in another Trust was the right choice.

Losing Ruth was a significant loss to our team and the organisation. It wasn't until years later, following a university classroom discussion on Imposter Syndrome, that I was distinctly reminded of the feelings described by Ruth.

At the time of my discussion with Ruth I documented the event in my professional portfolio for Nursing & Midwifery Council (NMC) revalidation, but did not explore it further. Several years later, a short classroom discussion on imposter syndrome during my doctoral studies prompted recall, and then reflection, on Ruth's experience, and I asked myself: *What had she felt?* Initially dismissing it as a past event, I then reconsidered: *What if her feelings were not unique?* These questions led me to think about the nature of the imposter syndrome experience in clinical educators.

Originally termed 'Imposter Phenomenon' (Clance and Imes, 1978), imposter syndrome describes persistent self-doubt and fear of intellectual fraudulence despite evidence of competence. While not formally recognised as a mental disorder (Ogunyemi *et al*., 2022; Conrad, 2007), it can significantly impact career progression and personal well-being. It was Ruth's case which inspired this research, evolving my perspective from *What?* to *What if?*

1.4 Role of the Clinical Educator and Research Context

In this thesis a ‘clinical educator’ refers to an experienced registered healthcare professional, who may have teaching qualifications, and who is working in educational positions within university, healthcare, or community settings. Clinical educators balance the dual role of maintained clinical expertise with teaching and training activity across diverse health disciplines and settings. As a former Lead Clinical Educator covering several hospitals within a Trust, I was aware of the evolving and diverse role of educators, who not only deliver clinical training and education but also provide professional support, service improvement, and contribute to organisational development.

1.5 Justification for the Research

Before commencing this research, I conducted a small pilot with clinical educators who acknowledged feelings of imposter syndrome. As presented in Section 3.3, the pilot study confirmed that further research would contribute to the understanding of imposter syndrome in clinical educators.

1.6 Introduction to the Methodology

This research adopted a two-study qualitative design to explore the lived experiences of clinical educators who initially identified with imposter syndrome. Study 1 used semi-structured interviews and Interpretative Phenomenological Analysis (IPA) (Smith, Flowers and Larkin, 2022; Smith and Osborn, 2015; Smith, Flowers and Larkin, 2009; Larkin, Watts and Clifton, 2006; Smith and Osborn, 2003), to capture rich, first-person accounts without imposing prior theoretical assumptions. As themes emerged, many participants described experiences more consistent with the transition-related disorientation of Transition Shock (Duchscher, 2008; 2009; 2012) than with imposter syndrome. In response to these findings, Study 2 used deductive phenomenological analysis (Bingham, 2023; Bingham and Witkowsky, 2022; Azungah, 2018, Gilgun, 2014; Perry, 1998) and semi-structured interviews to examine the data through the lens of the Transition Shock model (Duchscher, 2009). This sequential approach to the methodology allowed for inductive exploration and interpretation in Study 1, and theory-informed deductive interpretation in Study 2, enabling a deeper understanding of the participants’ experiences during their professional role transition to emerge.

Initially this thesis comprised a single study focused to address the research question and study aim. The unexpected emergent themes of Study 1, which led me to think that the imposter syndrome experiences of participants may have been experiences of transition shock, formed an hypothesis to that effect. In order to test the hypothesis, the second study was set up to interview most of the same group of participants. The result of Study 2 indicated that the hypothesis was neither accepted nor rejected in full because the results were mixed.

1.7 Scope of the Research

This research explored the personal narratives of registered health practitioners who undertook the full-time or part-time role of clinical educator, and who acknowledged experiences of imposter syndrome. Participants were located in Northeast England and had clinical registration in nursing, pharmacy, medicine, clinical psychology, or midwifery. Most participants worked in a university setting with undergraduate, or postgraduate, students of nursing, midwifery, or medicine. The remaining participants worked in hospital clinical education departments, or the Prison Service.

1.8 Original Contribution to Knowledge

The original contribution to knowledge of this research is the development of an overarching theory that in the role transition experience of clinical educators, there may be confusion between longer duration imposter syndrome and shorter duration transition shock.

1.9 Organisation of Chapters

This thesis is organised into eight chapters:

Chapter 1: Introduction
Chapter 2: Literature Review
Chapter 3: Methodology
Chapter 4: Study 1 Findings: The Lived Experience of Imposter Syndrome
Chapter 5: Targeted Literature Review and Development of Framework for Study 2
Chapter 6: Study 2 Findings: Reframing the Experience
Chapter 7: Discussion
Chapter 8: Conclusion

1.10 Summary

This thesis aimed to advance understanding of the imposter syndrome experience of clinical educators utilising two qualitative, phenomenological studies, and was driven by my reflections on a former colleague's experience. A pilot study indicated the relevance of this research, and led to the studies from which an hypothesis was developed and tested, and addressed the research question and aim. The original contribution to knowledge arising from this thesis is that clinical educators transitioning into their new role may experience confusion between longer duration imposter syndrome and shorter duration transition shock.

In the next chapter the literature on imposter syndrome will be critically reviewed.

Chapter 2 Literature Review

2.1 Introduction

The purpose of this chapter is to critically review the literature on imposter syndrome, including its terminology, and to discuss its background and development as a concept. An overview of research into imposter syndrome is examined, and critiques of its concept highlighted. Imposter syndrome in popular culture will be explored, and its position in relation to clinical educators reviewed.

2.2 Background to Imposter Phenomenon

In 1978, psychologists Pauline Clance and Suzanne Imes introduced the term 'Imposter Phenomenon' (IP) from a study of high achieving women, defining the term as meaning 'an internal experience of intellectual phoniness' (Clance and Imes, 1978, p. 241). The study indicated IP individuals do not believe themselves worthy of accolades or achievements, and when 'self-imposed standards of achievement' (p. 242) are not reached, they experience extreme fear of failure, increased anxiety, and remain continually striving to succeed.

The work of these two psychologists was not the first in this field. In the 1950s and early 1960s experimental psychologist, Matina Horner, had developed an interest in the motivation and achievement of capable and intelligent women in the working environment (Horner, 1968). Despite common perceptions that women feared failure, or being in competition with male counterparts (McClelland, 1961; McClelland *et al.,* 1953; Veroff, Wilcox and Atkinson, 1953), Horner was interested in whether this was the case, or whether other factors impacted on the motivation and achievement of women. In 1968 Horner looked at gender differences surrounding motivation and achievement, and proposed that:

> The motive to avoid success is a psychological barrier to achievement in women. When it is aroused, fear of success adversely affects performance. This fear exists because for most women, the anticipation of success in competitive achievement activity especially against men, produces anticipation of certain negative consequences, eg threat of social rejection and loss of femininity (Horner, 1968, Abstract p. 3).

Horner found that women in her study were not influenced by a fear of failure or gender competition, rather, it was the consequences of workplace success and achievement that was the greater barrier. The women reported being fearful of attaining greater success than male colleagues as the aftermath of 'winning against a man was to actually lose' (Horner,

1968, p. 118). Horner thus suggested fear of success was a psychological gender block which negatively impacted on women's involvement and progression in both the workplace and society, a concept subsequently developed as Fear of Success, later known as the 'Horner Effect' (Horner, 1973).

While studies developed from Horner's work generally found a more balanced gender bias around fear of success (Bremmer and Wittig, 1980; Cherry and Deaux, 1978; Janda, O'Grady and Caps, 1978), the conclusions indicated this bias was more likely socially derived than a psychological barrier (Engle, 2003). None of these earlier studies looked at the lived experience of such bias, however. For example, Horner (1968) concentrated on 'the effects of individual differences in achievement motivation, on risk preference, levels of aspiration, performance, and persistence in achievement-oriented activity' (p. 3), all measurable components rather than qualitative features that explored feelings.

Expanding on Horner's study, Clance and Imes examined imposter phenomenon with a sample of 150 highly successful women (Clance and Imes, 1978) to understand why extremely intellectual, capable, and successful women identified themselves as fooling others into believing they were more competent than they truly were. They found that women who experienced imposter phenomenon expressed 'a strong belief that they are not intelligent; in fact, they are convinced that they have fooled anyone who thinks otherwise' (p. 241). While acknowledging participant biases of primarily white, middle to upper class women between the ages of 20 and 45 from 'high achieving' (p. 242) professional or academic backgrounds, the study nonetheless formed the basis for considerable wider future thinking about imposter phenomenon. Indeed, the authors themselves questioned whether men experienced this phenomenon which 'occurs with much less frequency in men and that when it does occur, it is with much less intensity' (p. 241), but went on to suggest that 'this clinical observation needs to be researched' (p. 241).

Pauline Clance brought the defining features of imposter phenomenon into the literature subsequent to 1978 (Clance and Lawry, 2024; Clance *et al*., 1995; Clance and O'Toole, 1987; Clance, 1985a). She indicated imposter phenomenon was a response to a lifetime of negative messages in personal, professional, and sociocultural experiences, and the impact of long-standing negative self-evaluations. Clance further suggested that the presence of the Imposter Cycle (Appendix 1) appeared to play a critical role in how imposter syndrome is repeatedly, and somewhat predictably, maintained:

> 'The Imposter Cycle is one of the most important elements of the phenomenon… it's difficult for IP victims to function normally and be at ease with their success' (Clance, 1985b, p. 53).

The next section will examine the terminology used in the imposter syndrome debate, and its implications.

2.3 Terminology and its Implications

When Clance and Imes introduced the term “Imposter Phenomenon” into literature in 1978, they intentionally chose to describe their research entity as this. In their view, the word ‘imposter’ indicated the way an individual felt within the imposter phenomenon construct, like a fraud, despite clear evidence to the contrary. The word ‘phenomenon’ demonstrated it was not a transitory experience, but one that can persist over time and, “importantly, echo the experience of others in ways that are similar yet phenomenologically unique” (Clance and Lawry, 2024, p. 20). Terms intentionally *not* used by Clance and Imes (1978) were ‘disorder’ or ‘syndrome’ which, they believed, implied a level of individual clinical dysfunction or pathologising, not supported in their clinical practice (Clance and Lawry, 2024; Clance and O’Toole, 1987). Rather, it was suggested that imposter phenomenon had a powerful relationship with cumulative sociocultural contexts:

> ‘Exclusive use of individual-level framing denies IP’s origin story, and neglects a growing literature that demonstrates the powerful influence of context’ (Clance and Lawry, 2024, p. 21).

Implications surrounding potential medicalising terminology had also created, in some areas, the suggestion that imposter *syndrome* was a mental health disorder or psychiatric illness requiring professional treatment (Ogunyemi *et al.*, 2022; Conrad, 2007). A study with medical students by Maqsood *et al.* (2018) selected 200 participants who underwent a cross-sectional, psycho-social analysis of their imposter syndrome experiences. While the authors concluded that both genders are at equal risk of imposter syndrome, this study proposed that imposter syndrome ‘is associated with various psychological illnesses’ (Maqsood *et al*., p. 3431), in contrast to other research that supported the concept of cumulative sociocultural impact (Clance and Lawry, 2024; Clance *et al*., 1995; Clance and O’Toole, 1987; Clance, 1985a).

Imposter syndrome is not currently listed as a diagnostic classification in the American Psychiatric Association’s Diagnostic Statistical Manual of Mental Disorders (DSM) (APA, 2022), or the World Health Organization’s (WHO) Classification of Mental and Behavioural Disorders (WHO, 2022) as used in the UK. The outcome of increased research into the imposter syndrome construct had prompted researchers such as Bravata *et al.* (2019) to recommend its inclusion in the DSM as they concluded, in contrast to other literature (Clance and Lawry, 2024; Clance *et al*., 1995; Clance and O’Toole, 1987; Clance, 1985a) but in

support of Maqsood *et al.* (2018), that such feelings arise due to the 'psychological issues that are often found to co-exist with impostor syndrome' (p. 1271). In the follow-up Commentary to this work (Bravata *et al*., 2020), the authors further observed that although half of the 62 peer-reviewed publications published in the previous seven years described imposter syndrome as a significant clinical phenomenon, it remained not recognised as a psychiatric disorder. As a result, they continued to recommend that:

> 'Imposter syndrome should be considered for rapid inclusion in the next edition of the DSM so that patients with these symptoms can be identified and treated by behavioral health providers' (p. 14).

And Tulshyan and Burey (2021) held a different position, suggesting that the word 'imposter' had an inference of criminal fraudulence, despite Clance and Imes' (1978) emphasis it described women who believed they had fooled others into thinking they were intelligent, and were thus 'imposters' in their roles.

Nonetheless, although the term 'syndrome' has had its challenges relating to the pathologising of imposter phenomenon, 'imposter syndrome' has now become the mainstream descriptor across popular culture, lay literature, and the media (Cokley, 2024), with 'imposter phenomenon' generally used in academic journals (Bravata *et al.*, 2020). While the debate around the clinical position or pathological status of imposter syndrome continues, terminology was considered in the structuring of this research project. I believed there was much merit in moving away from the pathologising or dysfunctional inference of 'syndrome', and was aware that 'imposter phenomenon' was not a widely known term which may therefore negatively influence participant recruitment, engagement or response. In addition, I did not share the views of Tulshyan and Burey (2021) regarding the suggestion of criminality in the term 'imposter' as I believed the term was fully explained by Clance and Imes (1978) and subsequently Clance (1985a; 1985b). I chose therefore to use the term 'imposter syndrome' throughout the recruitment and research processes, and for consistency, have continued the term in writing this thesis. An exception would be quotes or direct references to the literature where the term 'imposter phenomenon' or 'IP' was used.

The next section will discuss further areas of imposter syndrome research following the original work of Clance and Imes (1978).

2.4 Imposter Syndrome Research

Research since 1978 identified other areas and populations in which imposter syndrome was examined. Hutchins and Rainbolt (2016) for example, in their study of academic faculty

from a human resources perspective, explored critical events that triggered imposter tendencies such as the psychological stress of having professional integrity and expertise questioned. The authors considered that management of such critical events sat ‘squarely within the HRD [HR Department] realm of learning and career development’ (p. 17) and believed their research served as a ‘call to action’ (p. 17) in support of academic faculty.

Research among college and university students, including medical, dental, nursing and pharmacy students, engaged participants with a measurement tool or scale, such as the Clance Imposter Phenomenon Scale (CIPS) (Clance, 1985) or the Harvey Imposter Phenomenon Scale (HIPS) (Harvey and Katz, 1985; Harvey, 1981), to enable self-identification of how individuals were affected by imposter syndrome. Research with measurement scales had also been undertaken among academic and support staff in higher education institutions (Walker and Saklofske, 2023; Hutchins and Rainbolt, 2016; Parkman, 2016; Hutchins, 2015; Clark, Vardeman and Barba, 2014), and cohorts of medical, nursing, and allied health care profession staff (Hutchins and Rainbolt, 2015; Henning, Ey and Shaw, 1998). I do nonetheless have reservations that measurement tools and scales cannot give a true sense of what it feels like to live with imposter syndrome. For example, a study with 135 participants by Kumar and Jagacinski (2006) explored the relationship between imposter syndrome and achievement goals through participant completion of the CIPS scale and tools relating to achievement goal theory. While the study found that imposter experiences in individuals ‘may be closely related to the goals they tend to adopt, and the structure of these goals may differ for men and women’ (p. 156), the ‘imposter fears’ (p. 156) were especially aligned to goal attainment, rather than the innermost imposter feelings of the individual.

Rather than being the construct of an individual, some researchers suggested imposter syndrome arose from either a pre-existing or newly arisen affective state such as anxiety, fear, or depression (Wilke, 2018; Cozzarelli and Major, 1990). A study undertaken with male and female marketing managers by Fried-Buchalter (1997) proposed imposter syndrome was a factor in ‘fear of success, fear of failure’ (p. 847) associated with anxiety and a lack of confidence. Using the HIPS Scale, the author noted that among both female and male managers, significant positive correlations were observed between fear of failure and imposter phenomenon, but fear of success was not related significantly to imposter phenomenon. Thompson, Foreman and Martin (2000) suggested perfectionist personality traits can springboard imposter syndrome but, in contrast,
Maehr and Zusho (2009), and Kumar and Jagacinski (2006), linked imposter syndrome with personal goal achievement, whether it was to display greater ability, or to learn and obtain mastery.

A significant area of continued research is around the context in which imposter syndrome develops. A doctoral study by Adiguzel (2021), for example, examined imposter syndrome in ten American nurse leaders (NL), and acknowledged that the 'backgrounds of each NL participant were helpful in promoting a deeper understanding of the meaning from which the experiences were derived or came from' (p. 33). Clance and Imes (1978) had proposed the origins of imposter phenomenon developed from early interactions within the family, and a study by King and Cooley (1995) of 127 undergraduates supported this premise, stating that a 'family environment which emphasizes achievement is associated with higher imposter phenomenon scores' (p. 308). Although this study had limitations as participants themselves subjectively rated the achievement orientation of their family, nonetheless family environment was denoted a significant factor in imposter syndrome experiences.

Gender role, racial, and class stereotypes have also been researched as areas in which imposter syndrome can develop from family of origin interactions. The initial work by Clance and Imes (1978) suggested that imposter syndrome typically presented in women, a premise supported by research such as Bell (1989) for example, who noted that primary school-aged girls are 'losing self-confidence, becoming extremely self-critical, and lowering their effort and aspirations in order to conform to gender stereotyped social expectations' (p. 119). Subsequent research had demonstrated, however, that its prevalence was just as frequent in men (Cokley *et al.,* 2024; Wilke, 2018; Cokley *et al.,* 2015; Clark, Vardeman and Barba, 2014; Kumar and Jagacinski, 2006), and while much early literature focused on women, a more recent systematic review found that:

> 'While women do suffer from imposter syndrome, half of the included studies that reported evaluating a gender effect found no difference in the rates of men and women suffering from imposter syndrome' (Bravata *et al.,* 2019, p. 1272).

Numerous studies have indicated imposter syndrome widespread among ethnic minority populations, significantly negatively correlated with psychological wellbeing, and potentially leading to anxiety and depression (McClain *et al*., 2016; Cokley *et al.,* 2013). Limitations were acknowledged in these studies, as 'few non-White individuals have been included in the samples used to standardize the assessment for impostor syndrome' (Bravata *et al.,* 2019, p. 1269) thus potentially discrediting study outcomes, and Cokley *et al.* (2024) suggested that although studies indicated imposter syndrome is experienced by people of colour, 'little research specifically focuses on racial and ethnic differences related to impostorism' (p. 47). Increasing research coming forward indicates that racial and ethnic differences do exist nonetheless, and sociocultural factors may create variances in the imposter syndrome experiences of different racial and ethnic populations (Bernard, 2024; Orbe-Austin and Orbe-Austin, 2024). More research is needed in these areas of diversity

and sociocultural contexts, as stated by Clance and Lawry (2024), and supported by the work of Cokley, 2024; Yafee, 2023; Bravata *et al.*, 2020; and Gottlieb *et al.*, 2020:

> ‘Reviews of 4 decades of subsequent research have underscored the powerful relationship between IP and sociocultural context’ (Cokley, 2024, p. 19).

One note of interest was the overall prevalence of imposter syndrome in the population, which varied considerably in literature, from 9% to 82% (Bravata *et al.*, 2020). This was probably a result of study recruitment strategies, such as population-based evaluations; the chosen assessment tool, for example, the Clance Imposter Phenomenon Scale (CIPS) (Clance, 1985a); researcher interpretation of specific assessment scores; publication bias potentially favouring positive findings (Bravata *et al.,* 2019; Chae *et al.,* 1995), and the impact of popular culture discourse. Cokley (2024) challenged the validity of some of the commonly referenced data put forward, for example, a journal article by Sakulku and Alexander (2011) estimated that 70% of people feel like an imposter, but the source of this figure was attributed to a short on-line article written by Gravois (2007) in the Chronicle of Higher Education and not an empirical study, thereby raising doubts as to its validity.

Critiques of the concept of imposter syndrome have arisen since 1978, for example, in a ‘fake it until you make it’ (Neville, 2024, Preface) attitude in the workplace. In the next section I briefly discuss some of the key critiques of the imposter syndrome concept that have developed.

2.5 Critiques of the Imposter Syndrome Concept

Clance and Imes (1978) first published on imposter phenomenon over 40 years ago, and the construct has become an increasingly popular topic. Approximately 150-200 internet articles are published monthly (Stone-Sabali, 2024); there is a growing scholarly interest; and an expanding discourse has arisen in popular culture, media, and dialogue (Cokely, 2024; Stone-Sabali, 2024). This increasing interest has, however, attracted criticism of the imposter syndrome concept itself.

The impact of sociocultural context now lies firmly within the debate (Clance and Lawry, 2024; Feenstra *et al.,* 2020), particularly around issues of racism and oppression. McGee *et al.* (2022) for example, in a study with 54 Black doctoral students in the engineering and computing fields, suggested strongly that institutional racism “takes a toll on their sense of belonging and acceptance as intellectually competent in comparison to White and some Asian peers” (p. 1). The authors go on to state that such students “experience racism marketed as imposter syndrome (syndrome meaning in their heads)” (p. 1), and their

imposter feelings are “peddled by campus administrators as a cover for racism, once again placing onus on students” (p. 1). Earlier work by Bernard, Jones and Volpe (2020), however, contradicted this view, and indicated that students of colour at higher education institutions attended by diverse racial and ethnic populations did experience imposter syndrome, despite the surrounding peer groups and environment. While both views have merit, I am wary of reducing imposter syndrome to racism or oppression as suggested by McGee *et al.* (2022), as I believe we could risk a cultural misattribution bias, and limit a wider understanding of human nature within different contexts.

Another major critique of the imposter syndrome concept is its position in relation to scientific theory. The concept had developed from Clance and Imes’ (1978) early clinical observations of high-achieving women, and Pauline Clance and colleagues continued the work through correlational and nonexperimental research. But such work could not be tested and verified as scientific theory. Cokley *et al.* (2024) nonetheless suggested that expanding narratives on the characteristics of imposter syndrome, and the increasing presence of academic literature on the subject, could be seen as establishing it as scientific theory. The authors argued that ‘Theories that are well-established and have contributed to scientific knowledge have been subjected to rigorous scrutiny’ (p. 48).

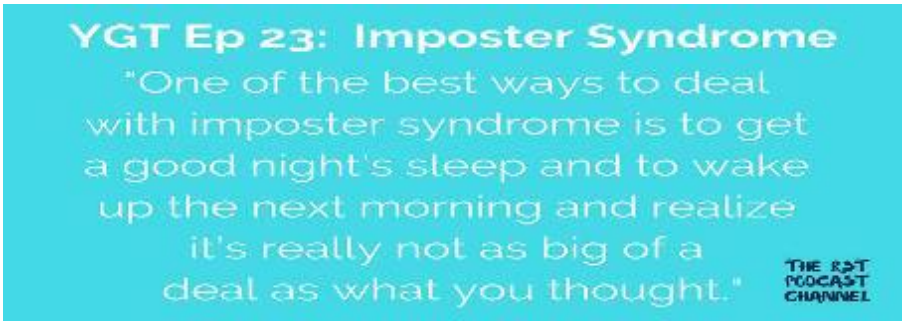
Against this backdrop, an extensive study by Leary *et al.* (2000) identified and tested three theoretical assumptions about imposter syndrome from existing descriptives: the sense that others see oneself more positively than merited; the fear that others will recognise fraudulence and view an individual as an imposter; and the difficulty in internalising success created behaviours supporting the imposter cycle (Appendix 1). Their research was shaped into three studies which covered each theoretical assumption, and the findings indicated that ‘behaviours attributed to imposters have a notable self-presentational element; people may respond in the non-enhancing manner characteristic of impostors because they believe such tactics will have interpersonal benefits’ (p. 751). In other words, individuals who experienced imposter syndrome may present themselves negatively to others in order to lower expectations; gain support; appear modest; or self-protect against failure. Leary *et al.* (2000) acknowledged the existence and modes of presentation of imposter syndrome in their study, but the findings did not support the presumed theoretical assumptions. As a result, a debate remains as to the theoretical structure of the imposter phenomenon construct introduced by Clance and Imes (1978), highlighting the need for further research to rigorously test its underlying assumptions.

Finally, work by Hugh Kearns (2015) had looked further into the source of imposter syndrome experiences and sought to uncover whether a more fundamental distinction

should be made within the imposter experience itself. He suggested that imposter *feelings,* which arose occasionally perhaps because of encounters with change or stress, are distinct from imposter *syndrome,* where a persistent and established awareness of imposterism was experienced. The nature of the imposter syndrome experience itself was thus challenged on whether imposter feelings are of the imposter syndrome construct, or of something else, such as a lack of confidence in a one-off situation or environment.

2.6 Imposter Syndrome in Popular Culture

Increasing scholarly interest in imposter syndrome is reflected in the rise of its significance in popular culture. Discussions about imposter syndrome are extensively featured in advice and self-help guides (Burford, Fyffe and Khoo, 2022; Kearns, 2015), podcasts (Cannon-Brookes, 2019; Linder, 2016;) and blogs (Thompson, 2016). In her podcasts on issues within higher education for example, Katie Linder recounts her own experience of imposter syndrome and lack of confidence, describing how she dealt with it using 'self-talk' (Linder, 2016, 3:06 min), and an approach as displayed in her podcast image:



In his blog '"I'm Not Worthy!" – Imposter Syndrome in Academia', Research Administrator Jay Thompson (2016) identified the elite and competitive sphere of academia as a significant reason why academic researchers can develop imposter syndrome. He then offered suggestions on how this condition can be overcome, or at least mitigated, through self-belief techniques, and productive relationships with colleagues. And entrepreneur Mike Cannon-Brookes of Australia, who refers to himself as the 'accidental billionaire', regularly shares on YouTube TED Talks his own experiences of imposter syndrome. In one TED Talk, he reflected that 'I knew I was an imposter' and that through an 'introspection of my own experiences', had realised that imposter syndrome 'doesn't go away with success' (Cannon-Brookes, 2019, 3:58 mins). Whether such media-accessed discussions and guidance give positive support or create challenges for individuals experiencing imposter syndrome is outside the scope of this study, but as discussed, sociocultural and media guidance on

managing imposter syndrome can be as interestingly diverse as self-talk; introspection of feelings; or a good night's sleep.

2.7 Imposter Syndrome and Clinical Educators

The intention of this research project was to advance understanding of the nature of the imposter syndrome experience in clinical educators, and the literature in this area is now considered.

A scoping review undertaken by Freeman *et al.* (2022) examined concepts of professional identity and imposter syndrome in clinical educators, and acknowledged that in a career move from a clinical to educator role:

> 'Healthcare educators' knowledge and skills in education and other relevant theories are often minimal, making them vulnerable to feeling fraudulent in the healthcare educator role. This threat and vulnerability is described as the imposter phenomenon' (p. 21).

The review further noted that the majority of literature focussed on the student transition experience from academia to the workplace, rather than the transition experiences of clinical professionals moving into educator roles. Indeed, they stated that 'imposter phenomenon is not being measured amongst healthcare educators' (p. 29), and concluded that there was 'a paucity of articles on the influence of imposter phenomenon on healthcare educators as they align their clinical and educator identities' (p. 30).

Issues around professional identity appeared in the literature to be significant to the clinical educator role. Highlighting that fewer clinicians are choosing to enter academia, impacting on undergraduate medical education, Browne and Collett (2023) focused on the formation of the medical educator identity. Emotional responses to that formation process were examined, the authors asserting that successfully establishing an educator identity was linked to 'greater role satisfaction, increased well-being and a decrease in feelings of imposterism' (p. 649). They concluded that 'becoming a self-identifying educator involves significant internal personal change' (p. 656). Lee *et al.* (2022), in their paper on nurse and other clinical educator roles, also acknowledged that commencement of such a role brought 'complex, emotion-laden processes' (p. 5), leading to challenges in professional identity where the individual is located between the clinical and educational arenas, and creating an experience 'associated with imposter feelings' (p. 6).

A later paper from Scheese *et all.* (2023) discussed practical strategies and processes, such as mentor guidance and awareness of organisational structures, to support the move from expert clinician to novice educator. They commented that 'imposter syndrome and loss of identity explain some of the struggles of healthcare professionals as they transition within various roles' (p. 146), but deeper examination into those feelings of imposter syndrome was not made.

Kalensky and Hande (2017) created 'A Blueprint for Success' to enable the novice nurse educator to utilise 'Ten Tips' (p. 433) to navigate the challenges of role change. The authors identified that 'the lack of nurse educators will exacerbate impending nursing shortages, yet graduate nursing education continues to ignore preparation for faculty roles' (p. 433), a point also made in the study by Browne and Collett (2023). Imposter syndrome was not mentioned by Kalensky and Hande, rather the authors suggested more vaguely that novice educators may lack the skills and knowledge required in the new role, leading to 'stresses associated with the academic role…resulting in difficult transitions that can lead to departure' (2017, p. 433).

The literature also offered personal perspectives about becoming a clinical educator. Grace Greenwood (2022) recounted her move from 'skilled practitioner to novice lecturer' (p. 2), and acknowledged such a move 'can lead to feelings that resonate with imposter syndrome' (p. 1). Interestingly, she suggested 'imposter syndrome can be a positive experience once you recognise that it is related more to owning and embracing oneself rather than an object to be conquered' (p. 3). Grace described using her imposter syndrome feelings as a tool for increased self-awareness, leading to strategies for management of her imposter syndrome feelings. Her perspective that the negative imposter syndrome narrative should shift to a more positive one, and could 'enable deeper self-awareness' (p. 1), has been strongly debated among some imposter syndrome researchers, with speakers such as Dr Valerie Young stating that 'this rebranding of imposter syndrome as a positive…is based on an incomplete understanding of how imposter syndrome shows up and what to do about it' (linkedin.com, 2024).

Similarly, Clare Blake in recounting her own clinical educator experience, advised novice educators that 'you will get imposter syndrome daily, so remind yourself you are amazing and you can do this' (2023, p. 27). This assertion suggested it was a transitory experience, especially in light of her subsequent advice that mentor support and being organised ensured 'you will feel much better the more you get into your new role' (p. 27). Such a view about imposter syndrome is in conflict with much of the literature by Clance and colleagues who position imposter syndrome as a long-standing and cyclical event (Clance and Lawry,

2024; Clance *et al.,* 1995; Clance and O'Toole, 1987; Clance, 1985a; Clance and Imes, 1978). Nonetheless, this view does resonate with Kearns (2015), discussed earlier, who drew a possible distinction between imposter feelings and imposter syndrome.

2.8 The Gap in Literature

It was my reflections on Ruth's feelings, as outlined in the Introduction chapter, which had led me to ask about the nature of her imposter syndrome experience and whether such experiences were shared by other clinical educators. The review of the literature on the imposter syndrome experience, and specifically that of clinical educators, demonstrated a lack of research in this area. While issues around emotional challenges and professional identity had been discussed, and personal or faculty strategies to enable transition from the clinical to clinical educator role suggested, the available literature largely concentrated on the *management* of imposter syndrome feelings. There appeared a gap in literature on exploring deeply, with individual educators, personal stories and sense-making of the feelings they had identified as their imposter syndrome. The research question and aim of this project were developed to enable exploration of that gap, and to advance understanding of the nature of the imposter syndrome experience in clinical educators.

2.9 Summary

In this chapter I have critically reviewed the literature on imposter phenomenon and imposter syndrome, and the terminology used. Concerns about the pathologising of the imposter phenomenon were discussed, and the debate around the inference of criminal fraudulence reviewed. Imposter syndrome research within a range of sectors, and varying stereotypes such as racial, gender and class, were examined and the use of measurement tools to identify the personal impact of imposter syndrome, such as the Clance Imposter Phenomenon Scale, deliberated. Critiques of the imposter syndrome concept were discussed, such as the focus being on the individual but not their environment, or whether imposter syndrome had positive benefits through enablement of deeper self-awareness. Challenges to the theoretical validity of the imposter syndrome concept were reviewed, and the position of imposter syndrome in popular culture and the media explored. The chapter concluded with a review of the literature on the relationship between imposter syndrome and clinical educators, acknowledged the lack of research in this area, and identified a gap in literature which this research project would address.

The following Chapter 3, Methodology, will consider the research methodologies selected for Study 1 and Study 2, and their appropriateness for this research project. Connectedness between the methods, research questions, and project design will be discussed, and the processes of participant selection, recruitment, data collection and management will be identified, leading to the Findings in Chapter 4.

Chapter 3 Methodology

3.1 Introduction

This chapter outlines the methodology used to explore imposter syndrome experiences following participant commencement of the clinical educator role. The research project is structured with two qualitative studies, both utilising a phenomenological methodology. The phenomenological research design reflected the probing nature I wished to take to enable an exploration of how individuals made sense of their lived experiences of imposter syndrome. British phenomenologist, Linda Finlay, stated that phenomenology 'is to return to embodied, experiential meanings aiming for a fresh, complete, rich description of a phenomenon as it is concretely lived' (Finlay, 2009, p. 6), and that was my objective. No theoretical lens would be used to view the Study 1 participants' narratives of their phenomenon of imposter syndrome, rather, interpretation of that phenomenon would give voice to the participant experience (Smith, Flowers and Larkin, 2022; Finlay, 2014; Smith, Flowers and Larkin, 2009). Such an approach would address the research aim of my project, and advance understanding of the lived experience of clinical educators who believed they had imposter syndrome.

3.2 Epistemological Framework

When I looked to the epistemological framework for this research, Robert Audi (2010) described epistemology as being 'concerned with how we know what we know, what justifies us believing what we believe, and what standards of evidence we should use in seeking truths about the human experience' (Audi, 2010, Abstract). To gather, justify, and evidence my knowledge of the lived experiences that participants believed to be imposter syndrome, this research project was positioned within an interpretivist paradigm. As a researcher I acknowledge that I have an interpretivist epistemology, or way of acquiring knowledge, and ontologically I believe that reality for my participants was created through their experiences and, therefore, multiple realities will exist. Each participant experienced imposter syndrome differently, based on their own reality, and as researcher I was interested in how these realities were individually experienced by the participants. I was interested too in how individual interpretations of their reality affected how they understood their world. I could only know the reality of my participants' imposter syndrome experiences through their subjective interview accounts, and the narratives they shared with me were the realities of their

interactions with the world around them. I rejected the positivist belief that reality is objective and measurable only through scientific methods; as an interpretivist I saw my participants as the experts of their own lived experiences of imposter syndrome. I sought to understand the subjective meanings that the participants attached to those lived experiences and had confidence that by 'giving voice' individually to each participant in Study 1 and Study 2 within the interpretivist paradigm, my knowledge of participants' experiences of imposter syndrome would be gathered, justified and evidenced. Bhattacharya (2012) identified understanding as centrally located within the interpretative stance, and this was the aim of the research, to advance an understanding of clinical educators' experiences of imposter syndrome.

3.3 Pilot Study

Before commencing Study 1, I conducted a small-scale, confidential, pilot study to explore the experiences of former colleagues who were aware of feelings of imposter syndrome in their clinical educator roles. The purpose of the pilot was to verify the study's research value, test the feasibility of phenomenology as a methodology, and identify any problems with a semi-structured interview design. I was looking to obtain rich responses from participants in this research project, and it was essential that my chosen collection tool produced a data quality that aligned with the research question and aim.

Former Clinical Development Team colleagues were confidentially invited, via email, to participate in the pilot if they were aware of imposter syndrome feelings in their role of clinical educator. Two participants volunteered to take part. Formed of a single, confidential, semi-structured interview, the pilot demonstrated that the process of enabling participants to uninterruptedly 'tell their story', produced significant and rich narratives. From this pilot, I was able to establish an estimate of the time and resources that would be required to interview, transcribe, and analyse the data. In addition, the pilot revealed that both participants had struggled significantly with their feelings of imposter syndrome, had never previously felt able to speak about these feelings, and interestingly, both found the interview process liberating and cathartic. The pilot study consequently built my confidence in the value of this research, in using phenomenology as the methodology, and in undertaking semi-structured interviews as the data collection method. I believe carrying out the pilot study prior to Study 1 demonstrated rigour and planning in this research project, minimised risk, and enhanced the overall quality of the research.

3.4 Sampling Strategy and Recruitment

Selecting the sample was a key element of my research design to ensure a clear audit trail from participant exchanges to study findings and conclusions, and as advised by Scott and Morrison (2006), the "methods used to select the sample will determine the nature and validity of the findings that are generated from the study of that sample" (p. 219). In my research there were three elements to be considered in the sampling strategy: the selection of participants from clinical educator populations who experienced feelings of imposter syndrome; the sample size was appropriate to the chosen methodology of IPA; and the method by which participants were recruited to the study. These three elements will now be discussed.

Firstly, I could not select participants through simple random sampling, that is, each member of the clinical educator population had an equal chance of being included in the sample, as I had no way of knowing who experienced imposter syndrome feelings. Participant selection therefore had to be designed to identify such a population subset to enable inclusion of information-rich participants (Gelo *et al.,* 2008; Stevens *et al.,*1993), in other words, it had to be purposive. To facilitate this purposive approach, I contacted clinical educator populations in a local hospital, a university, and across local community healthcare providers, and circulated the Research Study Information (Appendix 9). Because of the personal and confidential nature of imposter syndrome, identification of the population subset was only feasible when individuals contacted me subsequently to discuss their experiences of imposter syndrome. Inclusion criteria were participants who were registered health care professionals, were now in a clinical educator role, and believed they had imposter syndrome. Participants were excluded if they had previously worked with the researcher to remove the possibility of bias or influence on the study. I did not include a quota aspect to my sampling strategy, for example male/female ratios, because healthcare was still in the immediate post-Covid state and I feared that such a quota could limit potential participant recruitment opportunities. Rather, I chose to focus on a convenience sampling approach (Mears, 2012; Gelo *et al.,* 2008), that is, one that involved sample selection from the most easily accessible members of my target population. Sixteen applications were received from individuals interested in joining the study, 4 were later excluded, resulting in a sample of 12 clinical educators for Study 1.

Secondly, in terms of sample size Polgar and Shane (1995) suggested that "the optimum number in the sample depends on the characteristics of an investigation" (p. 47). Smith, Flowers and Larkin (2022) advised that for doctoral study using Interpretative Phenomenological Analysis, as in Study 1, a sample of 6-10 participants would be

appropriate. I chose to recruit slightly more than this to reduce the impact of possible participant withdrawal, and of the 12 participants originally in my sample, one hospital-based clinical educator did decide not to proceed due to post-Covid workload. The remaining 11 participants therefore formed the sample for Study 1, and I considered this number would allow flexibility should there be further participant withdrawal from the study.

Thirdly, participants were recruited to the study through self-selection, although I was aware that such a recruitment method was not without risk (Robson, 2002). The main disadvantage is that the sample may be unrepresentative, for example, distressing or emotive feelings about imposter syndrome may have prevented some individuals from coming forward to share their experiences in the study, thereby potentially skewing the results. Also, self-selection recruitment may over-represent strong feelings about imposter syndrome, possibly distorting conclusions.

Participant self-selection does nonetheless have advantages. The main advantage is high motivation which can result in quicker response times from deeply interested participants. Researching with participants who are committed to a study can also lead to improved data collection, enhanced data quality, and richer insights (Gray, 2004).

Participants who had contributed to Study 1 were able to be included in Study 2; all other individuals were excluded.

3.5 Participant Characteristics and Demographics

Eleven participants were recruited to the study, eight females and three males, aged between 24 and 49 years (Table 1). Each name was pseudonymised to ensure confidentiality. A descriptive summary of each participant can be found in Appendix 3, which was member-checked to ensure accuracy.

Table 1: Participant Characteristics and Demographics

Pseudonym, and Imposter Syndrome experience: New = N Existing = E	**Age, gender, and ethnic background**	**Years qualified as a healthcare professional**	**Time in CE role**	**Previous (or current part-time) clinical role**
'Annie' **E**	43 F Kashmiri/British	10 years	1 year	Acute Care Nurse
'Bridget' **N**	24 F British	3 years	2 months	Emergency Care Nurse
'Celia' **E**	46 F British	25 years	1 year	Registered Healthcare Professional
'David' **E**	44 M British	22 years	4 years	Emergency Care Nurse
'Eric' **E**	37 M British	4 years	6 months	Clinical Psychologist
'Fred' **N**	37 M British	12 years	1 year	Cardiology Nurse
'Ginnie' **N**	48 F British	24 years	1 year	Health Visitor And School Nurse
'Heather' **N**	48 F British	21 Years	18 months	Midwife
'Iris' **N**	39 F Indo-Caribbean/British	14 years	6 months	General Practitioner
'Jane' **N**	49 F British	27 years	18 months	Pharmacist
'Khloe' **N**	48 F British	27 years	1 year	Advanced Care Practitioner

3.6 Participant Interviews

With the permission of participants, I voice recorded the Study 1 and Study 2 interviews to enable me to completely focus on the interview itself without the distraction of note taking.

The Study 1 interviews were conducted either face-to-face or online. Despite reduced Covid restrictions in 2022, the aftermath of increased post-pandemic clinical workloads affected

opportunities for face-to-face interviews. Online interviews were offered as an alternative, and four participants chose this option. Study 1 comprised a single, semi-structured, interview, and mindful of the confidential and personal nature of the interview, the location of a face-to-face interview was decided by the participant. Seven participants met with me either in their own office, an open seated area within their workplace eg a café, or booked office space. I was also aware I was a lone worker, so ensured face-to-face interviews did not take place in participants' homes or a secluded location.

The Study 1 interviews took place over three months and ranged from 45 minutes to one and a half hours. After initial introductions I read a short pre-interview checklist (Appendix 4) to participants reiterating the purpose of Study 1. I re-checked consent to participation and reconfirmed the confidentiality of participation and that they could withdraw from the study at any time. I also acknowledged that talking about imposter syndrome may be a difficult, so referenced the Debrief Form (Appendix 5), and gave reassurance that the interview could be paused or stopped at any point. I then collected demographic details (Appendix 3, Table 1), and invited any questions before the interview commenced.

The Study 2 interviews were conducted over 10-weeks and online. As in Study 1, participants were assured of confidentiality, with each retaining the pseudonymised name used previously. At the start of the interview, participants were reminded of their right to withdraw at any time and also to let me know if they wished to stop at any point.

After the Study 1 and Study 2 interviews were concluded, I reflected on my method design. I believe my decision to undertake the semi-structured approach to the interviews was appropriate for both studies, as indicated in the earlier Pilot Study, and accurately reflected Vagle's comment that 'all interviews are treated as exciting opportunities to potentially learn something important…The goal is to find out as much as you can about the phenomenon from each particular participant' (2018, p. 87). The participants were the experts of their feelings of imposter syndrome (Smith, Flowers and Larkin, 2022), and my aim was to learn something important about those feelings.

3.7 Transcription

Interviews for Study 1 and Study 2 were transcribed immediately to ensure the detail was fresh in my mind. The phenomenological approach I had taken in this research required verbatim transcripts of participant interviews, recording all spoken words, but not necessarily rhythm and intonation. Unlike conversation analysis, it was the *content* of the narrative that

was being analysed and interpreted (Smith, Flowers and Larkin, 2022). I transcribed the voice recordings through headphones, to retain confidentiality.

3.8 Study 1: Rationale for Research Methodology

The literature demonstrated considerable debate amongst contemporary phenomenologists about the structure of phenomenology itself. Moran (2000) submitted that phenomenologists are 'extraordinarily diverse in their interests, in their interpretation of the central issues of phenomenology, in their application of what they understood to be the phenomenological method' (p. 3). For example, Giorgi (2008) sought to identify the vital and more general structures of a phenomenon; Dahlberg, Dahlberg and Nystrom (2008) and Ashworth (2003) explicitly focussed on the lifeworld where the human presence consisted of essential features; and others looked at the narratives emerging from data (Langdridge, 2008).

Reviewing the literature further for a research methodology that was a fit for what I wanted to achieve in Study 1 brought me into contact with the work of Max van Manen (2017) and Abayomi Alase (2017) on interpretative phenomenological analysis (IPA). Alase (2017) described IPA as giving 'researchers the best opportunity to understand the innermost deliberation of the 'lived experiences' of research participants' (p. 9), and van Manen stated the methodology brought forward the 'experiential concreteness, vividness, and descriptive detail' (2017, p. 810) of the lived participant experience. The work of Smith and Osborn (2003), Eatough and Smith (2006), Larkin, Watts and Clifton (2006), and Smith, Flowers and Larkin (2009) were notable here in their contributions to IPA, where the research approach gave voice to the claims and concerns arising from sense-making by participants, and the researcher contextualised and made sense, in turn, of those claims and concerns. The later work of Smith, Flowers and Larkin (2022) described IPA as involving a double hermeneutic where 'the researcher is trying to make sense of the participant who is trying to make sense of *x'* (p. 28). While IPA originated in psychology, its growing popularity within wider research areas had become apparent (Cronin-Davis, Butler and Mayers, 2009; Smith, Flowers and Larkin, 2009; Brocki and Weardon, 2006), and included broader health and social care settings (Maltby *et al.,* 2014; Clare *et al.*, 2008), social sciences (Mafura and Charura, 2021; Taylor *et al.*, 2020), and education (Noon, 2018; Creswell, 2012). These descriptions of IPA showed a correspondence with the epistemological stance of Study 1 where I wanted to take a knowledge making 'deep-dive' into participants' encounters with imposter syndrome. I believed IPA would enable that.

As a qualitative methodology, IPA has been structured upon three key philosophical areas: phenomenology, hermeneutics, and idiography (Smith, Flowers and Larkin, 2022). Phenomenology, as previously discussed, is the philosophical approach to the study of experience. First argued for by Husserl (1962), the approach is a form of inquiry which sought to examine experience in the way it arose, to 'go back to the things themselves' (Willis, 2001, p. 3). Developed as a counter to positivism and the application of science to human inquiry, phenomenology was the centre ground between the view that the world 'out there' is independent of human consciousness, and the belief that world reality was held as a mind construction (Willis, 2001).

Hermeneutics, the theory of interpretation, emanated most notably from the major work of the phenomenologist, Heidegger, in 1927. In 'Being and Time' (Heidegger, 2005), Heidegger argued that the outcome of an individual's phenomenological reflections were thoughts, discourses, and written texts. Interpretative action took place where the *thing itself* was presented to consciousness as a *named,* experienced thing. It cannot be the thing itself, rather it was expressed through the hermeneutic competences of the individual according to their terminology, and was influenced by values, culture, and world view. And this expression formed the concept of the 'hermeneutic circle' where 'to understand any given part, you look to the whole; to understand the whole, you look to the parts' (Smith, Flowers and Larkin, 2022, p. 22). Thus, the meaning of words in a narrative could only become clear within the context of a sentence, and the meaning of the sentence could only become clear within the cumulative meanings of the words, thus enabling interpretation. The constant shifting and movement between words and sentences facilitated close iterative analysis, leading to increasing understanding (Smith, Flowers and Larkin, 2022), and responded to the aim of this research project.

I appreciated that the hermeneutic approach of IPA differed from other hermeneutic methodologies in that, as the researcher, I was trying to make sense of my participant making sense of their imposter syndrome. Described as a 'double hermeneutic', I was aware that my sense-making was second order because I can only access 'the participant's experience through the participant's own account of it' (Smith, Flowers and Larkin, 2022, p. 29). The existence of the double hermeneutic was reassuring for me nonetheless as shifting and moving through participants' narratives ensured I was able to immerse myself in the analysis, and deeper engagement, of participant sense-making endeavours.

But hermeneutic interpretation, and thus IPA, is not without risk. The researcher tries to get close to the personal world of the participant, to obtain an 'insider perspective', but this cannot be entirely achieved because, clearly, the researcher is not the participant. A

relationship between researcher and participant is inevitable due to the close nature of the methodology, and interpretation of the hermeneutic of the participant is complicated by the personal preconceptions, knowledge, and experiences of the researcher (Smith, Flowers and Larkin, 2022; Finlay, 2014; Cronin-Davis, Butler and Mayers, 2009; Smith, Flowers and Larkin, 2009; Smith, Jarman and Osborn, 1999). While *a priori* knowledge, assumptions, and experience of the research phenomenon are expected to be 'bracketed', or put aside (Neubauer, Witkop and Varpio, 2019; Gearing, 2004), within a phenomenological framework, Smith, Flowers and Larkin (2022) suggested there should be a rethinking of the relationship between interpretation and the *a priori* 'fore-structure of our understanding' (p. 20). We should rather embrace the dynamic relationship which develops between fore-understanding and the phenomenon. Being unable to completely 'bracket-out' researcher experiences and knowledge should not be considered an obstacle to interpretation but rather, proposed Smith, Flowers and Larkin (2022), an enabler of rich, reflexive research.

The third major philosophical influence of IPA is idiography, or commitment to the particular, and comprises two levels of involvement. Firstly, IPA is pledged to the thoroughness of detail, the depth of analysis. Secondly, 'IPA is committed to understanding how particular experiential phenomena (an event, process or relationship) have been understood from the perspective of particular people, in a particular context' (Smith, Flowers and Larkin, 2022, p. 24). The detailed examination of the lived experience is revealed in its own terms, not from a broad-spectrum base. In this research project the focus on individual experiential meaning, drawn from a small participant sample selected from closely defined settings, enabled IPA to deliver the means by which the research question and aim of this project could be addressed.

As a research methodology IPA is not without controversy, however. Sousa (2008) argued that IPA 'presents its theoretical basis in two pages' (p. 149) and Giorgi (2010) contended that 'The originators of IPA have given no indication as to how their method is related to philosophical phenomenology' (p. 6). Contesting these views, Alase (2017) stated that 'a qualitative approach like IPA is equipped with all the necessary tools and mechanisms needed to conduct a rich and 'thick descriptive' research study' (p. 13). And Smith had earlier proposed that 'two theoretical touchstones' (1996, p. 263) were centred in IPA – phenomenology, which explored in detail how individuals made sense of their lived experiences, and symbolic interactionism whereby individuals 'assign' (p. 263) meanings to interpreted events.

Reynolds (2003) warned that the iterative nature of IPA could risk the study not achieving a definitive conclusion or convincing end point, and the data collection process itself, whereby

the researcher sought to engage in close connection with participants, may also be hindered. Indeed, as discussed earlier, I experienced a disruption myself during the Covid pandemic restrictions. Such hinderances could negatively impact on the relationship between researcher and participant, with the result that data interpretation may reflect more of the researchers' worldview than that of the participant. Despite these considerations, I was confident that IPA was the appropriate methodology for Study 1.

3.8.1 Method

The methodological commitment of IPA to the understanding of sense-making steered both the design of the research method and the subsequent interpretative approach to data analysis. The data collection method chosen for Study 1 was semi-structured interviews, a method that 'will invite participants to offer a rich, detailed, first-person account of their experiences' (Smith, Flowers and Larkin, 2022, p. 53), and as the authors further explained, 'participants should have been granted an opportunity to tell their stories, to speak freely and reflectively, and to develop their ideas' (p. 53). The flexibility to speak freely and reflectively was a cornerstone of IPA, which sought to facilitate understanding of how individuals made sense of significant life experiences. Kvale and Brinkmann (2009) commented that semi-structured interviews were 'particularly suited for producing knowledge grounded in the interviewees' own perspectives' (p. 27), and Eatough and Smith (2008) underpinned their appropriateness to IPA by observing that this method 'enables participants to offer rich, first-person accounts of their experiences', which can then be interpreted in depth (p. 182). For these reasons, I judged semi-structured interviews the most fitting method for empowering participants' sense-making of their imposter syndrome experiences in Study 1. The interviews were structured around a single question, 'Can you tell me about your imposter syndrome experiences as a clinical educator?', and participants were asked to speak freely about their imposter syndrome experiences in their role of clinical educator. There were no interruptions from myself during the narrative.

I was aware the presence of a recording device may impact on speaking freely, especially on such an emotive and personal topic. Participant awareness of a recording device 'is often deemed to have a detrimental effect on the 'authenticity' or 'naturalness' of the data collected' (Speer and Hutchby, 2003, p. 315), and while all participants gave permission for its use, I have no way of knowing whether there was a detrimental effect on the data collected.

3.8.2 The Diary Process

Participants were asked to keep a reflective diary over three months, documenting any imposter syndrome experiences, thoughts, or feelings. Three participants did not submit entries, which may reflect the burden of diary-keeping, emotional discomfort, or an absence of relevant experiences, an issue noted by Lee (1993) in relation to sample attrition. Conversely, two participants reported they found the diarising process cathartic and beneficial. Diary data, when analysed alongside interviews, offered a complementary chronological perspective, enriching the overall narrative and forming what Vagle (2018, p. 109) termed ‘gathering moments’. As Elliot (1997) suggested, diaries promote participant reflection and capture experiences close to their occurrence, enhancing depth, immediacy, and data integrity.

3.8.3 Data Analysis

The analytic focus of IPA in Study 1 was the participant’s attempt to make sense of their personal experiences of imposter syndrome. I was not aiming to uncover the frequency or regularity of a particular imposter syndrome experience, but to ‘learn something about the participant’s lived experience’ (Smith and Osborn, 2015, p. 38). It was necessary, therefore, that I establish an ‘interpretative relationship with the transcript’ (p. 38) to reveal those meanings.

Based on the idiographic steps of the IPA model outlined by Smith, Flowers and Larkin (2022), the framework of the data analysis was as shown in Table 2 below, and I had confidence this framework would enable me to uncover meaning in the transcripts. IPA uses a structured analysis model whereby participant data is continuously read, re-read, and reflected on, forming a constantly developing analytical cycle. The processes of the model are applied flexibly to the data, are not prescriptive, and form ‘an iterative and inductive cycle’ (Smith, Flowers and Larkin, p. 75) led by the analytic focus.

Table 2: Framework of the IPA analysis process (based on Smith, Flowers and Larkin, 2022)

Model Step	**Activity**
STEP 1: Reading and re-reading of participant narrative	Engage with transcribed narrative, world of participant, and their experience of imposter syndrome.
STEP 2: Exploratory noting	Familiarity with transcript, note language, search for key objects of concern, note meanings for participant. Unstructured commentary and detailed observations on data. Transcript page numbers and timings noted for cross referencing and checking throughout the analytic process.
STEP 3: Constructing Experiential Statements	Analytic shift working with exploratory notes, produce concise 'experiential statements' relating directly to participants' experience of imposter syndrome sense making. A synergistic process of description and interpretation.
STEP 4: Searching for connections across Experiential Statements	Map how experiential statements fit together, identify interesting significant aspects of participant's account. Construct a patterning of experiential statements to show interconnections reflecting participant experiences and world re research questions. Form groupings of connected clusters.
STEP 5: Naming the Personal Experiential Themes (PETs) and consolidating and organising into a table	Name experiential statement clusters to describe characteristics, and create Personal Experiential Themes (PETs). Create table to show named PETs, experiential statement clusters, experiential statements (with transcript page numbers) and key transcript phrases.
STEP 6: Continue with individual analysis of remaining participant narratives	Move to narrative of next participant to repeat analytical process, continuing double-hermeneutic approach of researcher making sense of participant making sense of their experience of imposter syndrome. Important to treat the next case on its own terms, as a complete entity, to allow new analytic structures to emerge.
STEP 7: Working with PETs to develop Group Experiential Themes (GETs) across all participant narratives	Look for similarities or differences across the PETs to create sub-themes and overarching Group Experiential Themes. Constantly referencing back to PET clusters, experiential statements, exploratory notes, and transcripts to ensure analysis has a creditable interpretative and evidenced based foundation.

The narrative of each individual participant was analysed in depth to uncover their key objects of concern or interest, in other words, their sense-making of the imposter syndrome experience. Following the 7-step IPA model above (Smith, Flowers and Larkin, 2022), each transcribed narrative was read and re-read (Step 1), a process that continued throughout analytical activity, and exploratory noting undertaken. Exploratory noting (Step 2) identified

descriptive elements in the narrative, such as places, events, language, and developed out of the participant's concepts of their imposter syndrome.

Construction of experiential statements (Step 3) required an analytical shift from directly working with the transcript to working mainly with my exploratory notes. This led to consolidation and interpretation of a large data set into statements that related directly to the participant trying to make sense of their experience of imposter syndrome, as shown in the extract from 'Ginnie' (Appendix 6a).

Searching for connections across those experiential statements formed the next step (Step 4, Appendix 6b). By printing out the individual experiential statements onto slips of paper, I moved them around the table searching for patterns or matchings. Clusters, or groupings, of connected and interconnected statements were interpretatively formed, and I found this both a creative and enlightening process as there was no prescribed or correct way to do this. Rather, I needed to be open to the material in front of me, examine the experiential statements for different possible connections, and allow their interconnectivity (or divergence) to become evident. Throughout this process, I actively recalled each participant individually, and their personal narrative of experiencing imposter syndrome, reaffirming my concentration on them solely.

The two sub-questions framed to address the aim of this thesis (Section 1.2) guided cluster formation, and I looked to draw together the most interesting and relevant aspects of my participant's narrative in response to them. For example, with Ginnie (Appendix 6b) the first cluster of experiential statements were grouped together because they related to previous positive, and negative, role experiences in clinical settings. The next cluster related to Ginnie's feelings about being in a team, and the following statements were linked because they showed Ginnie's thoughts around professional identity and responsibility. The final cluster drew together the associations Ginnie made between her experience of imposter syndrome and role. Not all of Ginnie's experiential statements were integrated into clusters, however. Singular content statements were retained separately in my working papers, so I could re-visit their relevance or importance, if required, during subsequent analysis.

In Step 5, each of the clusters of experiential statements were named according to its characteristics or features, to create the participant's Personal Experiential Themes (PETs). The PETs related directly to the participant's own experience of sense-making of their imposter syndrome and reflected 'analytic entities present within the transcript as a whole' (Smith, Flowers and Larkin, 2022, p. 94). A table was produced of the PETs for each participant, where each experiential statement was noted with the page number from the transcript to enable location in the narrative, thus contributing to rigour in research evidence,

and supporting the interpretative and analytic process which had taken place (Appendix 6c, Ginnie).

Step 6 of the IPA model was the continued individual analysis of other participant narratives through Steps 1-5. At this point I was especially aware of my position as researcher engaged in the interpretative double hermeneutic of this analytic process. During the process of analysis my hermeneutic 'fore-structures' (Smith, Flowers and Larkin, p. 99) borne from engagement with each of the participants' narratives would inevitably change. The fore-structures, or prior knowledge, experiences, and assumptions, were my carried-forward awarenesses of participant data previously analysed. The philosopher Heidegger proposed that 'Whenever something is interpreted as something, the interpretation will be founded essentially upon the … fore-conception' (Heidegger, 2005, pp 191). To maintain the idiographic nature of IPA, it was essential I approached and analysed each participant case on its own merits, holding to its individuality and uniqueness. Smith, Flowers and Larkin (2022) cautioned that 'you will inevitably be influenced by what you have already found' (p. 99) but judged that thoroughly following the 7-step IPA model would ensure a rigour, enabling individually personalised data to emerge for each participant. I therefore put my trust in this process.

In Step 7 I looked for similarities and differences between the PETs of each participant, and through continued cross-case analysis, created group sub-themes leading to Group Experiential Themes (GETs). The GETs identified shared and distinctive characteristics within participant transcripts, and while discussed individually, represented the wider context of the participants' narratives and their interconnectedness. All the GETs were thus clearly evidenced by the data, which could be traced backwards and forwards, and will be discussed in Chapter 4, Study 1 Findings.

3.9 Study 2: Rationale for Research Methodology

In response to the findings and hypothesis of Study 1, the purpose of Study 2 was to enable participants to engage with those outcomes and give opportunity for their right of reply. Study 1 brought forward emergent themes around relationships with others; the challenges of dual professionalism; and meaningful recollections, and these were recognised by participants to be significant to, and a source of, their feelings of imposter syndrome. Subsequent interpretative activity, including a focussed literature review, had prompted engagement with existing theory, and Duchscher's Stages of Transition Theory and transition shock model (Duchscher, 2012; 2009; 2008) had suggested an hypothesis that

participants' imposter syndrome experiences may more closely align with the characteristics of transition shock.

I am aware, however, that I had used the term 'hypothesis' to describe the inductive phenomenological statement created from integration of the Study 1 findings and Duchscher's transition shock model (2009). While more generally associated with quantitative research where testable predictions are put forward about the relationship between a set of events (Blackburn, 2008; Polgar and Thomas, 1995), in my thesis I chose to use hypothesis as a metaphorical proposition. Structured in this manner, hypothesis was inductive in nature, derived from the emergence and interpretation of the lived experience of the participants, and created from the Study 1 findings overlain with the transition shock model. Its purpose was to offer a potential rationale for the imposter syndrome experiences described in Study 1, and was both data-driven from the rigorous IPA analytical process (Smith, Flowers and Larkin (2022) and theory-supported by Duchscher's transition shock model (2009). Further, I believed that presentation of the statement as a metaphorical hypothesis offered a provocation to the participants in Study 2, and by inviting them to re-evaluate their imposter syndrome experiences, challenged their assumptions and beliefs about those experiences. It was important however that the methodological approach for Study 2 enabled the participant responses to the hypothesis to be accurately and meticulously obtained, and so build on my knowledge and understanding of the participants' imposter syndrome experiences.

When I considered the methodological approaches for Study 2 my initial thinking was to undertake a questionnaire-based method, via email. By presenting some background information and the hypothesis to participants, I would ask for their responses in light of their current feelings. I very quickly dismissed this approach however, for several reasons. Firstly, I would be removed from face-to-face conversations and personal interactions with the participants. I had enjoyed this immensely in Study 1 as it enabled me to listen closely to, and also record, the individual participant narrative, which facilitated my interpretation of their meanings. I therefore believed my analysis of questionnaire responses would be limited because of the 'constrained and pallid nature of the questionnaire "conversation"' (DeRosia and Christensen, 2009, p. 15).

Secondly, a questionnaire-based method would rely on a brief presentation of background information and the hypothesis before asking for a response, but there would be no mechanism for the participants to clarify any points or queries they may have. As a result, participant responses may be limited in detail or, and perhaps worse, the questionnaire

information and hypothesis may be misinterpreted resulting in responses not appropriate to Study 2.

Thirdly, in face-to-face conversations, the participants would engage in verbal and non-verbal interactions with myself as researcher, and I would be aware of the care and thoughtfulness they are giving to their conversation with me. In questionnaire completion, however, I would be unable to determine the level of conscientiousness applied to forming a response to the hypothesis, with the risk that their response was haphazard or not thorough.

And finally, asking for a response to the hypothesis could possibly require a lengthy written answer from some participants in a free-text questionnaire design, which may be daunting. But the alternative response design of specific questions may be too restrictive, and not capture the individual experiences of each participant, thereby limiting the data available to Study 2.

Reflecting on this approach led me to acknowledge that it was necessary for me to meet with the participants, and present the background information and hypothesis, face-to-face. Only by taking this methodological approach would I be able to capture rich data, and develop a true sense of the participants' thoughts and feelings on the hypothesis proposal. I reviewed the research literature and considered a structured interview with participants (Mears, 2012). While this method would provide a way for me to 'journey into another's perspective about a circumstance or event' (p. 24), I believed that the interview process itself would still constrain, even with open-ended questions, the unhindered flow of personal narrative-telling I found so fruitful, and engaging, in Study 1. Stepping back from my methodological search, I could see that I had an hypothesis that I wanted to 'test' with participants, I wanted to obtain their thoughts and feelings about it and, through analysis of their responses, determine whether the hypothesis was accepted or rejected. I had taken an inductive research approach in Study 1 whereby data relevant to the imposter syndrome experience of clinical educators had been collected, analysed through IPA, and resulted in the propositions forming the hypothesis. In Study 2, however, the approach needed to be reversed – I was starting with the hypothesis drawn from the work of Duchscher (2012; 2009; 2008) and my own findings, and wanted to review its implications with the participants. In other words, I wanted to take a deductive approach.

The literature indicated a growing awareness of the value of using a deductive approach when testing or confirming the outcomes of an earlier related qualitative data analysis (Bingham, 2023; Bingham and Witkowsky, 2022; Gilgun, 2014; DeRosia and Christensen, 2009; Perry, 1998), and as suggested by Azungah (2018):

> ‘The deductive and inductive approaches provide a comprehensive approach in analysing qualitative data’ (p. 383).

Gray (2004) had taken this view earlier, commenting that where a first study is ‘purely inductive or exploratory, starting from no theoretical position’ (p. 126), using a subsequent ‘deductive, or at least confirmatory, approach’ (p. 126) is valuable if the original data contradicted what was expected. This was my position; I had not expected the findings of Study 1 to suggest participants may have experienced transition shock instead of imposter syndrome.

As in Study 1, I wanted the participants in Study 2 to have the opportunity to share personal thinking, feelings, and understandings of their lived imposter syndrome experiences, but now in relation to the hypothesis. I therefore felt it essential to retain the phenomenological stance to the deductive analytical approach of the study, allowing participants to freely give their own story and responses to the hypothesis, and thus forming a relationship between the inductive and deductive approaches in the thesis. Following my reflection on alternative methodological approaches for Study 2, I was therefore reassured that undertaking a deductive phenomenological analysis approach in Study 2 was appropriate.

3.9.1 Method

The purpose of Study 2 was to test my hypothesis:

> On moving from the clinical to clinical educator role, participants may have experienced transition shock rather than imposter syndrome.

In contrast to the purpose of the Study 1 interviews, the Study 2 method of data collection required participants to give a response to the hypothesis in relation to their own experiences of imposter syndrome. Reviewing the research literature I did consider the structured interview method, but felt that the inability for me to ‘provide information beyond what is scripted’ (Conrad and Schober, 2008, p. 173) would stifle knowledge production arising from my discussion with participants. I wanted to hear the participants’ freely given reflections about the hypothesis, I did not want ‘passive recordings of people’s opinions and attitudes’ (Brinkmann, 2018, p. 579) as I felt that to be at odds with the phenomenological stance of this research project. My review of the semi-structured interview method indicated it would enable me to focus conversation on the important issue in relation to Study 2, that is, the participants’ response to the hypothesis:

> ‘It [semi-structured interview] is defined as an interview with the purpose of obtaining descriptions of the life world of the interviewee in order to interpret the meaning of the described phenomena’ (Brinkmann and Kvale, 2015, p. 6).

I designed a short semi-structured interview questionnaire comprising 5 questions which focussed in two areas (Appendix 7). Questions 1 to 4 referenced the participants’ own experience of imposter syndrome over the previous two years, reflected back to their feelings at our first interview, and enquired into any changes to, or influences on, their feelings since then. The purpose of this approach was to enable participants to recall their imposter syndrome journey at, and subsequent to, our first interview, and to support their contextualisation of current imposter syndrome experiences against my hypothesis.

Question 5 focused on the hypothesis. I read out a short document giving the rationale behind development of the hypothesis from the findings of Study 1 (Appendix 8), referencing the theoretical concepts of imposter syndrome (Clance and Imes, 1978; Clance, 1985a) and transition shock (Duchscher, 2008; 2009; 2012). Each participant was invited to reflect on the question: ‘Having discussed the hypothesis from Study 1, I am wondering what this could mean for you. Are you able to tell me what you feel about my hypothesis in relation to your own imposter syndrome experiences?’. This single, open-ended question enabled participants to evaluate their previous self-perceptions and articulate how the concept of transition shock now resonated with their personal experiences, initially believed to be imposter syndrome. The data collection method thus adopted a funnel approach to the interview process: building trust, a researcher-participant relationship, and presenting scaffolded questions in an unbiased manner (Azungah, 2018), thereby leading participants to the focus of the hypothesis question.

I was aware, however, of the potential influence and bias I may have introduced in the deductive framing of interview Question 5 (Appendix 6). Participants were presented with the concept of transition shock and the hypothesis following discussion of their previous and current imposter syndrome experiences. When I reflected subsequently, I acknowledged a risk that I led them, albeit unintentionally, towards the reframing of those experiences as transition shock. To counter this I had consciously presented the background and evidence for my hypothesis in as neutral a manner as possible by the reading of the discussion document (Appendix 8). The hypothesis was presented at end of the interview, and I later reflected that the introduction of an element entitled ‘an hypothesis’ may have skewed its message, with participants viewing the Question 5 as academically weighted, and perhaps nudging them towards a more affirmative response. This was a concern as Study 2 was deliberately positioned within a phenomenological framework and was supported by an

interpretivist constructivist stance. Further, by introducing the previously unknown concept of transition shock, there may have been fragmentation of the participant sense-making which had earlier arisen from Questions 1 – 4, creating feelings of bewilderment or confusion. A final risk may have been that participants felt some level of pressure to respond in favour of the hypothesis as they were aware it formed the outcome of my EdD work.

I was therefore subsequently relieved by the participants' responses which ranged from full acceptance of the transition shock hypothesis, to rejection in favour of imposter syndrome, and to a cross-over position that sat somewhere between the two. From this mixed outcome I was reassured that participants felt able to respond freely to Question 5 through critical engagement with the presented material and hypothesis, which built trustworthiness in the interview outcomes of Study 2.

3.9.2 Data Analysis

The data for Study 2 was analysed using a deductive phenomenological approach, led by the hypothesis which emerged from Study 1: 'On moving from the clinical to clinical educator role, participants may have experienced transition shock rather than imposter syndrome'. All interviews were audio-recorded and transcribed verbatim by the researcher. No qualitative data analysis software was used, instead the analysis was conducted manually, using printed transcripts, highlighters, and annotated notes in the margins. This process allowed for close, repeated engagement with the text and fostered an in-depth understanding of each participant's narrative (van Manen, 2014). Responses to the hypothesis question were considered both individually and across cases, and a deductive analysis of the data undertaken. Where participants reflected and agreed their Study 1 experiences were transition shock, rather than imposter syndrome, this was noted as acceptance of the hypothesis. Where participants continued to identify with imposter syndrome, or introduced the experience of hybrid feelings across both imposter syndrome and transition shock, this was noted as rejection of the hypothesis.

The deductive phenomenological approach allowed the hypothesis to act as a provocative lens, invited participants to re-evaluate their imposter syndrome experiences, and challenged their assumptions and beliefs. In doing so, the method supported rich, reflective data and offered deeper insight into how the participants understood their clinical educator transition experiences in relation to transition shock.

3.10 Ethics

Ethics approval for Study 1 was granted by the University School Ethics Committee (Ref: RECEDU 00053); the University Research Ethics and Integrity Sub Committee (Ref: UREISC 20/21-10); and the Integrated Research Application System (IRAS) of the NHS Health Research Authority (Ref: IRAS 296363). After receipt of ethical approvals, local Research & Development and Nursing & Midwifery gatekeeper permissions were obtained from the hospital to allow me to work with Clinical Educator staff.

Studies into emotive or sensitive topics, such as imposter syndrome, may deter potential participants (Crowther and Lloyd-Williams, 2012). To enhance information and assurance, potential subjects were given both written and verbal study information on several occasions: during recruitment advertising, and prior to consenting and interviews. The Participant Information Sheet (Appendix 9) was discussed to enable informed choices about participation. All participants acknowledged that the interview and diary completion could raise emotive feelings, but were happy to proceed. A Debrief Form (Appendix 5) was forwarded to participants giving information on external organisations should they require support. I also discussed with my supervisors that, should any form of concern for my own emotional well-being arise during the study, I would confidentially discuss the issues with them.

To commence recruitment, I linked with the hospital's Lead for Research in Nursing who had offered to email my Research Study Information sheet (Appendix 2) to clinical education managers for dissemination. The document outlined the proposed research study, and asked potentially interested participants to contact me confidentially via email for more information. I had previously planned a series of Open Discussion Q&A Meetings with clinical educators from the speciality teams to give details of the study. Unfortunately, the ongoing Covid 19 pandemic situation restricted me to email. No personal data was collected at this stage, and no incentives or inducements were given to participants before, during, or after the study.

Due to significantly increased workloads following the Covid pandemic, and staff sickness, it soon became apparent that I could not recruit sufficient participants solely from hospital staff. Following University ethical amendment (Ref: RECEDU 00053a; Appendix 10), I broadened recruitment to other areas where clinical educators were employed, remaining in alignment with my inclusion/exclusion criteria other than job location. As a result, only 2 of the 11 participants recruited worked in the hospital (Appendix 3).

When potential participants contacted me, I forwarded the Participant Information Sheet, and the Consent Form for their review (Appendices 8 and 11), and offered the opportunity to discuss further online. Participants were also asked to keep a diary for 3 months, so I also forwarded Guidance on confidential collection/storage of the diary entries (Appendix 11); and gave information about recording of the interview. Following ethical guidelines, a 'cooling-off' period of 7 days after consenting was given to participants.

Study 2 required a further full University ethics approval as the original application (Appendix 10) did not include a second study. The ethics application was granted (Ref: ETH2324-0342), and focused on participant recruitment to test the hypothesis. I contacted the original Study 1 participants and asked whether they would be willing to engage in a second interview at which an hypothesis arising from Study 1 would be discussed. I deliberately chose not to give participants any indication of the hypothesis at this stage to avoid any bias or pre-thinking prior to interview. Of the 11 Study 1 participants involved two years earlier, I successfully contacted 8 individuals (73%) who agreed to participate in a second interview, and completed the Participation-Consent Form. Within this grouping of 8, 6 had entered Study 1 with new experiences of imposter syndrome that arose on starting the clinical educator role, the remaining 2 participants had entered with long-standing imposter experiences. A Debrief Form was forwarded to interview participants, as in Study 1 (Appendix 5), because I was asking them to articulate perhaps uncomfortable, deep feelings and understandings about their imposter syndrome experiences. In addition, I checked with participants during the interview to ensure they were happy to continue, which ensured I was not relying solely on my own perceptive awareness.

One further point should be noted, however. As a result of the Study 1 findings leading to Study 2, and the final conclusions, the original thesis title was no longer an appropriate description of the thesis content. The title was therefore amended before submission, but the research documentation in the appendices retained the original title to accurately reflect its presentation at point of use.

3.10.1 Consent and Confidentiality

Given the human focus of this research, ethical standards were rigorously upheld (Arthur et al., 2012) in Study 1 and Study 2. Recognising the sensitive nature of discussing imposter syndrome, participants were fully informed of their right to withdraw at any time. Voluntary, informed consent was central to the study (Fleming and Zegwaard, 2018; Arthur et al., 2012). This was gained through verbal and written processes (Appendix 12), and pre-interview discussion, to ensure participants understood the study's purpose, process, risks,

and their role. An ‘opt-in’ approach was adopted, and all study materials were designed to be clear and robust. To be valid, consent required participants to: (1) have capacity, (2) understand the research, (3) comprehend any risks/benefits, and (4) make a free, unpressured decision (Allmark et al., 2009). While participants were known to me, their identities were protected through pseudonymisation. Pseudonyms were applied to all documents and data sources, and will be used in any dissemination. Contact details for the University’s Data Protection Officer were provided to participants for any data concerns.

3.10.2 Burdens, Risks and Benefits

Study 1 required time commitment from participants of a 1–2 hour semi-structured confidential interview and diary-keeping for three months. Given the deeply personal nature of imposter syndrome, emotional risks were acknowledged as interviews and diaries encouraged reflection on potentially uncomfortable experiences. Participants were regularly reminded of their right to withdraw. Notably, four participants later described the process as a positive, reflective experience.

Study 2 required time commitment from participants for a single semi-structured confidential interview, including listening and responding to, my reading of the discussion document (Appendix 8) and hypothesis. I was aware the hypothesis, which suggested participants may have experienced transition shock rather than imposter syndrome, could create potential emotional risks arising from such a change of perspective. Additionally, the interview could visit, or revisit, uncomfortable imposter syndrome experiences. Debriefing opportunities were provided throughout, and participants were regularly reminded of their right to withdraw at any time if they wished.

At the end of the interviews for each study participants were thanked for their voluntary involvement, and for their open and honest contribution to advance the understanding of imposter syndrome in clinical educators.

3.10.3 Conflict of Interest

My interests as a researcher were not in conflict with my duties as a health care professional as I am now retired from my former role in the NHS.

3.10.4 Data Management

The data obtained from Study 1 and Study 2 was identified, pseudonymised, held, and fully backed-up, on university encrypted OneDrive files. Versioning of data and documents was through numerical, date and pseudonymised labelling. Data leakage was assessed low risk by the University ethics process. Hard-copy files were locked securely in my personal University Graduate Centre (UGC) cabinet. Data analysis took place on private desk space in the UGC using a password protected OneDrive computer.

Pseudonymisation: pseudonymised data, where no personal information is included, was used throughout the research project. I used an alphabetical naming system for participants, Annie, Bridget, Chloe etc, and this was entered on Participant Information Sheets (Appendix 9) and Consent Forms (Appendix 12). Interview notes, audio recordings, all study documentation, and interview/diary transcriptions were also labelled with these pseudonymised names, and stored on my university OneDrive account.

Email contact: participants had the option to use either their work or personal password protected computer to facilitate study set-up, respond to or raise queries, and send diary entries.

Interviews: Face to face and online interviews were audio recorded, following consenting, on a hand-held voice recorder. The recordings were pseudonymised to ensure accurate identification and participant confidentiality, saved in pseudonymised .mp3 format, and securely uploaded to my account on the encrypted and password protected University OneDrive system. When not in use, the voice recorder was stored in my locked cabinet in the Graduate Centre of the University, entered by keypad admittance.

Diary management: the pseudonymised diaries were managed by participants. Data management guidance was given to participants at recruitment (Appendix 11).

The data gathered during this research project may be used for future journal articles and conference presentations and the same levels of confidentiality, privacy and pseudonymity will be applied. The data may be kept for up to ten years after completion of the thesis, as per university requirements. After this period, all data will be destroyed. This information was included in the Participant Information Sheet (Appendix 9).

3.11 Summary

This chapter has outlined the methodological approaches used in this research project, which was structured using two studies, and explored the imposter syndrome experiences of clinical educators. In Study 1, IPA investigated the participants' personal, and individual, experiences of imposter syndrome following commencement of the new role. IPA's inductive approach allowed for a deep-dive into the imposter syndrome experiences of participants, and provided rich insights into how they made sense of their feelings.

From the findings of Study 1 the suggestion emerged that the participants' imposter syndrome experiences may better align with transition shock, rather than imposter syndrome. This led to the formulation of an hypothesis that the feelings initially described by participants may have been transition shock rather than imposter syndrome.

To test this hypothesis participants were invited to engage in a second interview, which formed Study 2. Deductive phenomenological analysis was the chosen methodology and at interview participants considered the hypothesis, and what it could mean for them. Through this reflective interview, participants offered insights into how transition shock theory resonated with, or diverged from, their feelings of imposter syndrome since appointment as a clinical educator. The second interview thus provided me with the opportunity to examine the participants' narratives through the lens of transition shock theory, and led to an analysis in relation to an existing theoretical framework.

The following chapter presents the findings from Study 1.

Chapter 4 Study 1 Findings: The Lived Experiences of Imposter Syndrome

4.1 Introduction

The findings of Study 1 are reported in this chapter and address the question that guided this research and the two sub questions, as outlined in Section 1.2. The Group Experiential Themes (GETs) which emerged from interpretative analysis of the participants' narratives in IPA Step 7, as discussed in Chapter 3, form the structure of this chapter. The Group Sub-Themes gave voice to the participants, and the quotes demonstrate supporting evidence for the interpretation of attributed meanings. Table 3 below shows the GETs and Group Sub-Themes derived from the data analysis process.

Table 3: Group Experiential Themes (GETs) and Group Sub-Themes

Group Experiential Themes (GETs)	**Group Sub-Themes**
GET A: Critical incidents are recalled as significant	Group Sub-Theme A1: Past critical experiences remained meaningful Group Sub-Theme A2: Recollection of clinical expertise creates loss
GET B: Feeling 'in' or 'out' of the group has an effect	Group Sub-Theme B1: Group support makes all the difference Group Sub-Theme B2: Comparison with others brings distress
GET C: Challenges of the dual-professional role	Group Sub-Theme C1: Developing a dual-professional role brings difficulties Group Sub-Theme C2: Expectations of role transition were flawed

Following the advice of Smith, Flowers and Larkin (2022), to present a clear and full interpretative account capturing the lived experience of imposter syndrome in clinical educators, there is no reference to literature in this chapter. Discussion of the findings and relevant literature, placing the study in a wider context, will be undertaken in Chapter 5.

The findings are presented in two formats. Firstly, interpretation of the narrative accounts as demonstrated in the GETs and Group Sub-Themes (Table 3), identified the significant shared and distinctive characteristics of participants' experiences believed associated with their long-term, or new, feelings of imposter syndrome. To enable cross-referencing and source checking, direct quotes taken from the transcriptions are given the relevant pseudonymised name and page number. Diary entry quotes are denoted with 'D' and with the relevant name and page number.

Secondly, the findings are consolidated and visually presented in Table 4, and show the similarities and differences between the participants' narratives, as discussed in this chapter.

4.2 Group Experiential Theme A: Critical incidents are recalled as significant

Most participants spoke of past critical incidents which impacted negatively on their wellbeing and underpinned feelings of imposter syndrome in the new role. Childhood experiences, and occurrences in former clinical roles, were the key issues shared with the researcher. The participants' narratives developed into two sub-themes: 'past critical experiences remained meaningful' and 'recollection of clinical expertise creates loss'.

4.2.1 Group Sub-Theme A1: Past critical experiences remained meaningful

Six participants shared previous critical experiences which significantly impacted on self-confidence, wellbeing, and self-perception. Intense memories of these experiences clearly remained, and in four participants were verbally acknowledged as causing years of imposter syndrome.

David and Eric described upsetting school day memories. David experienced head injuries from a road traffic accident when aged 10, requiring significant medical input, and was unable to attend school for a year. He recalled his return to school with emotion, feeling he was not supported, but rather penalised for the outcomes of the car accident:

> *'I had obviously quite a marked educational deficit, but the school decided to put me, to continue erm… placing me in the year that I should have been in based on my age and not going back a year… I was placed in the bottom set for everything'* [emotion] (David, p. 1).

David wanted a healthcare career, but responses from teachers remained a distressing memory. His recall of these events was full of emotion, suggesting continued pain from a legacy of being seen as a failure:

> *'…then going to see the careers teacher and she said, well of course you're not clever enough to go into healthcare, you're in the bottom set for everything* [pause]*'* (David, p. 2).

> *'I think I was really* [emotion] *influenced and impacted by all the negativity that was around me which was, you know, 'you're not going to do very well' erm... 'you won't do very well', 'accept you're not going to do very well'*" (David, p. 2).

David believed his school experiences were responsible for his lifetime of imposter syndrome, the metaphor 'significant baggage' indicating the heavy emotional load he bore:

> *'it's significant baggage that you carry around, and it has an impact on, I suppose, it transcends all aspects of your life really…I think it's* [imposter syndrome] *really deep rooted, going back to everything that happened when I was at school'* (David, p. 11).

Like David, Eric retained strong memories of school difficulties:

> *'I remember struggling quite a bit at primary school with erm... reading and spelling and writing and handwriting'* (Eric, p. 1).

Also, like David, Eric was aware of being seen as, and feeling, a failure:

> *'…tables were set up so we were all obviously sat on different tables…the tables were arranged by kind of ability level erm…and I could tell that I was sat on the lowest ability level table in the classroom'* (Eric, p. 2).

Eric believed his years of imposter syndrome developed from being 'obviously' marked as low ability and 'different' to classmates:

> *'…yeah… going through high school, erm... yeah that sense of being different combined with that erm... pattern of putting things off and then being quite self-critical and self-blaming became a bit of a pervasive pattern erm... yeah which I kind of think is a big part of imposter syndrome'* (Eric, p. 8).

Annie spoke of childhood expectations within the family as meaningful to her long experience of imposter syndrome:

> *'I came from a family where there was an expectation that you just got a job. My mum's done various jobs but minimum wage kind of jobs, my father was a factory worker…And I think that possibly…definitely…added to it* [imposter syndrome]*'* (Annie, p. 5).

Annie believed it was luck, rather than ability, that secured her secondment to a Clinical Educator Team Leader role. This was a promotion, but Annie shared 'you don't believe yourself, and you think you're lucky' (p. 2). She knew she had worked hard to achieve this promotion, but long standing imposter syndrome made her feel 'not deserving' (p. 9) of success:

> *'I work really, really, hard, and I've worked hard to get to where I am…erm…so although I put the time in, the effort, the work, it's a struggle to still feel, like, I'm not deserving of it'* (Annie, p. 9).

Metaphorically depicting a 'monkey', Annie saw imposter syndrome as clinging to her, unable to be shaken off, suggesting it will always be there:

> '*I know it's the imposter syndrome, like a monkey on my back! Even when someone is giving you compliments, it's even if you take them, you don't believe them'* (Annie, p. 4).

Ginnie took a considerable amount of time to describe her feelings about organisational changes that had occurred in her previous clinical role. A former Health Visitor and School Nurse, she had felt a valued, major contributor to the service, but now she only felt a sense of injustice, even personal betrayal, when she recalled her experience:

> *'Commissioners came in and started scooping away parts of the service that I felt really passionate about [pause]...so I felt very undervalued, very deskilled in a way 'cos they kind of pulled away everything that I was confident and comfortable with'* (Ginnie, p. 2).

Ginnie had enjoyed teaching student nurses in the clinical role, confident in her expertise, and with no feelings of imposter syndrome, 'I didn't have the imposter syndrome then because I knew what I was doing in my job' (p. 3). The critical impact of the 'toxic environment' (p. 7) she described, arising from service changes, now created doubt in her self-perception as a clinician and teacher:

> *'I think that, well, if I've been doing a job that wasn't actually needed for the last 15 years, then who am I to come in and start teaching other people about how the job should be done?'* (Ginnie, p. 4).

Celia had moved from direct patient care to the clinical educator role, both hospital based. Although reluctant to discuss details, the recall of a past negative clinical event created flashbacks, and imposter feelings:

> *'And I get a tummy drop and nausea, a flash back to an event, 'it couldn't possibly be about…? I suppose it could but it's really, really, unlikely', but nevertheless it triggers that imposter fear' (Celia, p. 5).*

Like David and Annie, Celia appeared to accept feelings of imposter syndrome would always exist, '*My imposter syndrome…will be with me for life'* (Celia, p. 2).

An interesting factor raised by two participants in relation to imposter experiences was dyslexia. Eric now believed his academic struggles and anxieties had a foundation in undiagnosed dyslexia, and recent reflections on its possible impact in childhood had led Eric to a position of self-understanding about these critical school day experiences:

> *'I'm only starting now to kind of recognise that, actually, the problems with the reading and spelling weren't actually my fault. Erm.. it seems quite likely that I might have, might actually have, dyslexia which I never kind of really twigged at that point…that's just how my brain works'* (Eric, p. 14).

Through reflective thinking, Eric appeared to have removed a sense of self-blame for his school difficulties, and felt that his seat at the 'lowest ability level table in the classroom' (p. 2) may not have been justified. He believed the possible impact of dyslexia was foundational to his feeling 'different' (p. 8) in the classroom, 'which I kind of think is a big part of imposter syndrome' (p. 8).

Like Eric, Fred spoke of dyslexia in his narrative, which he linked with newly experienced feelings of imposter syndrome in the clinical educator role:

> *'I've only been diagnosed with dyslexia since starting this job…So not just the teaching topics, but spelling, grammar, punctuation, weighs quite heavily with me, just like it did at school…I've never experienced imposter syndrome in the clinical setting or when I was doing my nursing job…I think part of that* [imposter syndrome] *for me as well is because I've got dyslexia, so I'm very anxious.'* (Fred, p. 7)

When Fred recalled the past, he now linked his dyslexia diagnosis to former English grammar difficulties at school. Because of his recent dyslexia diagnosis, he was anxious about similar difficulties arising in the educator role, and this resulted in imposter feelings. These feelings were new, not something Fred had experienced in his career to date, but of which he was now fully aware.

Summary: in G*roup Sub-Theme A1: Past critical experiences remained meaningful,* six participants shared past critical experiences that meaningfully underpinned imposter syndrome in their role as a clinical educator. Four participants identified childhood experiences that either undermined their sense of capability or did not support career achievement, and two participants linked critical experiences with former clinical roles. Two participants, Eric and Fred, referenced dyslexia to past experiences of difficulties at school, and acknowledged a possible link between dyslexia and imposter syndrome. All six participants drew connections between past experiences and their feelings of imposter syndrome in their current clinical educator role. Two participants described their imposter syndrome as a new experience for them, but four had been aware of imposter syndrome previously, and there appeared to be some acceptance of its continued existence.

4.2.2 Group Sub-Theme A2: Recollection of clinical expertise creates loss

All participants worked as registered practitioners across either primary, secondary, or community NHS healthcare settings, with some continuing a part-time role alongside their clinical educator role (Table 1, Appendix 3). All participants, apart from Eric and Iris, identified an awareness of expertise in their clinical role which appeared to be 'lost', or not acknowledged by others, in their educator role. Eric made no reference to role expertise as

a clinician and, interestingly, Iris now believed her expertise was associated with her educator role, not to her clinical role as a doctor.

Bridget had worked in healthcare since she was 17, latterly in hospital emergency care before joining the university, and was confident in her clinical knowledge and expertise:

> '*And this was because you know clinical skills, you'd think, out of all the other lecturing stuff that's, that's, my bread and butter, that's something I know all about at least'* (Bridget, p. 8).

Recent questions from university colleagues about the correct procedure for intravenous line fluid disconnection had been perceived by Bridget as critical of her expertise, she now felt belittled and demeaned, and new feelings of imposter syndrome arose:

> *'And anyway, that made me feel [pause] crap [laughs]… they made me feel really like…I'd said something really stupid…and I felt a real hit of imposter syndrome'* (Bridget, p. 8).

Bridget agreed she was still learning the 'lecturing stuff' (p. 8) but by using the disparaging words 'crap' (p. 8) and 'stupid' (p. 8) Bridget portrayed the significant impact such questioning had on her, initiating feelings of imposter syndrome. Further, on visits to hospital settings (part of her clinical educator role), ward staff appeared dismissive of her former clinical expertise, seeing her as university staff not clinical, prompting feelings of status loss:

> *'But the reactions on peoples face sometimes, the smirks or the eye rolls, really makes me feel almost ashamed of what I do. Like I'm not a useful part of the team anymore'* (Bridget, p. 1. D).

Like Bridget, David was respected and skilled in his clinical career. He had worked for many years across all areas of Emergency Care and Resuscitation, demonstrating extremely high levels of clinical knowledge and competence. He felt distressed in the clinical educator role though, believing he was not seen by university colleagues in this way:

> *'I felt very, all of a sudden, I felt very out of my depth, and I'd gone from being a very good clinician and respected by colleagues to being a* [long pauses] *very junior member of staff that was perhaps very wet behind the ears* [pause – emotion]*'* (David, p. 6).

David believed he had journeyed from respected clinical expert to the position of a complete novice. By using the phrase 'to being a very junior member of staff' (p. 6) he appeared not to question the novice position, the word 'being' (p. 6) making this status a present fact. The journey to this point had been unexpected and overwhelming for David, and he looked back on his former self-confidence as being in sharp contrast to how he now felt:

> *'And whilst* [pause] *I would consider myself to be a really good clinician, and I was good at teaching by the bedside, it is quite different when working in a university'* (David, p. 6).

Ginnie confidently saw herself as knowledgeable and competent in her former Health Visitor and School Nurse roles:

> *'I was one of the senior nurses by that point…and I knew my stuff, and that sounds really arrogant of me, but I was really confident, and I knew my stuff'* (Ginnie, p. 2).

In contrast to David and Bridget, Ginnie's feelings of lost expertise arose from within herself, not from the responses of others. She recalled she enjoyed teaching in her former nursing role, had no experience of imposter syndrome, and felt self-assured about her clinical expertise:

> *'…regarding the clinical education part as a nurse I was always really confident, I didn't have the imposter syndrome then because I knew what I was doing in my job'* (Ginnie, p. 3).

The legacy of previous distressing organisational changes, however, had significantly undermined Ginnie's prior self-assured expertise. Despite the respect shown by clinical educator colleagues, Ginnie now felt astonishment that her expertise was valued in the university setting:

> *'I feel amazed that my opinion is valued especially since coming from a toxic NHS environment where no managers appeared to value other people's opinions'* (Ginnie, p. 11D).

The feeling of loss was her own internalised perception, perhaps because of damage to her self-esteem from the former organisational changes. Her university colleagues did value her input; it was Ginnie who felt 'amazed' (p. 11D) by their view of her.

Heather recalled she was confident in her clinical role as a midwife, greatly respected by former colleagues as a source of knowledge and information:

> *'I suppose in clinical practice I felt that I was erm.. always erm.. like I was really on, on you know on the ball with everything. I felt that I was a really excellent midwife…people used to come to me and ask questions you know, and I was the one that people would look to'* (Heather, p. 1).

Like David, Heather now saw herself 'naïve' (p. 10) and inexperienced as a clinical educator, unsure what to do or say, and no one came to ask her questions. She imagined that university colleagues, albeit kindly, attributed her reluctance to speaking at meetings to a lack of role knowledge:

> *'…when I do speak out at meetings, I always feel like I'm a bit naïve and that people think like 'oh bless her, she's new…I mean she obviously doesn't know things so that's why she's not speaking out''* (Heather, p. 10).

She felt her expertise lay only in midwifery, which made her 'an imposter to education' (p. 10), and highlighted a sense of loss for her former position:

> *'I'm an imposter to education, I don't know enough, and therefore then I can't speak out because I only know midwifery'* (Heather, p. 10).

Jane had previously worked part-time as a university lecturer but had retained clinical expertise as a part-time pharmacist in primary care. Since moving to a full-time educator role, she now felt she had lost her former acknowledged and respected expertise and was 'usually one of the least qualified people in the room' *(*Jane, p. 2).

Although formerly a part-time pharmacist, it appeared this had been sufficient for Jane to maintain 'balance' in how she perceived her clinical expertise and status. She had laughed, possibly demonstrating irony about how she saw herself now, and with new imposter feelings:

> *'I'm just really mindful that I've spent a large portion of my career being one of the most qualified people in the room, and now [laughs] I'm usually one of the least qualified people in the room. I'm an imposter and shouldn't be there'* (Jane, p. 2).

Khloe vividly described her clinical educator role at the university as 'an absolute void' (p. 7). This created a striking visual picture of barren emptiness, without direction, where her clinical expertise did not fit the educator role:

> *'I think that it* [clinical educator role] *feels like an absolute void because they knew that I was a clinician.'* (Khloe, p. 7)

She reflected on a lifetime in healthcare, working at a high level in varied fields of practice, latterly as a hospital Advanced Care Practitioner (ACP). She had confidently taught and supported students in practice when she was 'Khloe the ACP' (p. 6), but in the 'absolute void' (p. 7) of being 'Khloe the lecturer' (p. 6), she now saw, and felt, the loss of that confidence. Khloe believed the clinical educator role was 'dodgy' or difficult, and appeared to link it to her new feelings of imposter syndrome:

> *'As a clinician, and teaching students at the bedside, clearly, I don't have imposter syndrome, I know that…But 'Khloe the lecturer' is a much dodgier kind of subject'* (Khloe, p. 6).

Summary: in G*roup Sub-Theme A2: Recollection of clinical expertise creates loss,* participants recalled former roles, their clinical expertise, and the professional respect they had previously enjoyed. The move into a clinical educator role had altered participants' perceptions of where that expertise was now situated. For Bridget and Heather their skills appeared to remain with the former clinical role, prompting feelings of loss. In contrast, Ginnie and Jane were unable to acknowledge their skills in the educator role, despite knowing that university colleagues valued those skills. The expertise they confidently held when clinical, had become lost. The language used to describe this sense of loss by some participants, and how they felt as a result, was emotional. For some, feeling 'crap', 'stupid',

'naïve', 'ashamed' or 'wet behind the ears' painted a vivid picture of distress, and was aligned to long-term or new feelings of imposter syndrome.

4.3 Group Experiential Theme B: Feeling 'in' or 'out' of the group has an effect

All participants spoke of group, or team, relationships with former clinical, and current educator, colleagues. Such relationships were shown to be meaningful although, in some cases, participants related them to feelings of imposter syndrome. Most participants compared themselves to others in the clinical educator group, but many comparisons were not encouraging.

The GET which emerged gave two key group sub-themes which portrayed areas of significance shared by participants: 'group support makes all the difference', and 'comparison with others brings distress'.

4.3.1 Group Sub-Theme B1: Group support makes all the difference

All participants spoke of their relationships with work colleagues in clinical and educational settings. Being a part of a 'team' or 'group' was described as valued, but where such relationships did not exist, or had altered, hurtful situations resulted.

In her former clinical role Annie had been very involved for many years with the ward based teaching and education of student nurses, HCAs, and clinical support staff, and clearly valued being part of the team:

> *'I think that what's important about that is that you have a really strong infrastructure of people around you that help you'* (Annie, p. 16).

Interestingly, Annie was aware of 'team spirit' (p. 16) when working with colleagues and peers but went on to describe that her recent secondment to the Team Leader educator post, although still on the ward, had unexpectedly changed the dynamics of her position with others, she was no longer one of the team but in a management role. Annie felt a 'different relationship' (p.17) arose quickly, and there was a sense that the [role] 'shift' (p. 17) made a different, and challenging, relationship inevitable:

> *'It's a different relationship isn't it, all of a sudden, it's that shift and erm… it's always you whose looked on as the bad guy, yeah. And that can weigh heavy sometimes when it's repeated, repeated, repeated, repeated'* (Annie, p. 17).

Annie felt the loss of the previous 'team spirit' (p. 16) and linked her new leadership responsibilities with being 'always…looked on as the bad guy' (p. 17). The changed

dynamic had become a weighty burden, and reiteration of the word ‘repeated’ (p. 17) depicted weariness, reinforcing her belief she was outside the group.

Celia likened former clinical shifts to the army going ‘on a tour’ (p. 6) together, in a cohesive and supportive group:

> *‘…on a shift there’s a sense of we’re going on a tour… that real sense of ‘we’re off, we’re going out to do our tour of duty’’* (Celia, p. 6).

In her clinical educator role, no ‘tour’ metaphor existed for Celia. Rather, she felt that moving into education was a ‘MASSIVE change’ (p. 6), she felt externally located to the education team, and as an outsider had no way into the group:

> *‘…going into education, MASSIVE change… coming into these teams from the outside, and you’re just so outside the circles, there’s no group, where’s your in?’* (Celia, p. 6).

Jane, Fred, and Ginnie recalled positive experiences of being part of a group, both in clinical practice, and now as a clinical educator. Ginnie described former clinical colleagues as ‘teammates’ (p. 1), underpinning her role confidence and enjoyment:

> *‘From qualifying I went into an area I was very confident in, very comfortable in, I had great teammates around me erm…so I was really quite happy in my career’* (Ginnie, p. 1).

She subsequently had a positive welcome from educator colleagues, which made her feel valued as a person in the group:

> *‘I think I’ve found the whole experience of being in the university just so lovely, I mean everyone is so welcoming and so friendly, I mean, you feel valued’* (Ginnie, p. 10).

Fred also felt he fitted comfortably into the university department as he already knew several educators there, but he was nonetheless aware of some anxiety in his relationship with students:

> *‘I know a lot of the people here from my old job, so it was never an issue of, sort of, feeling how I fit in with the department. It was more, how I was perceived by the people that I’m teaching’* (Fred, p. 11).

In contrast, Heather and David described group cohesiveness in their former clinical positions which did not appear in their clinical educator roles. As a midwife, Heather regarded herself an equal to clinical colleagues as she ‘…felt like I was on the same level’ (p. 9), but as an educator she did not feel professionally equal because she did not have a formal teaching qualification:

> *'…that all changed then when I came into clinical education [laughs]… I felt that because I didn't have, I didn't have a qualification with teaching - that was the first issue I think'* (Heather, p. 2).

Heather's relationship with the group was also affected by her 'little secret' (p. 13) of new imposter syndrome feelings, which Heather wanted to hide:

> '*…but you have almost, have, like, that little secret there, that when you have bad* [imposter syndrome] *days, they don't know that you're having those bad days' (*Heather, p. 13).

Heather appeared under stress as an educator with feelings of 'fight or flight' (p. 14). The 'little secret' (p. 13) stopped her from accessing group support, and created a wish to run away:

> '…*you know those types of things where I feel like an imposter, I go back to my office and I just want to come home, because it's that 'fight or flight' where, you know, I need that security'* (Heather, p. 14).

David vividly shared feelings of not fitting in with the university group, and it was clear his former hospital role in emergency care was preferable:

> *'I felt very, very, very uncomfortable, I felt like I didn't belong here* [university] *at all erm.. to the point where I even reapplied for my old job back erm.. because I felt like I didn't fit in here* [pause] *at all'* (David, p. 8).

He had felt it necessary to take steps to 'fit in' (p. 8) with university colleagues, the majority of whom had PhDs, and '…enrolled on doing a Doctorate of Education' (p. 8). David's achievement in obtaining his Doctorate, however, was undermined by his imposter syndrome, he still considered himself outside of the group, and felt unable to hold validation in his educator role:

> *'And I think I've found, I found that* [EdD achievement] *really deflating…I was hoping that that might be the thing that could actually make me feel* [pause] *make me feel* [long pause – emotion] *not valued, but erm... justified in being in the position and job that I'm in. That's imposter syndrome for you"* (David, p. 11).

In contrast to other participants, Iris did not feel part of the group in her part-time clinical role, but as a clinical educator. As a GP within the Emergency Department and Out of Hours Service, she found part-time shift patterns isolating with no opportunities for team engagement:

> *'I don't know the people well, not at all really, they're just names, because we're all just doing our separate, you know, shifts, as it were, going in and out'* (Iris, p. 6).

A stark distinction, however, was the regular group meetings factored in the clinical educator working day which she felt were of great value. The regular personal interaction made Iris feel supported in the role:

> *'In my teaching role, I feel a lot more comfortable in that…we all meet up every day and have like a little meeting in the morning, then a little meeting halfway through, and it's great. I can ask if I'm not sure of anything or just talk stuff through'* (Iris, p. 5).

Unlike Iris, Khloe voiced intense challenges concerning her role in the university environment. Contrasting her former ACP role, she now felt unable to effectively interact with others. She identified 'language' barriers and felt unsupported as things were not explained, and felt outside the group in 'a different world' (p. 3):

> *'Yeah, since I've been here it's [pause] such a different world [pause]. And there's a whole language that you don't understand, and people don't explain things to you'* (Khloe, p. 3).

'Like living in a vacuum', (Khloe, p. 4) strongly illustrated Khloe's perception of isolated emptiness, unable to breathe freely, and reinforced her sense of 'not belonging' (p. 4). But for Khloe, it was more than 'belonging' she sought. Rather, if she felt authentic in the educator role she would also know she was 'needed and valuable' (p. 4), as in her clinical roles. Khloe did not feel this as an educator, but instead superfluous:

> *'It's a sense of belonging but not just that. It's a sense of kind of [pause] role validity…I guess I like feeling that I belong…that what I'm doing is needed and valuable… like here I'm sitting in this office and it's a total fog…I mean, I could do nothing, and nobody would really notice, nobody would really comment'* (Khloe, p. 4).

Bridget did not talk about her former clinical relationships but openly described her experience of sharing an office with colleague, 'J', another clinical educator:

> *'I'm sure I don't belong in this office with her. I'm so different to her…if you imagine somebody that's like picture perfect, comes in, hair's done perfectly, nails are done, perfect outfit'* (Bridget, p. 3).

Like Annie, who felt the Team Leader educator role made her 'different' to group colleagues, Bridget spoke several times of differences between 'J' and herself. Unlike other participants, however, these differences were based on physical appearance. Bridget's sense of belonging was undermined by her perception of these differences, and she felt continuously critiqued:

> *'It's really impacting my ability to feel like I belong in this role, and that the way I'm approaching it almost feels wrong, or at scrutiny all the time'* (Bridget, p. 3).

Bridget acted, like David, but later analysed her intentions. She insightfully self-questioned whether her actions were an attempt to look like her colleague, 'just to fit in' (p. 2D):

> *'Got my nails done, eyebrows & eyelashes. I'm not remotely girly. I've never had any of this done before. Am I doing it just to fit in?'* (Bridget, p. 2D).

Summary: in *Group Sub-Theme B1: Group support makes all the difference,* all participants spoke of the significance of a 'group' or 'team' connection. Some participants described

positive experiences of group interactions in former clinical roles, but if this did not occur in the clinical educator role, participants spoke of feelings of distress and upset, in some cases linked directly to imposter syndrome. Annie perceived herself as the 'bad guy' (p. 17) for example, David felt 'intimidated' (p. 7) and in referencing feelings of imposter syndrome, was 'constantly waiting to be found out' (p. 9), and Khloe felt no sense of belonging because 'it's just like living in a vacuum really' (p. 4). For some participants, feeling part of the educator group was positively described, with Ginnie stating, 'you feel valued' (p. 10). Isolation from colleagues because of shift patterns was seen by one participant as the cause of feeling outside of the group, and it was interesting to hear Bridget's story where she aligned her sense of group belonging with her physical appearance. As Bridget asked herself when she tried to mirror the appearance of her educator colleague, '*Am I doing it just to fit in?'* (Bridget, p. 2D).

4.3.2 Group Sub-Theme B2: Comparison with others brings distress

Most participants shared how they saw themselves in comparison with educator colleagues, and for some, there appeared to be a significant cross-over where unfavourable comparisons with others led to distress about feeling outside of the clinical educator group, as discussed in *4.3.1 Group Sub-Theme B1: Group support makes all the difference.*

Three participants directly linked self-comparisons to experiences of imposter syndrome. Celia felt she had different viewpoints and enthusiasms from colleagues:

> *'I feel really, erm...yeah, like an imposter because I sometimes don't share the passions of the people around the table. I don't feel it, I seem to come at things from a very different angle a lot of the time, erm...'* (Celia, p. 2).

Fred and Jane, when teaching in former clinical settings, felt validated as educators by their knowledge and expertise. In the current role outside of the clinical setting, comparisons were made with the perceived knowledge of students and the formal teaching qualifications held by colleagues, which generated experiences of imposter syndrome. For Fred, these feelings had additionally created 'dread' (p. 4) outside of the role environment:

> *'You start thinking that some of these people…potentially know more on the subject than you and you're teaching it [laughs]. And I think that that's a kind of underlying [pause] where imposter syndrome comes from for me'* (Fred, p. 2).
>
> *'It's also impacting on other parts of my life. I think I do come to dread some sessions, sometimes at home, where I've got erm... sessions coming up'* (Fred, p. 4).
>
> '*But in terms of imposter syndrome I think it's that validity of having an external qualification will just help to build your confidence as well as your competence. But I don't have that'* (Jane, p. 7).

Similar to Jane, Ginnie, Heather, and Khloe were conscious they did not have formal teaching qualifications when compared to colleagues, which created uneasiness. Ginnie, for example, doubted her ability to teach effectively despite an excellent reputation in former ward-based teaching:

> *'I mean, I'm not a qualified teacher, what if I'm not putting it across to them in the right way'* (Ginnie, p. 5).

And after watching an on-line teaching session, Khloe doubted she could compare with the lecturer, causing her to believe her teaching *'will be rubbish'* (p. 8):

> '*…and the woman was inspiring and upbeat and so good…and that's put doubt in my mind, can I do it? … All those kinds of worries, like I can do it, but it will be rubbish'* (Khloe, p. 8).

Eric, Iris, and David saw themselves as lacking in skills and abilities when compared to colleagues:

> *'This sort of sense that everybody else must be better erm... you know more intelligent, more knowledgeable, more experienced or whatever it might be erm...'* (Eric, p. 10).
>
> *'Other doctors you know, are out there reading all these journal articles and they're all super clever [laughs] and they're all doing these amazing things, they're you know, up on all these different things, that I'm not'* (Iris, p. 4).
>
> *A lot of the staff had, erm… had high degrees, so PhDs, and they were all sort of experts within their own discipline'* (David, p. 7).

Rather than the lack of teaching qualifications, these participants believed they lacked intelligence, competence, or knowledge when compared to colleagues. Eric felt 'everybody else must be better' (p. 10), Iris believed 'they're all doing these amazing things' (p. 4), and David felt that not having a PhD indicated he lacked expertise, when colleagues 'were all sorts of experts within their own discipline' (p. 7).

Both David and Bridget acted on their negative self-comparisons. As previously discussed, Bridget had some beauty treatments after comparing herself physically with her 'picture perfect' (p. 3) educator colleague but later questioned the rationale for these actions by reflecting 'I'm not remotely girly. I've never had any of this done before' (Bridget, p. 2D). David completed an EdD to be on par with PhD colleagues, yet subsequently felt his achievement had little impact on his self-perception:

> *But I remember having a full day of euphoria after my viva and literally the next day it was like, that was it, I was still me, I was just me, with another certificate'* (David, p. 11).

Summary*:* in *Group Sub-Theme B2: Comparison with others brings distress,* the majority of participants compared themselves to others, and these comparisons were all unfavourable. The comparisons largely focussed on a perceived lack of knowledge, competence, or skill, and the absence of formal teaching qualifications or university experience. But for one participant, the comparisons were on physical appearance. Three participants made direct comparative links to experiences of imposter syndrome, and one participant indicated a negative impact on home life. Two participants took action to mitigate their unfavourable comparisons, but there was a sense these actions resulted only in disappointment and self-questioning.

4.4 Group Experiential Theme C: Challenges of the dual-professional role

All participants discussed working in a role that spanned two professions, clinical and educational. They had retained clinical registration, a requirement of the clinical educator role, and while several still worked clinically part-time, the principal role for all participants was as an educator.

Challenges had arisen in moving to the dual-professional role, with half the participants sharing that their expectations about the move had been wrong. Two sub-themes had developed related to the dual-professional role: ‘developing a dual-professional role brings difficulties’, and ‘expectations of role transition were flawed’.

4.4.1 Group Sub-Theme C1: Developing a dual-professional role brings difficulties

The clinical educator role draws on clinical expertise, but is situated within the teaching profession. The two professions are thereby simultaneously aligned as each participant was both a clinician and a teacher, but difficulties had arisen as they attempted to straddle clinical and educational identities. The challenges narrated centred around two main areas, how the clinical educators saw themselves in the dual-professional role, and how they perceived they were seen by others.

Several participants appeared to struggle with their professional identity, as if they had a foot in both camps, which prompted self-questioning. Bridget, formerly confident in her nurse role, was now confused about whether her new role was as a nurse or teacher, and Jane questioned whether her educator role undermined her professional identity as a pharmacist:

> *'That was the question 'am I doing it as a Band 5, like a nurse?' or am I doing it as a Clinical Teaching Fellow? [pause…]'* (Bridget, p. 2).

> *'Am I a proper pharmacist working in education?'…I think there's that shift in identity because if I'm not working on the front line, am I still a pharmacist?'* (Jane, p. 4).

For all participants, except Iris and Eric, distinguishable uniforms were worn in clinical practice. Bridget and Khloe now consciously used their educator uniform or badge to address their identity, perhaps as reinforcement for themselves, but also for others:

> *'So, what I've decided to do…is to wear my CTF uniform…and then have my CTF badge on because I think it will be a big part of shaping the professional identity of the role'* (Bridget, p. 2).

Such visual identification had created a sense of imposter syndrome for Khloe. Despite the badge, she was personally challenged by the job title, 'Lecturer' (p. 6). It appeared that, as a lecturer, Khloe felt distanced from the clinical profession she knew she was competent in:

> *'It must be imposter syndrome in a way because my title, my job title, is 'Lecturer in Advanced Practice', not nurse, but I don't feel like a lecturer. But I am. My badge says 'Lecturer'.' (Khloe, p. 6)*

Several participants saw themselves formerly as competent and proficient educators in clinical settings, but now felt tested in the university lecturer role:

> *'I was good at teaching by the bedside; it was quite different when I was working in a university'* (David, p. 6).

Like David, Jane acknowledged her teaching skills in the clinical environment, and despite previous part-time university teaching, felt the full-time role different and a challenge:

> *'I think part of the challenge is having kind of built up your* [teaching] *skills, and experience in the clinical sector…then when you're in your 40's and coming to work [laughs] in a role that's entirely, entirely new, is challenging'* (Jane, p. 1).

The difficulties Iris described in the medical, not educational, aspects of her dual-professional role had raised self-doubt about her clinical skills and competence:

> *'I've had some periods of quite serious self-doubt about my, you know, ability to work in the clinical area… questioning my own ability, my suitableness for the role, things like that'* (Iris, p. 10).

Two participants, David and Heather, were so disheartened by experiences of the dual-professional role they had considered returning to clinical practice. Although they did not, it was clear they felt under considerable stress trying to straddle the clinical and educational identities:

> 'S*hould I really stay in education, or should I go back to clinical practice because it's clinical practice that I know?'* (Heather, p. 6).

> *'I felt very, very, very uncomfortable…to the point where I even reapplied for my old job back'* (David, p. 8).

In contrast to all other participants Celia perceived she had left the clinical profession behind when she entered education, and acknowledged this created a huge change for her:

> *'There's the whole world of being in the* [clinical*] profession…and that's been big for me, leaving that…leaving the NHS and going into education, MASSIVE change'* (Celia, p. 7).

Celia was a hospital-based clinical educator, and appeared to prefer fully aligning with education rather than clinical practice, perhaps to avoid challenging 'stress points' (p. 7) or personal ambiguity:

> *'So, like between professions, there can be stress points can't there, with 'they're in that professional role' and 'we're in this professional role', and so 'we don't go to their meetings'* (Celia, p. 7).

Some participants encountered misunderstanding from others about the role, creating feelings of personal difficulty. Bridget, for example, made regular ward visits, but often faced confusion from ward staff:

> *'But when you go into the NHS, and you go to the wards, you're always met with sort of hesitation and sort of confused faces…they don't know what it* [the role] *is. It's hopeless really'* (Bridget, p. 9).

Khloe believed the university and her colleagues did not understand the challenges of the dual-professional role. As a result, and like Bridget, she felt without the support she needed:

> *'They knew that I was a clinician coming here without that experience of academia and yet the support is [pause]…I don't think they understand what it's like, what they need to do to help really'* (Khloe, p. 7).

Summary: in *Group Sub-Theme C1: Developing a dual-professional role brings difficulties,* most participants spoke of the challenges they had experienced. Questions such as 'am I doing it as a Band 5, like a nurse?' (Bridget, p. 2) and 'am I still a pharmacist?' (Jane, p. 4) indicated the challenges felt about professional identity and role position. Some participants relied upon visual cues, such as uniforms and badges, to establish the role, but this then created imposter syndrome for one participant. Perhaps such labelling was a personal support mechanism as well as an identifier to others. Many participants felt tested by teaching in a formal educational setting, or the lack of understanding about their role from others. For some participants confidence in former clinical teaching did not transfer to the new role, brought feelings of imposter syndrome, or raised thoughts of returning to clinical practice. One participant deemed she had left the clinical profession altogether and psychologically relocated into education to perhaps avoid personal, emotional and

professional tensions, and for another dual-professionalism had raised new self-concerns about competence in her continued part-time clinical role.

4.4.2 Group Sub-Theme C2: Expectations of role transition were flawed

All participants reflected on their expectations of transition into the clinical educator role, and imposter syndrome was discussed by all participants in relation to those expectations.

Prior anticipation had been positive and exciting, but once in post, many participants found those hopes had been flawed. Three main areas arose: anticipated organisational support; transference of ward-based teaching skills into an educational setting; and the presence of new, or continued, feelings of imposter syndrome.

Several participants voiced that the organisational support they had anticipated had not occurred, and they were left to find their own way. Khloe described sitting alone in her office, not sure what to do, a situation far removed from the busy clinical environment she was used to. She analysed whether this feeling was a 'normal emotional response to change and perhaps not being adequately supported/guided' (Khloe, p. 9 D). Khloe recognised that undertaking the role change could have initiated such feelings, but had expected to feel more supported within the university structure when she took up the post.

Bridget described her exhilaration when appointed to the clinical educator role. She was '…so excited, that before I even started the role I made, like a 'notes' section, on my phone' (Bridget, p. 5). She had become disappointed, however. Her former clinical role had been clearly defined, both for herself and others, but now she appeared without direction or clarity:

> *'It's been hard to sort of shape my identity as a professional I think because [pause], there isn't really, because it's such a new role, there isn't really like set expectations I guess. Where's the guidance?'* (Bridget, p. 4).

Like Khloe and Bridget, David and Heather had expected organisational guidance and support when they moved to higher education. But David described how had he received little, or no, assistance from colleagues, 'I felt very out of my depth' (p. 6), and Heather felt she had been left to struggle alone with unfamiliar internal organisational processes:

> '*In education I've found that really difficult because there's so many different procedures and processes and getting your head round things, erm… it's very difficult'* (Heather, p. 10).

More than half the participants believed their expert knowledge and former clinical teaching experience would support a straightforward transition into the clinical educator role. Ginnie

recalled how she had greatly enjoyed teaching on the ward, and believed that same enjoyment would continue in the new role:

> *'Regarding the clinical education part as a nurse, I was always really confident…I loved teaching, I loved having students with me on the ward'* (Ginnie, p. 3).

Once in the university setting, however, Ginnie became aware her expectations had been flawed. Despite former competence in ward-based teaching, she now questioned her ability and integrity as a clinical educator because she had no formal teaching qualifications. She lost confidence as a result, and anxiously asked, 'what if I'm not putting it across to them in the right way?' (Ginnie, p. 5).

David commented that, despite his confidence and competence in bedside teaching, 'it was quite different when I was working in a university' (David, p. 6), and Eric, notwithstanding his clinical expertise, was disheartened and self-critical when he reflected on a recent teaching encounter:

> *'I went away from the session feeling quite dejected and questioning my ability to teach and communicate complex ideas in a clear, understandable, way'* (Eric, p. 21 D).

With a wealth of former bedside teaching, Heather was confident she had significant midwifery skills to offer university students, 'I could impart all of that [midwifery skills] to students, and students then would benefit from that' (Heather, p. 2). Once in post, however, Heather became aware these expectations had been flawed:

> '…*you believe that you know enough to be a clinical midwife, but you don't realise how much more you need to know to be an educator'* (Heather, p. 5).

All participants linked their transition into the clinical educator role with experiences of imposter syndrome. Four participants told of prior imposter experiences before starting in the new role, with three of them reporting that the role transition had, despite hopeful expectations, continued those feelings. Celia, alone, had the expectation that her feelings of imposter syndrome would continue, whatever role she was in:

> *'My imposter syndrome has been with me for life, and will be with me for life, and so if I didn't have it in this role, I'd have it in another role'* (Celia, p. 2).

Annie likened her continued imposter syndrome to 'a devil on your shoulder saying to you you're not good enough' (p. 3), and clearly identified its presence in her Team Leader educator role, 'Cue the dreaded imposter feeling!' (p. 20 D). Eric knew he had worked hard to achieve the educator position, but despite all his efforts and positive thinking about the new role, was unable to accept his success:

> *'I think imposter syndrome can almost spoil that in the sense of you've set yourself a goal of doing this* [clinical educator role] *but then when you achieve it, it still doesn't quite feel good enough or erm…you don't give yourself the credit'* (Eric, p.12).

And David commented on feedback he had received, but like Eric, was unable to accept its validity:

> '*It doesn't matter how many, how many accolades you get, it doesn't matter what your module evaluations say, it doesn't matter how many times someone says, 'you're really good at this', or 'David, we really like how you teach'* [pause] *it still, it's just still never enough'* (David, p. 10).

Heather had not experienced imposter syndrome previously, but now described herself as 'an imposter to education' (p. 10) despite her clinical expertise and former part-time university teaching:

> '*I'm an imposter to education, I don't know enough and, therefore, then I can't speak out because I only know midwifery'* (Heather, p. 10).

Heather perceived her level of expertise insufficient for the educator role, and if she researched teaching resources, believed this demonstrated her lack of knowledge:

> '*If I'm just looking things up and putting them into a presentation, and then delivering that, well, that's not my expertise, that's me being an imposter*' (Heather, p. 4).

She had the expectation that the knowledge and expertise required for the role should be at her fingertips, instinctively known, as in her former midwifery teaching. She could not see researched resources as acceptable, but rather as evidence she was not a real clinical educator but an imposter to the role.

Like Heather, Fred perceived his clinical expertise insufficient for teaching his master's level students. While he confidently taught ward-based staff, such as nurses and healthcare support workers, he unexpectedly felt intimidated teaching the 'more academic' (p. 1) master's students, and became aware of feelings of imposter syndrome:

> *'it's more intimidating from an imposter syndrome perspective than teaching at that other level'* (Fred, p. 1).

Iris' expectations of role transition were flawed, but in contrast to other participants, the flawed expectation arose in her continuing part-time clinical role. Positive educator experiences revealed unexpected feelings of imposter syndrome in her clinical post, alongside discouraging self-perceptions of knowledge and ability. Iris felt she was not clinically working 'in the way that I should be' (p. 8):

> *'Imposter syndrome's arrived…I always feel that I'm not quite clever enough or on the ball, or on top of things, in the way that I should be'* (Iris, p. 8).

Jane, like Iris, did not experience imposter syndrome from the clinical educator role itself, but from an expectation of role transition she had not foreseen. Attendance at classes for the Post Graduate Certificate in Academic Practice (PGCAP), a requirement of her educator role, had generated new imposter syndrome feelings:

> *'But when I think about my imposter syndrome, it was the workshop we had…when the guy who was leading the workshop had said "you might want to draw on your own research strengths"'* (Jane, p. 5).

With little previous research experience, Jane felt 'more on the back foot' (p. 3) compared to class colleagues, in contrast to her pharmacist role when she felt 'one of the most qualified people in the room' (p. 2).

In her former role as an ACP, Khloe was confident, knowledgeable, and felt in control. Unexpectedly, her position had changed:

> '*In short, I feel clueless and it's very uncomfortable. I don't know if any of this could be described as imposter syndrome or if it's about role transition' (*Khloe, p. 9D).

Interestingly, Khloe was the only participant who challenged whether such feelings were imposter syndrome or the impact of role transition. It was a feeling she did not comprehend and was seeking understanding. She later expanded on her thinking, even answering her own question, by reflecting that her feelings were 'most likely just a normal emotional response to change, and perhaps not being adequately supported or guided' (Khloe, p. 9D).

Summary: in *Group Sub-Theme C2: Expectations of role transition were flawed,* all participants described how prior expectations of moving into the clinical educator role had not been accurate. Anticipated organisational support had not materialised for many participants, leaving them "out of my depth" (David, p. 6) or struggling with "getting your head round things" (Heather, p. 10). Many participants believed former positive experiences of clinical teaching, coupled with their expertise, would enable a smooth transition into the clinical educator role. For most participants this did not occur, Ginnie or Eric for example who subsequently questioned their own teaching ability, or Heather who doubted she had the required clinical knowledge to effectively teach. Iris and Jane were exceptions as the clinical educator role had met their expectations, but after role transition, Iris experienced feelings of incompetence in her existing medical role, and Jane felt her lack of research experience created unanticipated, and unwelcome, challenges when attending PGCAP training.

4.5 Similarities and Differences between Participants' Narratives in Study 1

The Study 1 findings were consolidated to identify the similarities and differences between the participants' narratives, as shown in Table 4, to demonstrate areas of commonality and convergence, but also divergence and individuality. There appeared overlaps in many of the participant' expressed feelings, group belonging linking with self-comparison for example, and imposter syndrome ebbed and flowed through them all. Table 4 was configured to reflect the GET structure, and demonstrated that the significant concerns for participants were firstly their relationships with others (GET B: 21/22); secondly the challenges of the dual-professional role (GET C: 19/22); and thirdly, their meaningful recollections (GET A: 15/22).

Table 4: Similarities and differences between the participants' narratives in Study 1

Group Experiential Themes	**Group Sub-Themes**	**Annie**	**Bridget**	**Celia**	**David**	**Eric**	**Fred**	**Ginnie**	**Heather**	**Iris**	**Jane**	**Khloe**
GET A: Critical incidents are recalled as significant	A.1: Past critical experiences remained meaningful 6/11	✓		✓	✓	✓	✓	✓				
	A.2: Recollection of clinical expertise creates loss 9/11	✓	✓	✓	✓		✓	✓	✓		✓	✓
GET B: Feeling 'in' or 'out' of the group has an effect	B.1: Group support makes all the difference 11/11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
	B.2: Comparison with others brings distress 10/11		✓	✓	✓	✓	✓	✓	✓	✓	✓	✓
GET C: Challenges of the dual-professional role	C.1: Developing a dual-professional role brings difficulties 8/11		✓	✓	✓		✓		✓	✓	✓	✓
	C.2: Expectations of role transition were flawed 11/11	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓	✓

Following a reflective process on the findings and development of Table 4, an interpretative statement emerged drawn from the cumulative of each participant's narrated experience:

> The experience of role transition from a clinical to Clinical Educator post is significant to feelings of imposter syndrome which are shaped by relationships with others, the challenges of dual-professionalism, and meaningful recollections.

This statement amalgamated my interpretation of the participants' imposter syndrome stories shared in the Study 1 findings and revealed that transition from the clinical role towards the new role of clinical educator appeared fundamental to their imposter feelings.

The new role had already commenced, and participants were undergoing a personal restructuring as they journeyed towards orientation into that role. Feelings of imposter syndrome acted as a barrier to that role orientation and were shared by all participants, including Heather and Jane, who had previously worked part-time at the university as educators. It is interesting that their part-time roles did not create feelings of imposter syndrome, it was only when the role became full-time, a point that will be discussed later in this thesis. David, Khloe, and Iris had maintained a part-time link with clinical practice, although in contrast to all other participants, it was this clinical link that formed the new feelings of imposter syndrome for Iris.

Following considerable examination of the participants' experiences described in this chapter leading to the interpretative statement, and with reference to the literature review in Chapter 2, I wondered whether the process of role transition itself may have created, or retained, the imposter syndrome feelings experienced by participants. A targeted literature review was subsequently undertaken in light of this thinking which resulted in the framing of the second study and will be discussed in the following chapter.

4.6 Summary

This chapter has presented the Study 1 findings from the analysed and interpreted data under the headings presented in Table 3: Group Experiential Themes and Group Sub-Themes. The themes and sub-themes developed from the breadth of the participants' narrated imposter experiences revealed the feelings which arose during transition into the clinical educator role. Influences drawn from the memories of critical challenges at school and in clinical settings were shared, alongside recall of former expertise and professional respect, now perceived lost. Supportive team or group relationships were established as valued and a significant loss if not felt present, and all participants made unfavourable comparisons of themselves with colleagues. Most participants raised questions about how

they, and others, saw their identity in the role of clinical educator, and prior expectations of how the move into the role would develop were acknowledged as flawed by participants. It was also interesting to note that, for one participant, commencement of the educator role had created negative feelings in her continued clinical position which had, to her surprise, brought about her new feelings of imposter syndrome.

Reflection on the findings, the interpretative statement, and the literature, suggested that the process of role transition may have been a catalyst to feelings of imposter syndrome in the clinical educator role. A targeted literature review on the concepts of transition and role transition was subsequently undertaken, and as discussed in the following chapter, resulted in development of the framework for Study 2.

Chapter 5 Targeted Literature Review and Development of Framework for Study 2

5.1 Introduction

Using IPA (Smith, Flowers and Larkin, 2022), participant stories of imposter syndrome feelings were examined, interpreted, and synthesised in Study 1, resulting in the findings discussed in Chapter 4. This chapter will consider, through literature, the emergent suggestion from the findings that the process of role transition may have created feelings of imposter syndrome in the new role and leads to development of the framework for Study 2.

5.2 Role Transition

To place the concept of transition into context, we shall first model Bridges' (2004, p. 7) example and visit *Alice in Wonderland*:

> "Who are you?" said the caterpillar… "I – I hardly know, Sir, just at present", Alice replied rather shyly, "at least I know who I was when I got up this morning, but I think I must have been changed several times since then" (Carroll, 1967, p. 47).

In his seminal discourse (Bridges, 1980), the author used these comments by Alice to illustrate the personal impact of experiences of transition, the 'confusing nowhere of in-betweenness' (p. 5), which summarised awareness of what used to be and, following change, the shape of the present now. Like Alice, the participants struggled with feelings of imposter syndrome in the transitional state of role 'in-betweenness' (p. 5), and were unable to fully orientate and embed into the 'present now' of their new role.

Transition theory developed in the 1970s (Hopson and Adams, 1976; Parkes, 1971) and initially applied to situations of grief and loss, expanding on the work of Kubler-Ross (1969). Wider applications of transition theory subsequently developed across many fields including business (Bridges, 2017; Schlossberg, 2011; Schlossberg, 1981; Dreyfus and Dreyfus, 1980) social sciences (Anderson, Goodman and Schlossberg, 2021; Bridges and Mitchell, 2000; van Gennep, 1960), personal development (Bridges, 2004; Levinson 1986), education (The Quality Assurance Agency for Higher Education, 2023), and healthcare (Browne and Collett, 2023; Pleshkan and Hussey, 2020; Owens, 2018; Meleis, 2010; Benner, 1984). Much transition literature referenced frameworks and stages to plot an individual's movement towards an endpoint of personal stability. The focus was, however, on dealing

with or managing a change, the frameworks and stages providing mechanisms to enable successfull navigation of a newly emerged life event.

Schlossberg's theory (1981), for example, identified transition as an impactful event in one's life, such as a new baby, a new relationship, job loss, and focussed on the individual at the time of the transition: was it anticipated or unexpected? was it sudden or over a period of time? The theory looked to develop coping strategies, then controlling resources, to manage the change, and used a step-by-step model to enable navigation through the transition, proposing that:

> 'It is not the transition itself that is of primary importance, but rather how that transition fits with an individual's stage, situation and style at the time of the transition' (Schlossberg 1981, p. 5).

I believed this theory centred on managing a particular change event, however, not moving through transition, and appeared in conflict with the proposals of Bridges and Mitchell (2000) who argued that a change response is not transition. They asserted that 'transition is the state that change puts people into' (p. 31), in other words, the individual goes through transition in order to respond to a change.

Transition has also been described as a stage between two periods of stability, a dynamic movement from the known, through the unknown, to the newly known (Levinson, 1986), and often involved significant life events. This process is as much about what is relinquished as what is obtained, and how the factors of loss, and gain, are orientated by the individual (Bridges, 2004). Its application to role change can be appreciated of course, where the former role is let go in the obtaining of the new, and the transition activity is given a value in terms of loss (the old role) and gain (the new role). Such thinking built on the work of van Gennep (1960), a leading anthropologist, who proposed that transition was a status passage, from one social status to another, and incorporated the three main processes of separation, transition, and reincorporation. Although criticised for being too simplistic in its approach (Gluckman, 1962), I believe that its simplicity was its strength as any transition involves leaving behind, or altering, something from the status quo (separation); the journey into and through the new environment, relationship, and/or situation follows (transition); and the inevitability of presenting oneself, now newly shaped, at the end of the process (reincorporation). Of course, the instigator of the status passage, the nature of the journey with its stops, starts, and backward steps, and potentially the juggling of several such status passages at the same time, all move to create a person's individual experience of transition.

In contrast, Nicholson (1984) suggested that responses to transition and change were, instead, dependent on internalised personal dispositions which were underpinned by individual characteristics and traits:

> 'individual differences in the characteristics of people…mediate the relationships of change vs stability and individual vs situational adjustment' (p. 172).

More recently Anderson, Goodman and Schlossberg (2021), akin to the views of Schlossberg (1981), contended that transition 'focuses on life events entailing change' (p. 17), and acknowledged that social contexts present challenging influences across political, demographic, personal, technological, cultural, and historical adult situations. They argued that life events initiated a change, a dynamic process arising from the impact of these influences. Perhaps involving the self, family or friends for example, or wider events affecting the world community such as global warming and the recent pandemic, life events were often unexpected or beyond personal control. Change occurred requiring a change-response to deal with it. Whether such life events had positive or negative outcomes, were anticipated or unexpected, or were permanent or temporary, a change-response was actioned by the individual (and even inaction was a decided action).

In clinical literature the activity of role transition had been linked to imposter syndrome- like feelings but, as noted in the Literature Review Chapter 2, further research was often recommended. Lee *et al*. (2022), for example, identified that clinician transition to an educator role can create negative, emotional consequences such as 'feelings of confusion, conflict, and loss' (p. 6) while acknowledging that 'further research needs…to track novice educators' transition journeys' (p. 7). And a later scoping review by Halton, Ireland and Vaughan (2024) into the transition of nurses to nurse educator roles identified individuals as feeling 'unprepared, overwhelmed, unsupported, confused, uncertain, isolated, and vulnerable' (p. 5), but again there was no direct reference to imposter syndrome. Rather, recommendations were made for future research into 'support and preparation strategies' (p. 1) for novice nurse educators.

Murphy and Mortimore (2020), in their work on trainee advanced clinical practitioners (ACPs) and role transition, observed that:

> 'Thus, trainees experience de-skilling as they go from being an expert in one role to a novice in another, as well as potentially developing imposter syndrome' (p. 35).

Their work contended that, 'The expert-to-novice transition has been linked to imposter syndrome' (p. 38), but their discussion did not develop beyond this and the suggestion that:

> 'Imposter syndrome appears to be more prevalent in high-achieving women (Clance and Imes, 1978), which may be relevant when ACPs are more like to be female than male (Sullivan-Bentz *et al.,* 2010)' (p. 38).

Similarly, MacLellan, Levett-Jones and Higgins (2015) in their paper on nurse to nurse practitioner (NP) role transition, commented that:

> 'In the case of NP transition, consequences include loss of identity, loss of confidence, imposter syndrome, marginalization, isolation, role ambiguity' (p. 394).

Again, the paper had no further discussion on the status of role transition and imposter syndrome beyond one additional statement: 'These feelings of self-doubt can lead the newly promoted expert nurse to feeling what has been observed as Imposter Syndrome' (p. 394).

Nurse Practitioner role transition was also discussed by Barnes (2015), who proposed that the career change created a struggle which can result in experiences of 'self-doubt, the uneasy feeling of returning to the novice level, and feeling like an imposter' (p. 140), but nothing more.

Mindful of the above points discussed, I revisited each participant in my mind. They were already in the clinical educator role when they shared their narratives, the role change had taken place. They had experienced the physical separation, the breaking away, from their former roles (Gluckman, 1962) and were in the transition phase, the state of 'in-betweenness' (Bridges, 1980, p.5). Through this recall exercise I saw that moving into the clinical educator role was a recent event, a year or less for most participants (Table 1). This could suggest, maybe, that something had occurred during early role transition to cause participants to experience feelings of imposter syndrome. I decided, therefore, to extend the literature review further to search for early transition experiences which could lead to feelings of imposter syndrome, and possibly identify a theory to underpin my Study 1 findings. This further literature review is discussed in the following section.

5.3 Early Role Transition Experiences

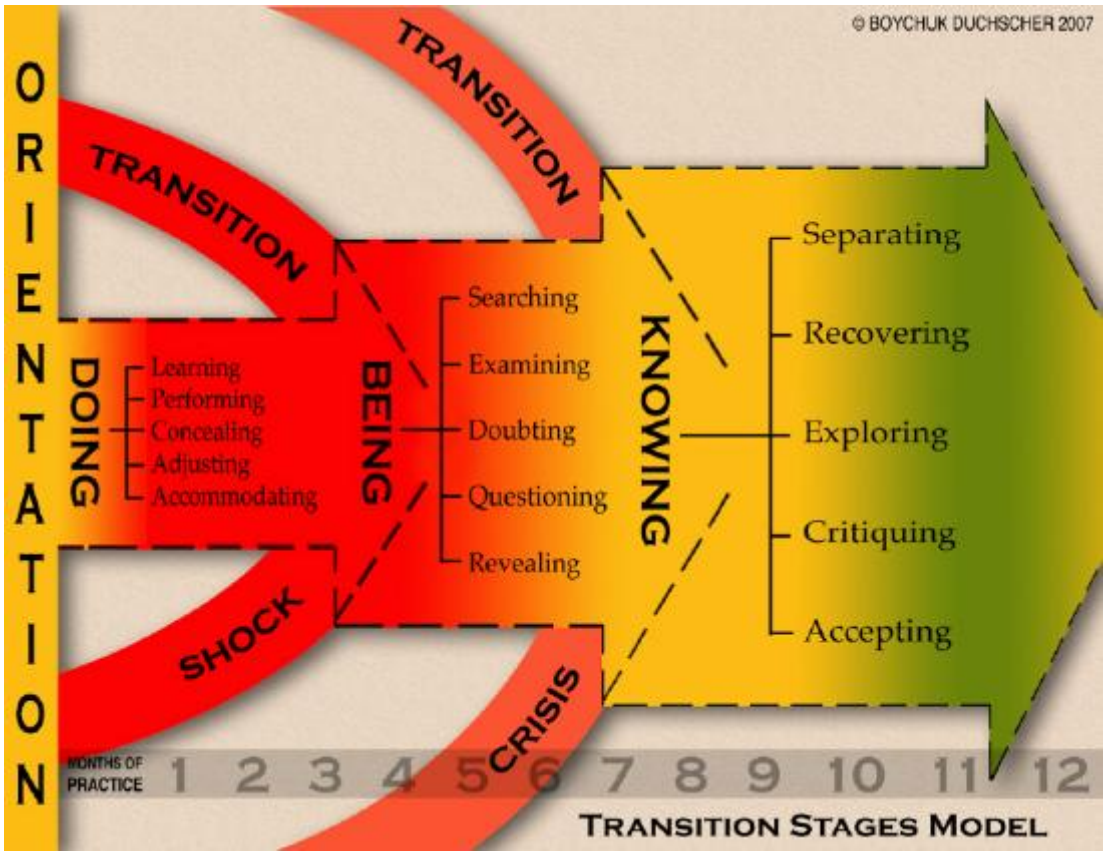
The seminal work of Marlene Kramer (1974), an American nurse, educator, and author, explored 'reality shock' in newly qualified nurses who were role transitioning from the academic environment to qualified nurse status in a clinical setting. Kramer (1974) described the reality shock process as a predictable pattern of four phases: honeymoon; shock; recovery; and resolution. These phases arose from her realisation that the academic-based values of the student nurse conflicted with the work-based values encountered by newly qualified nurses in clinical environments. Later collaborative work further identified a professional tension when 'one becomes shocked and learns that reality differs from expectations' (Schmalenberg and Kramer, 1979, p. 3). While the work of Kramer (1974) and Schmalenberg and Kramer (1979) could suggest 'reality shock' as the

early role transition experience because it showed alignments with the findings of Study 1, for example, that expectations of the clinical educator role were flawed, my study did not centre on conflicting professional values. I therefore believed the Kramer (1974) model of reality shock could not form an appropriate concept to underpin my research.

The PhD thesis of Anne Schoening (2009), and subsequent paper (Schoening, 2013) focused on how nurses made the transition to the role of nurse educator. This qualitative, grounded theory study established the Nurse Educator Transition Theory (NETT) and identified four phases of transition which concluded with 'identity formation' (p. 101) as a nurse educator. I acknowledged there were similarities between the Study 1 findings and the work of Schoening, for example, the positive expectations of clinicians before commencement of the educator role; the recognition that 'status as a clinical expert does not automatically translate into status as an educational expert' (p. 3); and a sense of disorientation, and fear of failure. The significant difference between the Study 1 findings and Schoening, however, was that the focus and aim of her study was to explore, then address, the practical processes that underpinned and enabled role preparation for role transition. There was nothing that could be identified as an early role transition experience which underpinned the feelings of her participants. While I realised in Schoening's (2009) findings that fear of failure arising from a lack of teaching skill, little feedback, and worry answering student questions, were conditions that initially blocked role transition in her participants, her study did not delve into the nature or lived experience of those feelings. Rather, it was the self-supporting strategies her participants employed that were discussed, such as 'self-directed orientation', peer mentoring', and 'establishing boundaries'. In Study 1, however, it was the feelings which had been intensely examined, leading to the findings. I therefore did not consider NETT (Schoening, 2009) appropriate to underpin my research project.

Judy Duchscher (2008) built on Kramer's (1974) concept of reality shock, and encompassed a 10-year research journey and her own PhD work, to develop her Stages of Transition Theory (2008; Figure 1) reflecting the stages of role adaptation experienced by newly graduated Registered Nurses as they move from academia to clinical settings.

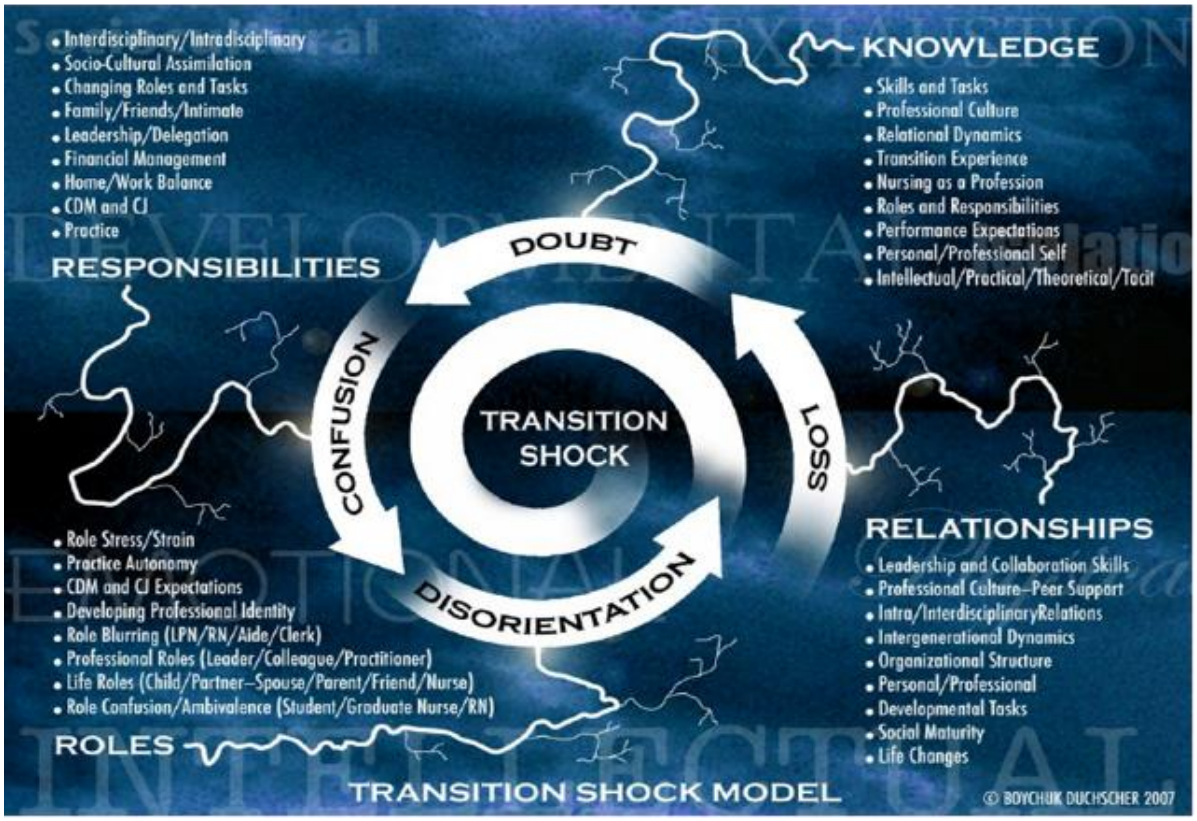
Figure 1: Stages of Transition Theory (Duchscher, 2008). Reproduced with permission.



Expanding on this work, Duchscher (2009) later proposed that an experience of 'transition shock' (Figure 2) was embedded within the early phases of professional transition, taking the individual on a non-linear journey which had:

> 'Developmental and professional, intellectual and emotive, skill and role-relationship changes, and contains within it experiences, meanings and expectations' (p. 1105).

Figure 2: Transition Shock Model (Duchscher, 2009). Reproduced with permission.



Developed in a nurse setting, the transition shock model focused on the personal feelings of loss, doubt, confusion and disorientation which arose from challenges and anxieties within the relationships, roles, responsibilities, and knowledge domains required in one environment (academia) and those now required in an altogether different transitioned one (clinical). The impact of transition shock on an individual was identified by Duchscher as 'feelings of anxiety, insecurity, inadequacy and instability' (2009, p. 1103) and, as further proposed by Duchscher and Windey (2018), are 'fluctuating states of emotional, sociocultural, intellectual, and physical well-being' (p. 228).

In her book 'From Surviving to Thriving: Navigating the first year of professional nursing practice' (2012), Duchscher defined transition shock as an occurrence which became apparent within the first few months of orientation into a new role. She believed the term fully captured:

> 'EVERYTHING related to roles, responsibilities, relationships and knowledge that both motivate and mediate the intensity and duration of a graduate's earliest experiences as a nurse' (p. 14).

Duchscher further suggested that the process of transition from one role to another cannot be uneventful, the initial period contained significant personal and professional growth but with that growth “necessarily comes struggle” (p. 15) while adjustment to the new reality occurred. For the participants in this research project, that struggle may have been the feelings they described as imposter syndrome. I was intrigued by the work of Duchscher on transition shock, more especially in relation to the Study 1 findings, and my further exploration of the transition shock model is discussed in the following section.

5.4 The Transition Shock Model and Study 1 Findings

When I initially reviewed the constituents of transition shock and overlaid them against the findings of Study 1 and the factors of the interpretative statement (Section 4.5), I was aware of significant alignments. I could see that the narrated imposter experiences of participants had distinct similarities to transition shock, as described by Duchscher (2008; 2009; 2012; Figure 2), and discussed in Duchscher’s interview with Maryann Windey (2018). Described as ‘the relative contrast between the relationships, roles, responsibilities, knowledge, and performance expectations required within the academic environment with those required in the professional practice setting’ (Duchscher and Windey, 2018, p. 228), the feelings in the newly graduated nurse were borne from the unexpected challenges they now faced in the new environment. The similarities between the experiences of participants captured in Study 1, and new nurses in the Duchscher (2008; 2009; 2012) and Duchscher and Windey (2018) studies where individuals had transitioned from the known to the unknown, led me to consider that transition shock may have been the early role transition experience the participants had encountered, and subsequently believed to be feelings of imposter syndrome.

One point I had to consider was my application of the transition shock model to my research. Duchscher had developed her work around the transition of individuals from education into new clinical practice roles whereas I was researching a different path, the transition of individuals from clinical practice to new education roles. And transition shock is not a theory in itself, Duchscher affirmed it is ‘encompassed WITHIN the 1st stage of transition’ (Duchscher, 2012, p. 61) as identified in her Stages of Transition Theory (Duchscher, 2008; Figure 1). To apply the transition shock model to my work as the underpinning of the Study 1

findings, I was therefore looking at this part of Duchscher's theory through a different lens, and I had some concerns about the validity of using her research in this way.

Reviewing the work of Wu and Volker (2009) on the use of theory in qualitative approaches to research, they identified that 'theory can be applied to qualitative studies at different times during the research process, from the selection of the research phenomenon to the write-up of the results' (p. 2721). I was clearly applying the transition shock model to the write-up of my results, but Wu and Volker did not consider applying theory differently to those results, only as a 'context or framework for data analysis and interpretation' (p. 2723).

It was the paper of David Nordberg (2023) that I subsequently found exceptionally illuminating, however. Entitled 'The lens of theory: seeing better or differently?', Nordberg took the view that, using an analogy of optics, there are four processes through which theory might act as a lens. It was the process of 'distortion', with the analogy of telephoto and wide-angle lenses, that resonated with my thoughts on applying the transition shock model to my study. Rather than focus on individuals it was the transition shock model itself, as a lens of distortion, which zoomed in to the study findings, and then zoomed back out wider to contextualise the participants' experiences. Through this optical mechanism I was able to 'see the detail that was hidden from normal, common-sense understanding' (Nordberg, 2023, p. 156), in other words, I was able to see, and tentatively consider, that transition shock may have been the participants' experience, not imposter syndrome. As a result of my deliberations on the lens of 'distortion', I was reassured that my application of Duchscher's model of transition shock to my research was both valid and appropriate.

5.5 Hypothesis Development and the Framework for Study 2

In the previous section the Study 1 findings and components of the interpretative statement, discussed in Chapter 4, were drawn together and, in relation to the participants' imposter syndrome experiences, potential alignments with transition shock (Duchscher 2009; Figure 2) were suggested.

In order to explore this thinking more fully, I carried out a piece of comparative work with the literature discussed in this thesis to review the key similarities and differences between the defining features of imposter syndrome and transition shock, shown in Tables 5 and 6. The purpose of this work was to uncover the central components which identified each entity, and enable a critical review in relation to the Study 1 findings, and interpretative statement.

Table 5: Key similarities between imposter syndrome and transition shock

Embedded negative views of own current competence, especially when compared to others
Feelings of intimidation in professional relationships believing others significantly more capable
Fear of being unable to live up to the expectations of others, and appearing to lack knowledge, skill or competence
Impact of the socio-cultural context where the unknown, and unfamiliar, creates feelings of discomfort, worry, and stress

Features similar to both imposter syndrome and transition shock (Table 5) were narrated by participants in the Study 1 findings, for example, negative views about personal competence, especially when compared with others; and awareness that the unknown environment had created feelings of stress and worry:

> '*I think it's that validity of having an external qualification will just help to build your confidence as well as your competence. But I don't have that'* (Jane, p. 7).
>
> *'This sort of sense that everybody else must be better erm... you know more intelligent, more knowledgeable, more experienced or whatever it might be erm...'* (Eric, p. 10).
>
> '*In education I've found that really difficult because there's so many different procedures and processes and getting your head round things, erm… it's very difficult'* (Heather, p. 10).
>
> *'Yeah, since I've been here it's [pause] such a different world [pause]. And there's a whole language that you don't understand, and people don't explain things to you'* (Khloe, p. 3).

Table 6: Key differences between imposter syndrome and transition shock

Imposter Syndrome Clance and Imes (1978); Clance (1985a)	**Transition Shock** Duchscher (2008; 2009; 2012)
Aetiology of imposter syndrome is understood as a reaction to a cumulation of experiences and negative messages that occur in personal, professional, and sociocultural domains across a lifetime.	Transition shock is presumed to be influenced by the histories and contexts that cultivate expectations about professional roles and responsibilities, work ethic, and culture.
The literature indicates feelings of imposter syndrome will be experienced across a lifetime.	Transition shock occurs unexpectedly within the first stages of role transition, emerging from a contrasted reality between former and current roles.
One of the most dominant characteristics of imposter syndrome is that individuals are unable to hear and believe received compliments, despite objective evidence regarding their success or intellectual ability.	Supportive statements from colleagues are greatly valued and have a significantly positive impact on individuals experiencing transition shock.
Individuals with feelings of imposter syndrome believe their achievements are a result of luck or chance, and not genuinely deserved. They have continual expectations therefore that others will find out they are the intellectual fraud they believe they are.	An individual experiencing transition shock has meaningful intellectual confidence in their former role, it was the transition into the new role that had created feelings of doubt and anxiety.
The continued existence of the Imposter Cycle where individuals fear role failure, work extremely hard to succeed, discount evidenced success, believe they lack competence, then fear future role failure. It is a never ending cycle.	These feelings will, over successive months, evolve through a process of adjustment to enable professional orientation into the new role. The negative feelings arising from transition shock will thus diminish.

Although I acknowledged that there were similarities it was nonetheless the differences between imposter syndrome and transition shock (Table 6), drawn from participant narrations, which I believed to be the more significant to the Study 1 findings. For example, the majority of participants had become unexpectedly aware of uncomfortable feelings only on commencement of the educator role, in line with transition shock, whereas the four participants who entered Study 1 with imposter feelings shared descriptions of the long-standing nature of those feelings:

> *'You start thinking that some of these people…potentially know more on the subject than you and you're teaching it [laughs]. And I think that that's a kind of underlying [pause] where imposter syndrome comes from for me'* (Fred. p. 2).

> *'My imposter syndrome has been with me for life, and will be with me for life, and so if I didn't have it in this role, I'd have it in another role'* (Celia, p. 2).

Another transition shock similarity was the impact of supportive statements or evidence of achievement. For those with newly arisen disturbed feelings such comments were welcomed, but for participants with long-standing imposter syndrome, they were dismissed:

> *'I think I've found the whole experience of being in the university just so lovely, I mean everyone is so welcoming and so friendly, I mean, you feel valued'* (Ginnie, p. 10).

> *'But I remember having a full day of euphoria after my viva and literally the next day it was like, that was it, I was still me, I was just me, with another certificate'* (David p. 11).

But I was unable to examine the presence, or absence, of the Imposter Cycle at this stage of my critical review. Participants with long standing imposter syndrome had indicated in the Study 1 findings the continued existence of those feelings in their lives, with Annie describing them as 'a monkey on my back' (p. 4) for example, supporting the presence of the cycle. While all participants were relatively new in post there was no way of knowing, however, whether new uncomfortable feelings had evolved, adjusted, or diminished since Study 1, akin to the features of transition shock. Nonetheless, I believed there could be alignment between the Transition Shock Model and Study 1 findings, and the comparative work with Tables 5 and 6 led me to think that participants may have experienced transition shock rather than imposter syndrome. As a result, an hypothesis was formulated to that effect:

> On moving from the clinical to clinical educator role, participants may have experienced transition shock rather than imposter syndrome.

This hypothesis was theoretical, based on my application of Duchscher's model of Transition Shock (2009; 2012; Figure 2) to the findings of Study 1. In order to test my hypothesis, and following discussion with my supervisors, I undertook an additional interview with participants, which formed the second study. The purpose of this was two-fold: firstly, all participants had entered Study 1 with their personal experiences of imposter syndrome. By presentation of my hypothesis, I would be suggesting that their self-assessment of imposter syndrome may have been incorrect, and this would be ethically unacceptable. It was therefore essential that I gave my participants the right of reply to the hypothesis. Secondly, the purpose of Study 2 was to ask, some two years after the first interview, how they now felt about their imposter syndrome experiences in the light of the hypothesis. As noted above and in Table 6, Duchscher (2009; 2012) proposed the unexpected feelings of role disorientation and confusion, self-doubt, and emotional challenge arising from transition shock would, over successive months, evolve through a process of adjustment to enable professional orientation into the new role. The negative feelings created by transition shock

would diminish. I was therefore extremely interested to learn about the current imposter syndrome experiences of the participants in relation to my hypothesis.

5.6 Summary

In this chapter I discussed the Study 1 findings and the interpretative statement, and explored them in relation to role transition. Participants' experiences were found to have similarities to Transition Shock, as described by Duchscher (2008; 2009; 2012) and Duchscher and Windey (2018) in their work with newly qualified nurses. This exploration led me to think that what participants had experienced may have been transition shock rather than imposter syndrome, so an hypothesis was formulated to that effect. In order to test my hypothesis and give participants an opportunity to evaluate it, I arranged a second interview. Study 2 and its findings are discussed in the following chapter.

Chapter 6 Study 2 Findings: Reframing the Experience

6.1 Introduction

This chapter presents the findings of Study 2 which explored participants' responses to an hypothesis presented during the interview. As discussed in the previous chapter, the hypothesis was developed from discussion of the findings of Study 1, and the application of Duchscher's model of Transition Shock (2008; 2009; 2012; Figure 2) to those findings. The aim of Study 2 was to test my hypothesis that the participants' experience may have been transition shock rather than imposter syndrome, and was undertaken by asking participants to now consider their imposter syndrome experiences shared in Study 1 with reference to the hypothesis. The responses were analysed using deductive phenomenological analysis as described in the Methodology, Chapter 3.

6.2 Study 2 Findings

Following reflective discussions with the participants (Appendix 6, Questions 1-4), an overview of the features of imposter syndrome and transition shock was given, and presentation of the hypothesis (Appendix 8) made. Each participant was then invited to respond to the following question: *'Having discussed the hypothesis from Study 1, I am wondering what this could mean for you. Are you able to tell me what you feel about my hypothesis in relation to your own imposter syndrome experiences?'* (Appendix 6, Question 5).

From the interview discussions it was clear that none of the participants had previously been aware of transition shock, it was a totally new entity for them, and brought a fresh perspective to their personal experiences, and perceptions of, imposter syndrome. Introduction of the concept of transition shock, and demonstration of the differences between imposter syndrome and transition shock, enabled participants to reflect on their own experiences with a greater sense of awareness and understanding.

The key participant comments received in response to Question 5 are given in Table 7, "Study 2 – Key comments following participant reflection on hypothesis", and have been structured under the three themes which emerged from the deductive phenomenological analysis of the data: Reframed Feelings as Transition Shock; Continued Identification with Imposter Syndrome; and Identification with both Transition Shock and Imposter Syndrome.

Table 7: Study 2 – Key comments following participant reflection on hypothesis

	Bridget	David	Eric	Fred	Ginnie	Iris	Jane	Khloe
Reframed feelings as Transition Shock: "I hadn't expected to find out about this…but transition shock would be a better way to describe my feelings." (Bridget, p. 3) "I mean, it's making absolute sense to me, definitely, what I was feeling was transition shock back then." (Ginnie, p. 2) "Listening to the features describing transition shock…I realise that that was what I was feeling, not imposter syndrome at all." (Iris, p. 2) "This really resonates with me! Now, listening to what you've been saying about transition shock, and I'd never heard of it, that was what I felt when I started this role." (Jane, p. 2) "I think that transition shock really does ring true, doesn't it?...it's what I experienced when I came into this role, without a doubt" (Khloe, p. 3)	✓				✓	✓	✓	✓
Continued identification with Imposter Syndrome: "Well, not knowing any of this about transition shock, I do know I definitely still fit the view of imposter syndrome…And this cycle, I'm just constantly trying to cram more things in to see whether I can prove to people, and I don't know who those people are, that I actually know what I'm doing." (David, p. 2) "What you're saying is very interesting…but my imposter syndrome is definitely still there, going round and round. It's a huge mountain I need to climb every time I go into the classroom. I still have the imposter feelings that are out of control." (Eric, p. 2)		✓	✓					
Identification with both Transition Shock and Imposter Syndrome: "I felt like an intellectual fraud when I first came into this role, like you describe as imposter syndrome. That really does ring true. I do think some of the things were transition shock but over a period of two years my feelings around being an intellectual fraud are still being resolved, but they are definitely diminished. Two years ago, I was very much there with imposter syndrome, but its only sitting and thinking about it now, that I can see the place of transition shock." (Fred, p. 4)				✓				

As shown in Table 7, the responses from participants fell into three distinct categories and these categories will now be discussed.

6.2.1 Reframed Feelings as Transition Shock

Five participants, Bridget, Ginnie, Iris, Jane, and Khloe, shared that they now no longer experienced imposter syndrome feelings in their clinical educator roles, or clinical role in the case of Iris. For example, Bridget stated that 'I'm now sure that I'm actually good enough to do this' (p. 1) and Iris felt 'My confidence in both roles has definitely grown and my clinical self-doubt has totally evaporated' (p. 1). Ginnie was very honest about her current position:

> *'I feel really comfortable there now in my current role, so different to two years ago, totally different. I know I know a lot of the answers now, and I also know people I can trust and go to if I'm not sure about anything, which is not how I felt before. In my current role, I'd definitely say that I'm in my comfort zone' (p. 2).*

Following discussion of the hypothesis, the five participants reappraised their thinking about the imposter syndrome experiences shared two years earlier in Study 1. These participants had been unaware of the concept of transition shock, and introduction to the concept altered the perceptions they previously had resulting in a reframing of the source of their imposter syndrome feelings. For these five participants, transition shock gave a more accurate explanation for what they had experienced when they moved into the clinical educator role.

Bridget, for example, identified the personal shift in awareness about her feelings:

> *'I hadn't expected to find out about this…but transition shock would be a better way to describe my feelings'* (Bridget, p. 3).

Similarly, by describing the information about transition shock as 'making absolute sense' (p. 2), Ginnie confirmed how this conceptual model aligned with her former imposter syndrome experience.

At interview Iris, Jane and Khloe clearly identified their former feelings as transition shock, with Jane commenting that 'This [transition shock] really resonates with me!' (p. 2)2); Khloe stating that 'I think that transition shock really does ring true, doesn't it?' (p. 3); and Iris definitively asserting:

> *'Listening to the features describing transition shock…I realise that that was what I was feeling, not imposter syndrome at all'* (p. 2).

The responses shared by these participants in Study 2 suggested they now saw their earlier feelings of lack of confidence, self-doubt, and confusion as not rooted in imposter syndrome,

but rather in transition shock. They expressed the belief that these feelings arose from the role ambiguity, and adjustments in relationships, responsibilities, and knowledge (Duchscher, 2008; 2009; 2012) associated with the shock of transitioning into their new professional role of clinical educator.

6.2.2 Continued identification with Imposter Syndrome

In contrast, two participants continued their self-identification with imposter syndrome. David and Eric had entered Study 1 with long-standing imposter syndrome, and although previously unaware of transition shock and acknowledging that it was an interesting concept, imposter feelings had 'still' (David, p. 2; Eric, p. 2) continued to significantly impact on their clinical educator roles, without diminishment, during the previous two years. David's moving response demonstrated an ongoing internal struggle with feelings that indicated definitive features of imposter syndrome, such as persistent self-doubt, fear of being exposed as a fraud, the imposter cycle, and perfectionism (Clance and Imes, 1978; Clance, 1985a):

> 'Well, not knowing any of this about transition shock, I do know I definitely still fit the view of imposter syndrome…And this cycle, I'm just constantly trying to cram more things in to see whether I can prove to people, and I don't know who those people are, that I actually know what I'm doing' (David, p. 2).

Eric described his feelings equally movingly, using visual metaphors to underpin the formidable and repetitive nature of his imposter syndrome experiences:

> '…but my imposter syndrome is definitely still there, going round and round. It's a huge mountain I need to climb every time I go into the classroom' (Eric, p. 2).

Reviewing the narratives of Eric and David in Study 2, it could be suggested that their feelings are more consistently aligned with experiences of imposter syndrome rather than the more short-term and context-related experiences of transition shock. Both participants had lived with imposter syndrome for many years, but as neither participant indicated any personal association to transition shock other than acknowledgement of the concept, it appeared transition shock may not have had any impact on their continued imposter syndrome experiences.

6.2.3 Identification with both Transition Shock and Imposter Syndrome

As with the other participants of Study 2, Fred was previously unaware of the concept of transition shock. In the interview discussion he responded to Question 5 by identifying that feelings of both transition shock and imposter syndrome currently existed in his clinical educator role:

> *'I do think some of the things were transition shock but over a period of two years my feelings around being an intellectual fraud are still being resolved, but they are definitely diminished'* (p. 4).

In Study 1 Fred had aligned strongly with experiences of imposter syndrome, but in Study 2 he reflected that, retrospectively, some of his experiences were transition shock. He commented on how his feelings of intellectual fraudulence 'are definitely diminished' (p. 4), which could suggest an encounter with transition shock, but not a cessation of his imposter-related experiences. Returning to Duchscher (2008; 2009; 2012), she indicated that transition shock arises within the initial weeks or months after role commencement (Figure 1) and can extend to approximately 12 months before 'strategies can be created or implemented to remove the obstacles to a successful professional transition' (2012, p. 16). For Fred the obstacle of his feelings of fraudulence, albeit diminishing, were perhaps 'still being resolved' (p. 4) some two years after appointment.

6.3 Summary

Study 2 used deductive phenomenological analysis to test the hypothesis which had emerged from the findings of Study 1. The findings from Study 2 suggested that although the majority of participants felt the concept of transition shock gave a more accurate and meaningful source for their initial feelings in the clinical educator role, rather than imposter syndrome, the hypothesis was neither accepted nor rejected in full because the overall results were mixed.

Chapter 7 Discussion

7.1 Introduction

The aim of this chapter is to offer a deep, analytical synthesis of my research by providing context, interpretation and evaluation of the Study 1 and Study 2 findings. Engagement with the literature and theory will explore the significance of this work, highlight its implications for clinical education, and demonstrate its contribution to knowledge.

As an initial step to this discussion, I restate the aim and key questions that guided this research into the lived experiences of imposter syndrome in clinical educators:

Research Aim: To advance understanding of the lived experience of clinical educators who believed they had imposter syndrome.

Research Question 1: What do participants perceive as significant to their feelings of imposter syndrome in the role of clinical educator?

Research Question 2: How do participants describe the source of their feelings of imposter syndrome?

This research comprised two studies applying phenomenological methodologies, Study 1 utilising IPA, and Study 2 utilising deductive phenomenological analysis. As researcher, my objective was not to critique, or appraise, participant descriptions and beliefs about their imposter syndrome experiences, but to listen and interpret the narratives as they, too, interpreted their experiences. The insights of participants and researcher thus formed a double hermeneutic, and offered perceptive discernments in response to the research aim.

Study 1 explored the lived experiences of imposter syndrome in clinical educators (Clance 1985a; Clance and Imes, 1978). Participant narratives identified three key overarching Group Experiential Themes (GETs) as significant to those experiences, underpinned by group sub-themes, and established the Study 1 findings: Critical incidents are recalled as significant; Feeling ‘in’ or ‘out’ of the group has an effect; and Challenges of the dual-professional role. Review and reflection of the work leading to the GETs of Study 1 indicated that transition into the clinical educator role had been significant to the feelings of imposter syndrome, and shaped an interpretative statement:

> The experience of role transition from a clinical to Clinical Educator post is significant to feelings of imposter syndrome which are shaped by relationships with others, the challenges of dual-professionalism, and meaningful recollections.

A targeted literature review, arising from the findings and interpretative statement of Study 1, led to the conceptual model of Transition Shock (Duchscher, 2008; 2009; 2012), and the suggestion that participants' experiences may have been transition shock rather than imposter syndrome. An hypothesis was developed to this effect:

> On moving from the clinical to clinical educator role, participants may have experienced transition shock rather than imposter syndrome

Study 2 was undertaken to test this hypothesis with most of the same group of participants. They were asked to consider what this possible reframing of their imposter syndrome experiences, following commencement of the clinical educator role, could mean for them. While the majority of participants believed they could identify their feelings as transition shock, others continued with the classification of imposter syndrome, or believed a hybrid of both imposter syndrome and transition shock more accurately described their feelings.

The hypothesis was neither accepted nor rejected in full because of these mixed results. This led to the development of an overarching theory that participants may confuse longer duration imposter syndrome with shorter duration transition shock.

7.2 Discussion of the Study 1 Findings

In this section interpretation and context of the research findings of Study 1 will be discussed and interwoven with the literature and theory on imposter syndrome and Duchscher's Transition Shock (2008; 2009; 2012). The discussion will be guided by the GETs and group sub-themes developed in Study 1 (Table 3; Table 4), and provide orientation for the findings of Study 2.

7.2.1 GET A: Critical Incidents are recalled as significant

Group Sub-theme A.1: Past critical experiences remained meaningful
Group Sub-theme A.2: Recollection of clinical expertise creates loss

The lasting impact of past negative, critical, incidents on personal wellbeing underpinned many of the imposter syndrome experiences shared in Study 1. Several narratives revealed that feelings of imposter syndrome had interlocked with participant lives for a considerable time, arising from critical childhood, or clinical, events, and for some these feelings had provoked an ongoing acceptance that they had to 'live with it'. The findings which demonstrated the impact of past negative critical incidents on imposter syndrome correlated

with the literature, for example, the work of Clance (1985b) indicated that experiences from the past had a significant influence on the feelings of the present:

> 'To truly understand the Imposter Phenomenon and those people who experience it with such intensity, it's essential to start at the beginning' (p. 32).

And much later, collaborative work by Clance and Lawry (2024) continued this standpoint:

> 'In truth, the totality of one's lived experiences are inextricably linked with one's experience of IP' (p. 21).

Adiguzel (2021) had similarly acknowledged the effect of past experiences in her work with nurse leaders and their experiences of imposter syndrome, commenting that the background and life history of individuals can influence from where 'the experiences were derived or came from' (p. 33). Clance and Imes (1978) had earlier suggested that negative family and academic environments in childhood can create a path to later imposter syndrome feelings, a position reinforced by Hutchins, Penney and Sublett (2018) who asserted that negative or punitive childhood feedback can lead to a defensive coping strategy resulting in imposter syndrome, situations that resonated with some participants in the Study 1 findings. Emotion was exceedingly raw in some of the narratives, with distressing descriptors of imposter syndrome given. For example, Annie described her feelings as 'a monkey on my back' (p. 4), perhaps indicating her sense of continuously carrying feelings of imposter syndrome.

The significance of difficult past life experiences was also taken by Duchscher in her work on Transition Shock. She referenced past events as meaningful to the adjustments needed following initial role transition, and noted that 'The degree to which you experience transition shock, and the relative skills you have to manage that experience, depend to a large degree on previous life experience…' (2012, p. 19), reinforcing the impact of past events on a transition shock encounter.

For two participants painful recall of childhood struggles with reading, writing, and classroom tasks was narrated in the Study 1 findings as significant to their imposter syndrome experiences. Although later framed by these participants as dyslexia, it had nonetheless created feelings of childhood inadequacy and difference which had carried through into adulthood, a position supported by the dyslexia literature (Livingston, Siegel and Ribary, 2018; Leitão *et al.,* 2017; Shehu, Zhilla and Dervishi, 2015). A study by Glazzard (2010) on the impact of childhood dyslexia concluded that such pupils compared themselves to others; noted differences between themselves and the group; had feelings of isolation; and a lack of confidence, corresponding with the Study 1 childhood experiences narrated by these two participants. While outside the scope of this study, I would suggest that factors underpinning

dyslexia could raise meaningful questions about its relationship to subsequent feelings of imposter syndrome, and would be an interesting area for future research.

Although from different fields of practice, all participants had developed clinical skills, knowledge, and expertise as a result of lengthy professional training and consequent clinical working. As described in Study 1, becoming an educator required a status of demonstratable clinical expertise which ensured that teaching of a particular clinical speciality or field was accurate, up-to-date, and professionally recognised as best practice. Participants shared that entering the new educator role had suddenly created a loss of this previously held status although, interestingly, for Iris this feeling newly arose instead in her existing clinical role as a doctor. No longer were participants the confident experts, instead they now felt like a novice who is 'wet behind the ears' (David, p. 6). These unsettling feelings are described in the literature, where the change from a previously known status becomes a significant factor in an unexpected struggle to establish a new role identity (Clegg, 2008; Wright, 2007; Trowler and Knight, 2000). The participants considered they had transitioned from 'expert' to 'novice' (Benner, 1984), and as demonstrated in the Study 1 findings, some participants felt this as significant to their feelings of imposter syndrome, a point noted in the literature by Murphy and Mortimore (2020) who argued that 'the expert-to-novice transition has been linked to imposter syndrome' (p. 38). No longer being the knowledgeable authority had created feelings of being unworthy and imposters in the educator role, a finding also supported by Lee *et al.* (2022) and Greenwood (2022). Scheese *et al.* (2023) stated that 'as expert clinical nurses transition to the faculty role, they can feel lost in the novice academic role' (p. 150), a position reflected by Khloe who stated of being in the new clinical educator role '…it's [pause] such a different world [pause]. And there's a whole language that you don't understand, and people don't explain things to you' (p, 3), or, as described by Schoening (2009), they felt a 'stranger in a strange land' p. (40). Emotive language such as feeling 'crap'; 'stupid'; 'naïve'; and 'ashamed' was used by some participants to illustrate the view they had of their novice selves in the new role. As shown in the findings, the personal distress some participants experienced following role transition had even suggested resignation from the educator role and a return to clinical practice, a point echoed in the literature by MacLellan, Levett-Jones and Higgins (2015), that the challenges of navigating personal tensions in an educator career led to fewer practitioners entering medical education 'and still others are leaving to return to clinical practice' (p. 649), and subscribed to by Browne and Collett (2023) and Lee *et al*. (2022).

Resigning from the educator role because of the encountered challenges also emerged from participants in a study by Duchscher (2012):

> *'…I found I was very hard on myself. Very critical of what I was doing and wanted to quit a few times'* (p. 19).

Duchscher (2012) stated that navigation of the initial weeks of role transition into a strange environment, and finding a place in it, can cause significant struggle, which aligned to the Study 1 findings. She believed such feelings were symptomatic of transition shock, and prompted individuals to feel surrounded by uncertainty, with a desire to 'let's get things back to the way they WERE' (p. 21). For participants, there was no familiarity in the clinical educator role as in the previous role, no sense of 'I've seen THIS before…and I know EXACTLY what to do about it!!' (p. 27).

Recollection of former clinical expertise in Study 1 emphasised the comfortable security, acknowledged peer respect, and established personal confidence, that was suddenly no longer there for participants, everything had become unfamiliar, and it was a shock. In its place was a feeling of dependency on those around, a stark contrast to former status and position, and the fear that new colleagues either expected them to perform independently or were critical of their abilities as a clinical educator.

7.2.2 GET B: Feeling 'in' or 'out' of the group has an effect

Group Sub-theme B.1: Group support makes all the difference
Group Sub-theme B.2: Comparison with others brings distress

Transition into the clinical educator role made it necessary to establish new relationships with co-workers, and navigate relationships with authority figures and wider organisational power structures, but as shown in the findings, for some participants this proved unexpectedly difficult. The outcome of transition had created a lack of confidence in previously held collaboration skills which was unanticipated, and undermined abilities to become part of the professional educational culture and environment, with one participant even describing herself as 'living in a vacuum' (Khloe, p. 4).

The importance of relationships and connections with the group or team were valued by participants. Where such connections had not occurred in early school life because of educational difficulties, feelings of isolation and 'being different' had formed an interplay with feelings of inadequacy and anxiety, and the Study 1 findings demonstrated these had been retained into adulthood. Role transition had visited, or revisited, this desire to be part of the new group as a clinical educator, but where this had not occurred, its loss was mourned and linked directly to feelings of imposter syndrome. The findings from all participants in Study 1 spoke of their relationships with former, and current, colleagues and positive relationships

were identified as extremely important to their sense of wellbeing in the workplace. These findings were supported within the literature, where a positive support network developing from good relationships with others was seen as essential (Duchscher, 2012; Fleming and Carberry, 2011; Kelly and Mathews, 2001; Anderson, 2009), a point taken further by Wenger (1998) who identified that encouraging communication and interaction with new colleagues had a greater positive impact than formal induction programmes. This perspective was challenged by Trowler and Knight (2000), however, who believed that a formal induction which focussed on work environment, role, and responsibilities, and would build such relationships. Such a view was not found in the Study 1 findings, rather, it was the positive or negative personal relationships that were felt to be the most important. For example, Ginnie recounted that 'I mean everyone is so welcoming and so friendly, I mean, you feel valued' (p. 10). Interestingly, relationships with students were not mentioned by participants other than in reference to direct teaching delivery (Fred, p. 11), possibly suggesting it was personal relationships with colleagues that were considered most significant.

The findings indicated that where participants felt included, it contributed significantly to feelings of assurance and of being valued, as supported by Anderson (2009) who stated that 'fitting in and establishing relationships' led to 'regaining comfort and confidence' (p. 207). Lee *et al.* (2022) described a sense of belonging and community as 'something the educator desired and needed as they transitioned' (p. 6), but also noted 'this was often unavailable' (p. 6). A review by Scheese *et al.* (2023) identified this deficit, recommended the development of 'strategies to thrive in an academic position' (p. 150), and noted that for new educators 'social isolation at work can degrade even the best nurses and educators' (p. 150). The participants that felt isolated and unsupported had struggled to find their place in the new culture, and as suggested by Freeman *et al.* (2022) and supported in the findings, 'this threat and vulnerability is described as the imposter phenomenon' (p. 21).

While most relationships were positive, the findings from several participants indicated negative experiences on transition into the clinical educator role. Some felt an unexpected sense of loss for their former clinical relationships, and others discovered it difficult to fit-in and feel part of the new group. The challenges identified in the findings were supported in the literature, Archer (2008) suggesting that 'becoming an academic is not smooth, straightforward, linear or automatic, but can involve conflict and instances of inauthenticity, marginalisation and exclusion' (p. 387). Such a stance reflected the feelings expressed by some participants which were associated with experiences of imposter syndrome, for example, Bridget was aware of a challenging personal relationship with her office colleague, 'I'm sure I don't belong in this office with her. I'm so different to her…' (p. 3), which resulted

in the unsettling feelings of ‘It’s really impacting my ability to feel like I belong in this role’ (p. 3).

As in the Study 1 findings, the Transition Shock model (Duchscher, 2009; Figure 2), indicated that support of the group, peers, or colleagues was highlighted as an important factor in role transition. As experienced by some participants the desire to fit-in, to belong, ‘is often determined not by ourselves, but by OTHERS (those individuals with whom we seek to belong)’ (Duchscher, 2012, p. 44). For example, Celia felt ‘you’re just so outside the circles, there’s no group, where’s your in?’ (p. 6). When the sense of belonging did not arise, this was inconsistent with the need to be accepted by colleagues as a fellow professional. Socialisation into the cultural group then became a struggle (Duchscher, 2008; 2009; 2012; Jones, 2012), with resultant feelings of distress and upset arising from this struggle being described as imposter syndrome.

New relationships with others prompted comparisons with colleagues, even participants situated in supportive environments compared their abilities to those around them. None of the comparisons were favourable but focussed on perceived skills and knowledge deficits, lack of qualifications, even unbecoming personal appearance. Participants felt this impacted adversely on self-confidence, created anxiety, and reinforced the loss of former expertise. Jane, for example, had observed that:

> *‘I’m just really mindful that I’ve spent a large portion of my career being one of the most qualified people in the room, and now [laughs] I’m usually one of the least qualified people in the room’ (*Jane, p. 2).

Anderson’s (2009) study carried the metaphor of a mermaid swimming in a ‘sea of academia’ (p. 205) to describe the ebbs and flows, eddies and currents, that the novice clinical educator had to navigate to enable role transition. She suggested that ‘feeling undercredentialed *[sic]* in the academic community’ (p. 205), created a need to establish credibility, and felt like ‘drowning’ (p. 205), a situation supported in the Study 1 findings. Duchscher (2012) expanded on this point, and while stating that ‘It is ‘normal’ for you to have some anxieties around your ability to perform with confidence and competence’ (p. 19) goes on to confirm that ‘the experience of transition shock feels ‘like I just jumped into the deep end of the pool’’ (p. 20).

The findings revealed that the participants felt this way, they were suddenly out of their depth and drowning because they believed they did not have the knowledge and skills of established clinical educators to undertake the role, or the clinician role in the case of Iris. Even further, one participant believed she did not have the physical appearance of an educator when compared to a colleague. The range of fears and emotions arising from role

transition had created feelings of imposter syndrome in participants and, indeed, prompted the undertaking of an EdD by one participant, and nail and beauty treatments by another, in order to compare more favourably with colleagues. Interestingly, Duchscher (2012) commented on the impact of transition shock in respect of colleague relationships, and when queried on how far an individual will go to be accepted by others, responded, “The answer is sometimes quite far” (p. 45).

When faced with the need to knowledgeably perform, the fear of being unable to repeat accomplishments led some participants to respond to unfavourable self-comparisons by constant lesson over-preparation. This supported the concept of the imposter cycle (Clance, 1985b; Appendix 1), one of the key features of imposter syndrome. Clance believed ‘The question ‘How good am I really?’” (p. 25) rendered “…the Imposter Cycle a very difficult one to break’ (1985b, p. 26), a sentiment shared by some participants of Study 1. In contrast, Duchscher (2012) gave reassurance, stating ‘that this intellectual ‘black hole’ into which your mind seems to have fallen…doesn’t necessarily mean that you are incapable or incompetent”’ (p. 47). Rather, self-questioning about knowledge was identified by Duchscher (2009) as one of the four core categories within the transition shock experience (Figure 2).

7.2.3 GET C: Challenges of the dual-professional role

Group Sub-theme C.1: Developing a dual-professional role brings difficulties
Group Sub-theme C.2: Expectations of role transition were flawed

The findings indicated that development of a professional identity appeared a significant and unexpected struggle for many participants, with some querying whether they were still a clinician as they now worked in education, despite retention of their professional clinical registration. Duchscher (2012) stated that such unexpected feelings of disorientation would arise following role transition, and confusion, blurring, and ambivalence would occur. And while many participants had undertaken clinical education at the bed-side, or even as part-time university lecturers, they now felt in a totally different environment. They had moved into the role because of a love of teaching, but experienced disorientation in their professional identity. ‘Am I a clinician or am I a teacher?’ was the sentiment shared by many, and reflected Bridges’ (1980) picture of Alice who was in the ‘confusing nowhere of in-betweenness’ (Carroll, 1967, p. 5). The in-betweenness of their identity created feelings of uncertainty and anxiety, and challenged how participants believed they were perceived by others. Responses to such feelings had been varied, some participants relied on visual cues such as uniforms and ID badges to embed, or perhaps reinforce, identification in the clinical

educator role. Interestingly, many participants had held highly responsible roles in areas such as cardiac care, ICU, or emergency care and felt confident, knowledgeable, and respected in their chosen fields of expertise.

Awareness of the expectations of others to deliver academic teaching in a formal setting created unforeseen role stress, despite teaching subjects based on their own clinical expertise and knowledge. These feelings had been unanticipated, and were supported in studies by Browne and Collett (2023); Scheese *et al.* (2023); Lee *et al.* (2022) which highlighted the emotional difficulties experienced during the identity formation process. Further, and as suggested by the findings, Barnes (2015) proposed that the struggle 'to form an identity as the role is navigated' (p. 140) potentially resulted in imposter syndrome feelings, a view reinforced by Greenwood (2022) in her work on Clinical Skills Fellows who are educators but 'are expected to know what is happening in practice and vice versa. This is where imposter syndrome could start to creep in' (p. 2). This perspective was also taken by Freeman *et al.* (2021) who asserted that 'As healthcare educators undergo a career transition from providing care to providing education, their professional identity can also transition accompanied by significant threat' (p. 21). The authors go on to explain, 'This threat and vulnerability is described as the imposter phenomenon' (p. 21). Transition into the dual-professional role had unexpectedly diminished participants' sense of expertise, they struggled to establish a professional identity, resulting in feelings of imposter syndrome.

Duchscher (2012) commented that disorientating role stress initiated by transition shock 'turns into role strain when you are unable to reconcile for yourself or others what role you are assuming' (p. 40). For many participants, the findings demonstrated that feelings of imposter syndrome were the results of that role strain. Duchscher (2012) further observed that transition shock 'can cloud your vision such that what was previously quite comfortable and familiar to you becomes partially or sometimes completely unrecognizable' (p. 42). This appeared to have been the participant experience; they still possessed abundant skills and knowledge but in the in-betweenness of the clinical and educator role it had become 'partially or sometimes completely unrecognizable' (p. 42).

The Study 1 findings were, however, in contrast to studies by Boyd *et al.* (2009) and Smith and Boyd (2012) who proposed that entry into the new educational environment can lead novice educators to hold on to their clinical identity, and only later move to the identity of a clinical educator. This was not supported by the findings, rather, there appeared an impatience to actively establish and become the new role as suggested by the uniforms, badges, academic attainment, and beauty treatments previously discussed.

The literature indicated that prior expectations on entering education can be feelings of excitement and anticipation, and they 'would be met by a welcoming collegial environment' (Duchscher, 2012, p. 20) which distinguished their professional knowledge and expertise. This was shown in the findings as experienced by some participants, Bridget, for example, stating that she was '…so excited, that before I even started the role I made, like a 'notes' section, on my phone' (Bridget, p. 5). Scheese *et al.* (2003) go further, and advised novice clinical educators to 'Celebrate and enjoy the leap to a new opportunity. Successful new faculty benefit from self-awareness and self-actualization – two antidotes for the imposter syndrome' (p. 150). This did not happen for participants in Study 1, however, despite any initial positive mindsets. Rather, the unexpected reality of transition into the new workplace soon made it feel like an isolating minefield waiting to explode, most especially by participants who had long-standing feelings of imposter syndrome and who felt they were constantly waiting to be found out. As shown in the findings and supported by literature, all participants felt their prior expectations about moving to the clinical educator role had not been accurate (Anderson, 2009; MacNeil, 1997; Table 4), and while Duchscher (2012) observed that 'prior to the onset of the transition shock experience there are often feelings of elation, excitement and anticipation' (p. 19), these feelings soon vanished for participants.

For the majority of participants in Study 1, it was at this vanishing point that the first indications and feelings of imposter syndrome unexpectedly emerged. For some, working alone without the anticipated organisational support or direction, gave rise to self-doubt and a lack of confidence leading to feelings of not being qualified or competent for the role; for others, when the expectation of an easy transition from bedside to full-time clinical teaching did not happen, they questioned their abilities as an educator, or even clinician. Interestingly, some participants assumed former part-time experiences as a university clinical lecturer would enable an easy transition into the full-time role. But this assumption faded, and participants then doubted their teaching competence and skills. Although familiar with the university environment and culture, their colleagues and the curriculum, the transition had brought unexpected challenges which they struggled to understand, and feelings of imposter syndrome had developed. For these participants, their situation had changed. They previously held 'a foot in both camps' and maintained a secure and significant role in practice alongside that of university clinical lecturer. Transition to the full-time clinical lecturer role had removed participants from this split clinical/lecturer role, they had left the comfort zone discussed by Anderson (2009), and were now uncomfortably swimming in a 'sea of academia' (p. 205), having experienced a shock which produced confusion, disorientation, and doubt.

Duchscher (2012) stated that ‘An impressive finding throughout my research has been the ‘surprise’ expressed by new nurses as they are faced with the challenges of transitioning into a professional workplace role’ (p. 15). The findings of Study 1 also demonstrated feelings of surprise for some participants. It was a surprise to realise, for example, that former part-time clinical lecturing did not guarantee a smooth transition into the full-time role, or that ward-based teaching skills were not comparable to the requirements of the clinical educator role in a university (Carr, 2019; Jones, 2012;), suggesting that the role was possibly not fully understood, a point made by Davis *et al.* (1992). Infante (1986) had earlier stated that the transition from a clinical to educator role was not just adding ‘educator’ to that of their clinical identity, rather ‘it requires a change in knowledge, skills, behaviors, and values to prepare for the new assimilated role’ (p. 94). Such concerns had led Davis *et al.* (1992) to develop a competency framework for the novice clinical educator whom, they proposed, although clinically competent was educationally unprepared for an academic post. As shown in the findings, for some participants this sense of educational unpreparedness created bewildering feelings of doubt in their teaching ability, even their clinical knowledge despite former role accomplishments, and such self-doubt underpinned their feelings of imposter syndrome.

7.2.4 Orientation of the Findings of Study 2

Discussion of the findings of Study 1 above, and their relation to theory and the literature, indicated significant alignments between the features of imposter syndrome and Transition Shock in participant experiences. These alignments suggested that participants may have experienced shorter duration transition shock, rather than longer duration imposter syndrome, on commencement of the clinical educator role. It was the testing of these alignments that formed the structure of Study 2 and presentation of the hypothesis formulated from the findings of Study 1:

> On moving from the clinical to clinical educator role, participants may have experienced transition shock rather than imposter syndrome.

As demonstrated in the Study 2 findings, which were focused on the responses to Question 5, participants had not been formerly aware of the concept of Transition Shock, but recalled feeling confused, self-doubting and overwhelmed following commencement of the clinical educator role, some two years earlier. As discussed in the Literature Review, Chapter 2, there is widespread public knowledge and awareness of imposter syndrome, however, and the feelings it can engender are ‘immensely relatable’ (Cokley, 2024, p. 4). As illustrated in Table 5, there are key similarities between the experiences of imposter syndrome and transition shock. Perhaps it is not surprising, therefore, that all participants believed they

had experienced imposter syndrome as they embarked on transition into the clinical educator role.

Move forward two years and the situation is different. For the majority of participants in Study 2, following discussion of the key differences between imposter syndrome; the unknown concept of transition shock (Table 6); and the hypothesis, they now believed their former experiences were transition shock rather than imposter syndrome (Table 7):

> *'I hadn't expected to find out about this…but transition shock would be a better way to describe my feelings.'* (Bridget, p. 3)

These participants described themselves now as confident in the clinical educator role, or clinical role in the case of Iris, dealing with challenges it is true, but without the feelings of imposter syndrome. And several participants commented that the passage of time had appeared to resolve many previous issues. But what had happened during those two years? Browne and Collett (2023), in their study on the transition journey of medical educators, identified that the passage of time enabled individuals to understand the transitional impact of role change, 'incorporate these meanings into their self-identity and behaviour' (p. 654), and internalise their position within the new role. And Kalensky and Hande's 'A Blueprint for Success' (2017) advised that 'realizing that academia is a marathon, and not a sprint, is imperative to sustainability in the nurse educator role' (p. 438), and leads to role orientation. Duchscher and Windey (2018) reflected that 'the increasing levels of intensity and anxiety' (p. 229) of transition shock arose in the first few months of role orientation, after which 'graduates continue to progress through deliberate and sequential stages of socialization and skill advancement' (p. 229). The literature appeared to reflect the Study 2 findings for the majority of participants, their feelings of imposter syndrome had gone, suggesting they had graduated through the 'stages of socialization and skill advancement' (Duchscher and Windey, 2018, p. 229) to the role of clinical educator. The Study 1 interviews, which had taken place within the first year of appointment, may therefore have captured feelings of transition shock, rather than imposter syndrome. **The hypothesis was accepted by these participants.**

For two participants in Study 2 there was self-identification of continued imposter syndrome which remained to impact on their educator role, and the concept of transition shock was rejected as the source of their feelings (Table 7). The findings indicated their feelings of persistent self-doubt; fear of being exposed as a fraud; immersion in the imposter cycle; and perfectionism, had continued, as supported in the literature (Clance, 1985a; Clance and Imes, 1978):

> *'Well, not knowing any of this about transition shock, I do know I definitely still fit the view of imposter syndrome…'* (David, p. 2).
>
> *'What you're saying is very interesting…but my imposter syndrome is definitely still there, going round and round. It's a huge mountain I need to climb every time I go into the classroom'* (Eric, p. 2).

The poignant, and largely negative, depictions of these participants' feelings in Study 2 reinforced a perspective in literature that 'the phenomenon is reflective of a negative and critical self-concept, and negatively affects the individuals who experience it' (Feenstra *et al.,* 2020, p. 2). This 'critical self-concept' appeared to underpin the feelings of these participants, challenged confident orientation into the educator role, and unlike the experience of transition shock, existed with no end point.

There are challenges to the approach of 'critical self-concept', however, which focuses imposter syndrome on the individual rather than considering the possible influence of context and environment. Clance drew the distinction that imposter feelings may emerge from 'interpersonal and social contexts' (Clance *et al*., 1995, p. 80), and work by Bernard, Jones and Volpe (2020), McGee *et al.* (2022), and Tulshyan and Burey (2021) suggested 'that the answer to overcoming "imposter syndrome" is to fix the environment rather that to fix individuals' (Cokley, 2024, p. 5). But in contrast, the Study 2 findings indicated the very personal nature of the imposter syndrome feelings expressed by these two participants, '*I* do know *I* definitely still fit the view of imposter syndrome…' (David, p. 2) [my italics], and '…but *my* imposter syndrome is definitely still there, going round and round. It's a huge mountain *I* need to climb every time *I* go into the classroom' (Eric, p. 2) [my italics]. There appeared a personal ownership of the feelings of imposter syndrome, there was no reference to other influences.

In the literature there remain many unresolved questions around the experience of imposter syndrome, for example, is it part of one's identity (Matthews and Clance, 1985); is it a personality trait or predisposition (Leary *et al.,* 2000); is it the outcome of one's sociocultural context (McGee *et al.,* 2022); or is it an experience created by being too highly evaluated (McElwee and Yurak, 2010)? While outside of the scope of this research project, such questions raise thought-provoking perspectives on imposter syndrome experiences. Interestingly, Duchscher (2008; 2009; 2012) and Duchscher and Windey (2018) do not discuss imposter syndrome specifically in relation to the Transition Shock Model. Many of the transition shock feelings described by the authors such as belief of skills or knowledge deficits; feelings of intellectual phoniness; questioning of professional identity; difficulties with establishing relationships; and self-doubt, are nonetheless widely described in the literature as manifest in imposter syndrome (Cokley, 2024; Burford, Fyffe and Khoo, 2022; Freeman *et*

al., 2022; Morris *et al.,* 2022; Hutchins and Rainbolt, 2016; Clance, 1985a; Clance, 1985b), and further suggested the alignments between feelings of imposter syndrome and transition shock.

For these two participants in Study 2 the concept of transition shock did not have resonance. Rather, if they had unknowingly experienced transition shock, it appeared to have become completely blended within existing feelings of imposter syndrome. **The hypothesis was rejected by these participants.**

One Study 2 participant identified encounters with both transition shock and imposter syndrome, the findings describing imposter feelings of intellectual fraudulence that were 'definitely diminished' (Fred, p. 4; Table 7) in contrast to strong former associations which newly arose following role appointment. A study by Maqsood *et al.* (2018) suggested '…imposter syndrome has more recently been studied as a reaction to certain situations' (p. 3431) and could support this participant's original belief that his imposter syndrome was created as a result of transition into the new role. Study 2 prompted some reflective thoughts, however,:

> *'I do think some of the things were transition shock…Two years ago, I was very much there with imposter syndrome, but its only sitting and thinking about it, now, that I can see the place of transition shock'* (Fred, p. 4).

The Study 2 findings of Fred's hybrid experience may reflect the work of Duchscher (2008; 2009; 2012) who indicated that transition shock arose within the initial weeks of role commencement (Figure 1) and can extend to approximately 12 months before 'strategies can be created or implemented to remove the obstacles to a successful professional transition (Duchscher, 2012, p. 16). For Fred his sense of diminishing fraudulence was 'still being resolved' (p. 4) some two years after appointment and may indicate his ongoing strategies to enable professional transition. A recent scoping review by Halton, Ireland and Vaughan (2024), however, interestingly suggested a longer transition period and commented that rather than a 12-month marker, 'for novice nurse educators in the reviewed sources of evidence, this turning point is more likely to be between 2 and 5 years' (p. 11). The authors go on to explain that their variance with the timeframe of Duchscher reflected the individuality, life experience, and organisational support received by novice clinical educators. The findings of Fred's hybrid position suggested that further research to review his perceptions of the imposter syndrome experiences, after a further period of time, would be valuable. **The hypothesis was neither accepted nor rejected by this participant.**

One further interesting point was made in Study 2 by most of the participants in that they wished they had been aware of transition shock when first in post, and that the distressing feelings would not continue indefinitely. Ginnie, for example, commented that:

> *'If transition shock was introduced and people knew about it, it would save a lot of worry and feeling uncomfortable, like a fish out of water, and your own feelings of inadequacy. Because you'd know that's normal, that's a normal part of transitioning into a new role, which would help significantly. You'd know you'd be fine in a few months'* (p. 3).

Bridget had a similar perspective by suggesting that 'I think this will be a very valuable contribution to practice, knowing about transition shock' (p. 3), and Fred commented that:

> *'I wish someone had had this conversation with me when I first came into role, to look at imposter syndrome and transition shock, to look at my feelings through a different lens'* (p. 4).

Eric, although retaining his own feelings of imposter syndrome in the educator role, observed that:

> *'Perhaps telling people about transition shock would help them when they move into teaching, stop them feeling so bad, it doesn't work for me, but it might help someone else'* (p. 2).

Jane indicated she would take discussions about transition shock a step further:

> *'I've found this very interesting indeed, and I'll certainly research about transition shock, to help me, but maybe I would be able to have a helpful discussion with any new colleagues coming to the department from a clinical setting and feeling like I did two years ago"* (p. 3).

And Iris stated emphatically, 'Transition shock needs to be talked about more!' (p. 1).

7.3 Review of the Hypothesis and Development of Overarching Theory

In this discussion of the findings from Study 1 and Study 2 it was demonstrated that the hypothesis was neither accepted nor rejected in full because results were mixed. This led to the development of an overarching theory that in the role transition experience of clinical educators, there may be confusion between longer duration imposter syndrome and shorter duration transition shock.

7.4 Summary

The aim of this chapter was to offer an analytical synthesis of Study 1 and Study 2 with reference to literature, and through contextualisation, interpretation, evaluation of the findings, and response to the hypothesis. While Duchscher's (2012) work does not discuss imposter syndrome, it was demonstrated that many of the factors displayed in the Transition Shock model (Figure 2) were in alignment with the participants' personal stories of their imposter syndrome experiences as portrayed in the Study 1 GETs, the narratives of Table 4,

and the interpretative statement. It was these factors that produced the feelings of imposter syndrome and led me to propose Transition Shock was the appropriate underpinning concept model for this research. As discussed in this Chapter, although the findings from Study 2 suggested that although the majority of participants felt transition shock gave a more accurate and meaningful source for their initial experiences in the clinical educator role, the hypothesis was neither accepted nor rejected in full because the results were mixed.

Chapter 8 Conclusion

8.1 Introduction

This chapter will review the aim and research questions of the thesis, and discuss the conclusions that arose from the findings of Study 1 and Study 2. Leading from these conclusions the contribution to knowledge will be examined, and the implications for practice considered. The limitations, strengths, and dissemination of the research will be deliberated, as will my reflexive experiences in undertaking this research. The thesis will end with my final thoughts on my journey as an EdD researcher.

8.2 Review of the Research Question and Aim

The question which guided this research was:

- How do clinical educators make sense of the lived experience they believe to be imposter syndrome?

The aim of this research project was:

- To advance understanding of the lived experience of clinical educators who believed they had imposter syndrome.

The two sub-questions framed to address the aim were:

- What do participants perceive as significant to their feelings of imposter syndrome in the role of clinical educator?
- How do participants describe the source of their feelings of imposter syndrome?

In the findings from Study 1, the IPA methodology directly addressed the research question and sub-questions by capturing detailed, first-person accounts of participant's experiences, leading to convergence with the research aim. The idiographic and inductive nature of IPA had enabled participants to articulate, and make sense of, three significant areas located as underlying their feelings of imposter syndrome experienced during transition from the clinical to clinical educator role: Relationships with Others; the Challenges of Dual-Professionalism; and Meaningful Recollections. Deep exploration of these areas, the emerged interpretative statement, and literature, led to development of an hypothesis which was tested in Study 2 through deductive interpretative analysis. Thesis conclusions were formulated, and resulted in the contribution to knowledge which addressed the aim of this research project.

8.3 Thesis Conclusions

This thesis explored the imposter syndrome experiences of clinical educators transitioning from professional healthcare disciplines into teaching roles. Themes identified in the initial data analysis unexpectedly revealed the possibility that participants may have experienced transition shock, rather than imposter syndrome, during their transitional orientation into the new role. An hypothesis was formulated to reflect these findings, and was then tested with most of the same participant group. How they reflected on their transition experience was examined, and the question asked whether they now believed imposter syndrome, or transition shock, offered a more accurate framing as the source of their imposter experiences. While the hypothesis was neither accepted nor rejected in full because results were mixed, awareness of this uncertainty was identified as helpful to clinical educators in that transition shock feelings would not continue indefinitely.

8.4 Contribution to Knowledge

The contribution to knowledge of this research is the development of an overarching theory that in the role transition experience of clinical educators, there may be confusion between longer duration imposter syndrome and shorter duration transition shock.

8.5 Recommendations for Practice and Future Research

This research contributed to the growing discourse on the emotional labour involved in the role transition of clinical educators. Recommendations for practice highlighted the need for organisations to recognise, and respond to, the challenges faced during that role transition experience. The opportunity to raise awareness and openly discuss imposter syndrome and transition shock in the induction training of new clinical educators, supported by literature and research, would potentially enable newly appointed educators to review their own feelings and experiences from a different perspective. Research on the effectiveness of such an addition to induction programmes would subsequently be necessary to evaluate its impact on the transition experience of clinical educators into their new role.

I had not anticipated the finding that, for one participant, successful orientation into the educator role had initiated unexpected feelings of imposter syndrome in her existing clinical role. While Iris' feelings reflected the imposter experiences of other participants, the impact of transition shock appeared to have brought such feelings into sharp focus within her role

as a doctor. The imposter experiences of Iris were outside the scope of this project, but I believe research into such an experience would add to the imposter syndrome - transition shock discourse going forwards.

A third area of future research would be the experience of dyslexia which some participants felt was significant to their feelings of imposter syndrome. Examination of the possible relationships between dyslexia and imposter syndrome in clinical educators, and potentially in other health care sectors, may enable strategies to be developed in support of personal well-being and career progression.

The fourth area of future research would be continued follow-up of Fred's experience of diminishing imposter syndrome, and exploration of his subsequent perception regarding transition shock.

8.6 Strengths and Limitations of the Research

The methodologies of IPA and deductive phenomenological analysis enabled rich data to be created from participants' interviews and allowed the researcher to obtain unique insights into the personal experiences of each individual, a distinctive strength of the research project.

Strengths also arose in the chance gender mix of participants which created a more balanced voice in both studies; the involvement of two participants from ethnic minorities enabled greater narrative diversity; and the cross-section of clinical roles provided broader professional engagement with the research.

There were limitations, however. Participants were self-selected, therefore were emotionally motivated to engage with the research which may lead to response bias, and the participant group was small, consequently the findings are not transferable. Additionally, clinical encounters during the Covid pandemic may have had a bearing on feelings of imposter syndrome. Participants were not screened for this, therefore influence on the research outcomes cannot be excluded.

Finally, I must acknowledge that the findings of both studies were established from my own personal analysis, and interpretation, of participant narratives. While a reflexive understanding of self and perceptive discernment were engaged to identify personal bias or judgements, a limitation of the project was the beliefs, knowledge, and world view I

possessed as researcher which would have been present during my analysis and interpretation processes.

8.7 Dissemination

Dissemination of this work will be through the writing of professional journal articles, book chapters, conference presentations, and teaching. In addition, this thesis will be included in the University's repository, RaYDaR. I believe the outcomes of my research are significant, and I would seek to share my findings across the wider clinical education sector.

8.8 My Reflexive Position

At the commencement of this study, I was aware of my position as researcher, and the influences and biases that position brings to the research process. My knowledge of qualitative research at that point was that my own subjectivity should be counteracted, or 'bracketed' (Neubauer, Witkop and Varpio, 2019; Gearing, 2004), to establish the objectiveness of distance to explore the research phenomenon. Work undertaken by later qualitative researchers (Olmos-Vega *et al.,* 2022; Holmes, 2020; Marcus, 2011) sought to instruct that an approach which positioned the researcher as a neutral observer, far removed from the studied phenomenon, risked the possibility of understood realities being remote from participant experiences. And Smith, Flowers and Larkin (2022) identified the subjectivity of the reflexive researcher as fundamentally intertwined with the IPA research process, which sought to convey the confusion of participants' experiences. A note of caution was raised by Olmos-Vega *et al.* (2022), however, in that while researcher subjectivity has many positive impacts, failure to appropriately engage a reflexive stance can negatively impact the knowledge built through qualitative research.

With reference to the above, and in order to harness reflexivity in my research, I kept a diary throughout the study incorporating personal memos, field notes, and journaling entries. The memos and field notes recorded issues impacting on individual participants and their data, such as illness or work pressures, or to record the background to my decision making or data interpretations. My position as a former ward-based nurse, then clinical educator, and ultimately Professional Education Lead, had the potential to shape my engagement with the data as I was aware of the transition journey from a clinical to educator role. Through the lens of my own experiences I was able to remember, appreciate, and understand the role

transition experiences of participants. But it was the reflexive note taking that ensured my focus remained on the transition journey of each participant, and enabled me to identify the significant issues in participants' narratives which my prior knowledge could understand, but in the context of their experiences not mine.

Journaling was used to explore and open up my own preconceptions, beliefs, and knowledge which ebbed and flowed throughout the entire project. For example, in my former role of leading and managing several teams of educators I had encountered the situation with Ruth, and it was journaling that enabled me to put Ruth's story into perspective. Stripping back the story to look at myself in retrospect, I realised that I had cared deeply about the impact of her situation on her, on the department, and on the organisation. We had all been losers in that situation. I did not see it at the time as I worked in 'professional mode', but this research project and journaling brought to me a sense of personal guilt for failing a colleague. And yet, the continued reflective journaling enabled me to effectively work through this feeling, and became an essential tool in recognising that my feelings had been the positive impetus for undertaking this research.

Journaling also played an important role in my own passage as a new researcher. I had entered an unknown world where the path had taken me to great heights but also to great depths and, very often, right into the 'slough of despond'. The act of writing such disparate feelings down was cathartic, and being able to turn back to see where I had travelled from, and where I was now, demonstrated my research progress. While it was a constant backwards and forwards trajectory, through the journaling I could see that the overall direction of the project was forwards, creating immense reassurance.

Prior to meeting with participants, I had been concerned they might have found difficulties in talking to me, albeit confidentially, about their experiences of imposter syndrome. As already discussed, imposter syndrome is an emotive subject and can attract negative connotations. Although the participants had volunteered for the study, I was aware that there may have been some reticence in speaking openly about their experiences due to embarrassment, fear of being seen weak, or thought not up to the job. Such potential data limitations could compromise the genuineness of the project outcomes. As researcher I was consciously aware my presence, and the use of a voice recorder, could influence participant responses. Imposter syndrome is extremely personal, therefore assurances of confidentiality, the use of appropriate wording in the interviews, and member checking throughout were reflectively undertaken. It became evident that as a fellow clinician, rather

than researcher, participants freely and opening engaged with me, and I felt both appreciative and privileged by their frank honesty and trust in me.

In writing this section of my research project I came to understand the courage that is needed to engage with reflexivity. My diary was created over several years, from many different perspectives and focuses, and often disjointedly. Reading through the diary, I confronted several uncomfortable truths and experiences about the assumptions and viewpoints I had made at different stages in my research journey. But from this uncomfortableness I found a belief that by freely admitting my confusion and struggles throughout this journey to both myself and others, I had opened dialogue about the value of reflexivity as an asset in research, and this was ultimately an indication of my strength and integrity as a researcher.

8.9 Final Thoughts

The move to a clinical educator role is distinctly different from clinical career changes because of its location in non-clinical environments. Often a mid-career decision, the move is commonly undertaken because of enjoyed teaching within clinical settings, but as demonstrated in this research, distinctive changes are suddenly encountered by the novice clinical educator. I believe this thesis has contributed significantly to the limited knowledge on imposter syndrome and transition shock in clinical educators and supports the development of evidence-based induction programmes to enable, and sustain, their role transition journey.

For me personally, I wish to share with others the additional understandings of imposter syndrome and transition shock and advance the implications for clinical educator practice. I had maintained a professional dialogue with former clinical colleagues throughout this research project and, I am thrilled to say, in early 2025 I received invitations to contribute to clinical educator induction programmes in both a local teaching hospital and a GP group practice upon attainment of my doctorate. The opportunity to use the outcomes of my research to support future clinical educators in their role transition journey is both exciting, yet humbling, and I look forward to working with successive cohorts of new educators in the years to come.

But I cannot close this thesis without returning to the unaware initiator of this work, Ruth. While I have no way of knowing the source of the feelings she experienced that led to her resignation, Ruth’s honest and open discussion with me vividly told of the impact of those

feelings on her. And it was that vividness, openness, and honesty that had created the impetus for this research project and developed its recommendations for clinical educator practice. Thank you, Ruth.

References

Adiguzel, A. (2021) *Navigating the Imposter Phenomenon: The Lived Experience of Nurse Leaders.* EdD Thesis. Columbia University.

Alase, A. (2017) 'The Interpretative Phenomenological Analysis (IPA): A Guide to a Good Qualitative Research Approach', *International Journal of Education and Literacy Studies,* 5(2), pp. 9-19.

Allmark, P., Boote, J., Chambers, E., Clarke, A., McDonnell, A., Thompson, A. and Tod, A.M. (2009) 'Ethical issues in the use of in-depth interviews: literature review and discussion', *Research Ethics Review*, 5(2), pp. 48-54.

American Psychiatric Association (2022) *Diagnostic and Statistical Manual of Mental Disorders (DSM) DSM-5-TR.* 5th edn. Washington: American Psychiatric Association.

Anderson, J.K. (2009) 'The Work-Role Transition of Expert Clinician to Novice Academic Educator', *Journal of Nursing Education,* 48(4), pp. 203-208.

Anderson., M.L., Goodman, J. and Schlossberg, N.K. (2021) *Counseling adults in transition: Linking Schlossberg's theory with practice in a diverse world.* 5th edn. New York: Springer Publishing Company.

Arthur, J., Waring, M., Coe, R. and Hedges, L.V. (2012) *Research Methods & Methodologies in Education.* Los Angeles: SAGE.

Ashworth, P.D. (2003) 'An approach to phenomenological psychology: the contingencies of the lifeworld', *Journal of Phenomenological Psychology*, 34(2), pp. 145-156.

Audi, R. (2010) *Epistemology: A Contemporary Introduction to the Theory of Knowledge*. 3rd edn. Available at: https://doi-org.yorksj.idm.oclc.org/10.4324/9780203846469 (Accessed: 12 May 2025).

Azungah, T. (2018) 'Qualitative research: deductive and inductive approaches to data analysis', *Qualitative Research Journal*, 18(4), pp. 383-400.

Barnes, H. (2015) 'Nurse Practitioner Role Transition: A Concept Analysis', *Nursing Forum,* 50(3), pp. 137-146.

Bell, L. (1989) 'Something's wrong here and it's not me: Challenging the dilemmas that block girls' success', *Journal for the Education of the Gifted*, 12(2), pp. 118-130.

Benner, P. (1984) *From Novice to Expert.* Menlo Park, California: Addison-Wesley Publishing Company.

Bernard, D. L. **(**2024) 'Racism and the Imposter Phenomenon Among African American Students: A Socioecological Analysis', in K. Cokley (ed) *The Imposter Phenomenon: Psychological Research, Theory, and Interventions.* Washington: American Psychological Association, pp. 181-202.

Bernard, D.L., Jones, S.C.T. and Volpe, V.V. (2020) 'Imposter phenomenon and psychological well-being: The moderating roles of John Henryism and school racial composition among Black college students', *Journal of Black Psychology*, 46(2), pp. 195-227.

Bhattacharya, H. (2012) 'Interpretative Research', in L.M. Given (ed) *The SAGE Encyclopedia of Qualitative Research Methods.* Los Angeles: SAGE Publications, pp. 465-467.

Bingham, A.J. (2023) 'From data management to actionable findings: A five-phase process of qualitative data analysis', *International Journal of Qualitative Methods,* 22. Available at: https://doi.org/10.1177/16094069231183620 (Accessed: 13 May 2025).

Bingham, A.J., & Witkowsky, P. (2022) 'Deductive and inductive approaches to qualitative data analysis', in C. Vanover, P. Mihas and J. Saldaña (eds) *Analyzing and interpreting qualitative data: After the interview.* Thousand Oaks, CA: SAGE Publications, pp. 133-146.

Blackburn, S. (2008) *The Oxford Dictionary of Philosophy,* 2nd edn. Oxford: Oxford University Press.

Blake, C. (2023) 'Why I love my new nursing lecturer role: Tips on making the transition from clinical practice to nurse academia, including managing imposter syndrome', *Nursing Standard,* 38(10), pp. 26-27.

Boyd, P., Smith, C., Lee, S. and MacDonald, I. (2009) 'Becoming a health profession educator in higher education: The experiences of recently-appointed lecturers in nursing, midwifery and the allied health professions', *Health Science and Social Care,* 8(4), pp. 292-300.

Bravata, D. M., Madhusudhan, D. K., Boroff, M. and Cokley, K.O. (2020) 'Commentary: Prevalence, Predictors, and Treatment of Imposter Syndrome: A Systematic Review', *Journal of Mental Health and Clinical Psychology,* 4(3), pp. 12-16.

Bravata, D. M., Watts, S.A., Keefer, A, L., Madhusudhan, D.K., Taylor, K.T., Clark, D.M., Nelson, R.S., Cokley, K.O. and Hagg, H.K. (2019) 'Prevalence, Predictors, and Treatment of Impostor Syndrome: A Systematic Review', *Journal of General Internal Medicine,* 35(4), pp. 1252–1275.

Bridges, W. (2017) *Managing Transitions.* 4th edn. Cambridge, MA: Da Capo Lifelong Books.

Bridges, W. (2004) *Transitions: Making sense of life's changes.* 2nd edn. New York: Addison-Wesley.

Bridges, W. (1980) *Transitions: Making sense of life's changes.* Reading, MA: Addison-Wesley.

Bridges, W. and Mitchell, S. (2000) 'Leading transition: A new model for change', *Leader to Leader*, 16(3), pp. 30-36.

Brinkmann, S. (2018) 'The Interview', in N.K. Denzin and Y.S. Lincoln (eds) *The SAGE Handbook of Qualitative Research,* 5th edn. Los Angeles: SAGE, pp. 576 – 599.

Brocki, J. and Weardon, A. (2006) 'A critical evaluation of the use in interpretative phenomenological analysis (IPA) in health psychology', *Psychology and Health,* 21(1), pp. 87-108.

Browne J. and Collett T. (2023) 'Transition theory and the emotional journey to medical educator identity: A qualitative interview study', *Medical Education*, 57(7), pp. 648-657.

Burford, J., Fyffe, J. and Khoo, T. (2022) 'Working with/against Imposter Syndrome: Research Educators' Reflections', in A. Addison, M. Breeze and Y. Taylor (eds) *The Palgrave Handbook of Imposter Syndrome in Higher Education.* Cham, Switzerland: Springer Nature Switzerland AG, pp. 377-394.

Cannon-Brookes, M. (2019) *How you can use imposter syndrome to your benefit* [Podcast]. 21 December. Available at: Youtube blog of Cannon-Brookes talking on his Podcast about how he uses imposter syndrome to his benefit in business (Accessed: 19 November 2021).

Carr, H. (2019) *Academic induction: Perceptions of newly appointed university lecturers in nurse education: An interpretative phenomenological inquiry.* Doctoral Thesis. University of Chester.

Carroll, L. (1967) *Alice in Wonderland*. London: Dobson.

Chae, J.H., Piedmont, R.L., Estadt, B.K. and Wicks, R.J. (1995) 'Personological evaluation of Clance's Imposter Phenomenon scale in a Korean Sample', *Journal of Personality Assessment,* 65(3), pp. 468-485.

Cherry, F. and Deaux, K. (1978) 'Fear of Success Versus Fear of Gender-Inappropriate Behavior', *Sex Roles,* 4(1), pp. 97-101.

Clance, P.R. (1985a) *The imposter phenomenon: When success makes you feel like a fake.* Toronto: Bantam Books.

Clance, P.R. (1985b) *The imposter phenomenon: Overcoming the fear that haunts your success.* Atlanta: Peachtree.

Clance, P.R., Dingman, D., Reviere, S.L. and Stober, D.R (1995) 'Imposter phenomenon in an interpersonal/social context: Origins and treatment', *Women and Therapy,* 16(4), pp. 79-96.

Clance, P.R. and Imes, S (1978) 'The imposter phenomenon in high achieving women: Dynamics and therapeutic intervention', *Psychotherapy: Theory, Research & Practice,* 15(3), pp. 241-247.

Clance, P.R. and Lawry, S. (2024) 'Imposter Phenomenon, Origins and Treatment', in K. Cokley (ed) *The Imposter Phenomenon: Psychological Research, Theory, and Interventions.* Washington: American Psychological Association, pp. 17-43.

Clance, P.R. and O'Toole, M.A (1987) 'The imposter phenomenon: An internal barrier to empowerment and achievement', *Women and Therapy,* 6, pp. 51-64.

Clare, L., Rowlands, J., Bruce, E., Surr, M. and Downs, M. (2008) 'The Experience of Living with Dementia in Residential Care: An Interpretative Phenomenological Analysis', *The Gerontologist*, 48(6), pp. 711–720.

Clark, M., Vardeman, K. and Barba, S (2014) 'Perceived inadequacy: A study of the imposter phenomenon among college and research librarians', *College & Research Libraries,* 75(3), pp. 255-271.

Clegg, S. (2008) 'Academic identities under threat?', *British Educational Research Journal,* 34(3), pp. 329-345.

Cokley, K. (2024) 'Introduction: The Importance of Empirical Research on the Imposter Phenomenon', in K. Cokley (ed) *The Imposter Phenomenon: Psychological Research, Theory, and Interventions.* Washington, American Psychological Association, pp. 3-13.

Cokley, K., Awad, G., Smith, L., Jackson, S., Awosogba, O., Hurst, A., Stone, S., Blondeau, L. and Roberts, D. (2015) 'The roles of gender stigma consciousness, impostor phenomenon and academic self-concept in the academic outcomes of women and men', *Sex Roles: A Journal of Research,* 73(9), pp. 414–426.

Cokley, K., Harris, K., Hall, S. and Singletary, M. (2024) 'An Overview of the Imposter Phenomenon: Definitional and Theoretical Considerations', in K. Cokley (ed) *The Imposter Phenomenon: Psychological Research, Theory, and Interventions.* Washington: American Psychological Association, pp. 45-60.

Cokley, K., McClain, S., Enciso, A. and Martinez, M. (2013) 'An examination of the impact of minority status stress and imposter feelings on the mental health of diverse ethnic minority college students', *Journal of Multicultural Counseling and Development*, 41(2), pp. 82-95.

Conrad, P. (2007) *The medicalization of society: On the transformation of human conditions into treatable disorders.* Baltimore: Johns Hopkins University Press.

Conrad, R.G., Schober, M. (2008) 'New Frontiers in standardized survey interviewing', in S.N. Hesse-Biber and P. Leavy (eds) *Handbook of emergent methods.* London: Guilford Press, pp. 173-188.

Cozzarelli, C. and Major, B (1990) 'Exploring the validity of the imposter phenomenon', *Journal of Social & Clinical Psychology,* 9(4), pp. 401-417.

Creswell, J.W. (2012) *Educational Research: Planning, Conducting and Evaluating Quantitative and Qualitative Research*. 4th edn. Boston, Mass: Pearson.

Cronin-Davis, J., Butler, A. and Mayers, C.A. (2009) 'Occupational therapy and interpretative phenomenological analysis: comparable research companions?', *British Journal of Occupational Therapy,* 72(8), pp. 332-338.

Crowther, J. L. and Lloyd-Williams, M. (2012) 'Researching sensitive and emotive topics: The participants' voice', *Research Ethics,* 8(4), pp. 200–211.

Dahlberg, K., Dahlberg, H. and Nystrom, M. (2008) *Reflective Lifeworld Research*. 2nd edn. Lund, Sweden: Studentlitteratur.

DeRosia, E.D. and Christensen, G. L. (2009) 'Blind insights: a new technique for testing a priori hypotheses with qualitative methods', *Qualitative Market Research: An International Journal,* 12(1), pp. 15-35.

Davis, D.C., Dearman, C., Schwab, C. and Kitchens, E. (1992) 'Competencies of new nurse educators', *Journal of Nursing Education,* 31, pp. 159-164.

Dreyfus, S.E. and Dreyfus, H.L. (1980) *A Five-Stage Model of the Mental Activities Involved in Directed Skill Acquisition.* Available at: https://www.semanticscholar.org/paper/A-Five-Stage-Model-of-the-Mental-Activities-in-Dreyfus-Dreyfus/efa296060526e40fb81b7498786aba72d546e555 (Accessed: 20 February 2024).

Duchscher, J.E.B. (2012) *From Surviving to Thriving: Navigating the first year of professional nursing practice*. 2nd edn. Saskatoon, SK: Nursing the Future.

Duchscher, J.E.B. (2009) 'Transition shock: the initial stage of role adaptation for newly graduated Registered Nurses', *Journal of Advanced Nursing*, 65(5), pp. 1103-1113.

Duchscher, J.E.B. (2008) 'A process of becoming: The stages of new nursing graduate professional role transition', *Journal of Continuing Nursing Education*, 39(10), pp. 441-450.

Eatough, V. and Smith, J. A. (2008) 'Interpretative phenomenological analysis' in C. Willig and W. Stainton-Rogers (eds.) *The SAGE Handbook of Qualitative Research in Psychology*. Thousand Oaks, CA: SAGE Publications, pp. 179–194.

Eatough, V. and Smith, J. (2006) '"I was like a wild wild person": Understanding feelings of anger using interpretative phenomenological analysis', *British Journal of Psychology,* 97, pp. 483-498.

Engle, J. (2003) '"Fear of Success" Revisited: A Replication of Martina Horner's Study 30 Years Later' (from the Sessions presented at the Annual Meeting of the American Educational Research Association, Chicago, IL, 21 - 25 April 2003). Available at: https://files.eric.ed.gov/fulltext/ED479387.pdf (Accessed: 15 January 2023).

Elliot, H. (1997) 'The Use of Diaries in Sociological Research on Health Experience', *Sociological Research Online,* 2(2). Available at: http://www.socresonline.org.uk/2/2/7.html (Accessed: 1 August 2022).

Feenstra, S., Begeny, C.T., Ryan, M.K., Rink, F.A., Stoker, J.I. and Jordan, J. (2020) 'Contextualizing the Imposter "Syndrome"', *Frontiers in Psychology*, November 13, article number 575024. Available at: doi:10.3389/fpsyg.2020.575024 (Accessed: 14 July 2023).

Finlay, L. (2014) 'Engaging phenomenological analysis', *Qualitative Research in Psychology,* 11, pp. 121-141.

Finlay, L. (2009) 'Debating Phenomenological Research Methods', *Phenomenology & Practice,* 3(1), pp. 6-25.

Fleming, J. and Zegwaard, K.E (2018) 'Methodologies, methods, and ethical considerations for conducting research in work-integrated learning', *International Journal of Work Integrated Learning (Special Issue),* 19(3), pp. 205-213.

Fleming, E. and Carberry, M. (2011) 'Steering a course towards advanced nurse practitioner: A critical care perspective', *Nursing in Critical Care,* 16, pp. 67-76.

Freeman, K.J., Carr, S.E., Phillips, B., Noya, F. and Nestel, D. (2022) 'From clinician to educator: A scoping review of professional identity and the influence of imposter phenomenon', *Asia Pacific Scholar,* 7(1), pp. 21-32.

Fried-Buchalter, S. (1997) 'Fear of success, fear of failure, and the imposter phenomenon among male and female marketing managers', *Sex Roles,* 37, pp.847-859.

Gearing, R.E. (2004) 'Bracketing in research: a typology', *Qualitative Health Research*, 14(10), pp. 1429–1452.

Gelo, O., Braakmann, D., and Benetka, G. (2008) 'Quantitative and Qualitative Research: Beyond the Debate', *Integrated Psychological and Behavioral Science,* 42, pp. 266-290.

Gilgun, J. (2014) *Introduction to The Chicago School: Deductive Qualitative Analysis and Grounded Theory.* Available at: https://www.researchgate.net/publication/262528261 (Accessed: 13 May 2025).

Giorgi, A. (2010) *Phenomenological and Psychological Research*. Pittsburgh: Duquesne University Press.

Giorgi, A. (2008) 'Concerning a serious misunderstanding of the essence of the phenomenological method in psychology', *Journal of Phenomenological Psychology*, 39, pp. 33-58.

Glazzard, J. (2010) 'The impact of dyslexia on pupils' self-esteem', *Support for Learning,* 25(2), pp. 54-103.

Gluckman, M. (1962) *Essays on the Ritual of Social Relations*. Manchester: University Press.

Gottlieb, M., Chung, A., Battaglioli, N., Sebok-Syer, S.S. and Kalantari, A. (2020) 'Imposter syndrome among physicians and physicians in training: A scoping review', *Medical Education*, 54(2), pp. 116-124.

Gray, D.E. (2004) *Doing research in the real world*. London: SAGE Publications.

Gravois, J. (2007) *You're not fooling anyone*. Available at: https://www.chronicle.com/article/youre-not-fooling-anyone/ (Accessed: 12 February 2024).

Greenwood, G. (2022) 'How imposter syndrome can help shape professional identity', *Nursing Times (online)*, 118(11). Available at: https://www.nursingtimes.net/roles/nurse-educators/how-imposter-syndrome-can-help-shape-professional-identity-10-10-2022/ (Accessed: 3 March 2023).

Halton, J., Ireland, C. and Vaughan, B. (2024) 'The transition of clinical nurses to nurse educator roles – A scoping review', *Nurse Education in Practice*, 78. Available at: https://doi.org/10.1016/j.nepr.2024.104022 (Accessed 25 March 2025).

Harvey, J.C. (1981) *The Imposter Phenomenon and achievement: A failure to internalize success.* Doctoral Thesis. Philadelphia: Temple University.

Harvey, J.C. and Katz, C. (1985) *If I'm so successful, why do I feel like a fake? The imposter phenomenon.* New York: St Martin's Press.

Heidegger, M. (2005) *Being and Time.* Translated from the German by J. Macquarrie, and E. Robinson. Oxford: Blackwell.

Henning, K., Ey, S. and Shaw, D. (1998) 'Perfectionism, the impostor phenomenon and psychological adjustment in medical, dental, nursing and pharmacy students', *Medical Education,* 32(5), pp. 456-464.

Holmes, A.G.D. (2020) 'Researcher positionality–a consideration of its influence and place in qualitative research–a new researcher guide', *Shanlax International Journal of Education,* 8(2), pp. 1–10.

Hopson, B. and Adams, J. (1976) 'Towards an understanding of transition: defining some boundaries of transition dynamics', in J. Adams, J. Hayes, J. and B. Hopson(eds) *Transition: Understanding and Managing Personal Change*. Oxford: Martin Robertson & Co., pp. 3-25.

Horner, M.S. (1973) 'Toward an understanding of achievement-related conflicts in women', Journal *of Social Issues,* 25(9), pp. 157-175.

Horner, M.S. (1968) *Sex differences in achievement motivation and performance in competitive and non-competitive situations.* PhD Thesis. University of Michigan. Available at: https://searchworks.stanford.edu/view/2010672 (Accessed 13 March 2023).

Husserl, E. (1962) *Ideas: General introduction to pure phenomenology*. Translated from the German by W.B. Simpson. Bloomington: Indiana University.

Hutchins, H.M. (2015) 'Outing the imposter: A study exploring imposter phenomenon among higher education faculty', *New Horizons in Adult Education and Human Resource Development,* 27(2), pp.3-12.

Hutchins, H.M., Penney, L.M. and Sublett, L.W. (2018) 'What imposters risk at work: Exploring imposter phenomenon, stress coping, and job outcomes', *Human Resource Development Quarterly,* 29(1), pp. 31-48.

Hutchins, H.M. and Rainbolt, H. (2016) 'What triggers imposter phenomenon among academic faculty? A critical incident study exploring antecedents, coping, and development opportunities', *Human Resource Development International,* 20(3), pp.1-21.

Hutchins, H.M. and Rainbolt, H (2015) 'Who wears the mask? exploring imposter phenomenon, work outcomes and social support among academic and medical faculty', *Academy of Human Resource Development Conference in the Americas.* St. Louis, Missouri: 19th – 21st February 2015.

Infante, N.S. (1986) 'The conflicting roles of nurse and nurse educator', *Nursing Outlook,* 34 (2), pp. 94-96.

Janda, L.H., O'Grady, K.E. and Caps, C.F. (1978) 'Fear of Success in Males and Females in Sex-Linked Occupations', *Sex Roles,* 4(1), pp. 43-50.

Jones, R. (2012) 'Reflecting on the transition from practice to education: The journey to becoming an effective teacher in higher education', *Journal of Pedagogic Development,* 2(2), pp. 11-15.

Kalensky, M. and Hande, K. (2017) 'Transition from Expert Clinician to Novice Faculty: A Blueprint for Success', *The Journal for Nurse Practitioners,* 13(9), pp. 433-439.

Kearns, H. (2015) *The imposter syndrome: Why successful people often feel like frauds.* Adelaide: Thinkwell.

Kelly, N.R. and Mathews, M. (2001) 'The transition to first position as nurse practitioner', *Journal of Nursing Education,* 40, pp. 156-162.

Kramer, M. (1974) *Reality shock: Why nurses leave nursing*. St. Louis, MO: C.V. Mosby.

Kubler-Ross, E. (1969) *On Death and Dying.* New York: The Macmillan Company.

Kumar, S. and Jagacinski, C.M (2006) 'Imposters have goals too: The imposter phenomenon and its relationship to achievement goal theory', *Personality and Individual Differences,* 40, pp.147-157.

Kvale, S., Brinkmann, S. (2015). *InterViews: Learning the Craft of Qualitative Research Interviewing*. 3rd edn. Thousand Oaks, CA: SAGE publications.

Kvale, S. and Brinkmann, S. (2009). *InterViews: Learning the Craft of Qualitative Research Interviewing*. 2nd edn. Thousand Oaks, CA: SAGE Publications.

Langdridge, D. (2008) 'Phenomenology and critical social psychology: Directions and debates in theory and research', *Social and Personality Psychology Compass*, 2, pp. 1126-1142.

Larkin, M., Watts, S. and Clifton, E. (2006) 'Giving voice and making sense in interpretative phenomenological analysis', *Qualitative Research in Psychology,* 3, pp. 102-120.

Leary, M.R., Patton, K.M., Orlando, E. and Funk, W.W (2000) 'The imposter phenomenon: Self-perceptions, reflected appraisals, and interpersonal strategies', *Journal of Personality,* 68(4), pp. 725-756.

Lee, R.M. (1993) *Doing Research on Sensitive Topics*. London: SAGE.

Lee, S.L., Rees, C.E., O'Brien, B.C. and Palermo, C. (2022) 'Identities and roles through clinical-educator transitions: A systematic narrative review', *Nurse Education Today,* 118. Available at: https://doi.org/10.1016/j.nedt.2022.105512 (Accessed 29 March 2025).

Levinson, D.J. (1986) 'A conception of adult development', *American Psychologist,* 41, pp. 3-13.

Linder, K. (2016) *You've Got This: Imposter Syndrome*. [Podcast]. 21st December. Available at: https://katielinder.work/ygt23. (Accessed: 30 March 2024].

Livingston, E.M., Siegel, L.S. and Ribary, U. (2018) 'Developmental dyslexia: emotional impact and consequences', *Australian Journal of Learning Difficulties,* 23(2), pp. 103-135.

Locasto, L.W. and Kochanek, D. (1989) 'Reality Shock in the Nurse Educator', *Journal of Nursing Education,* 28(2), pp. 79-81.

MacCullagh, L., Bosanquet, A. and Badcock, N.A. (2017) 'Fractured academic identities: Dyslexia, secondary education, self-esteem and school experiences', *British Journal of Special Education*, 44(4), pp. 372–390.

Marcus, J. (2011) 'Orientalism', in A. Atkinson, A. Coffey, S. Delamont, J. Lofland, and L. Lofland (eds) *Handbook of ethnography*. Thousand Oaks, CA: SAGE, pp. 443–452.

McClain, S., Beasley, S.T., Jones, B., Awosogba, O., Jackson, S. and Cokely, K. (2016) 'An examination of the impact of racial and ethnic identity, imposter feelings, and minority status stress on the mental health of Black college students', Journal *of Multicultural Counseling and Development,* 44(2), pp. 101-107.

McClelland, D.C. (1961) *The achieving society*. Princeton: De Van Nostrand Company, Inc.

McClelland, D.C., Atkinson, J.W., Clarke, R.A. and Lowell, E.L. (1953) *The achievement motive.* New York: Appleton-Century-Crofts.

McElwee, R.O. and Yurak, T (2010) 'The phenomenology of the impostor phenomenon', *Individual Differences Research,* 8(3), pp.184-197.

McGee, E.O., Botchway, P.K., Naphan-Kingery, D.E., Brockman, A.J., Houston, I.I. and White, D.T. (2022) 'Racism camouflaged as impostorism and the impact on Black STEM doctoral students', *Race, Ethnicity, and Education,* 25(4), pp. 487- 507.

MacLellan, L., Levett-Jones, T. and Higgins, I. (2015) 'Nurse practitioner role transition: a concept analysis', Journal *of the American Association of Nurse Practitioners,* 27, pp. 389-397.

MacNeil, M. (1997) 'From nurse to teacher: recognizing a status passage', *Journal of Advanced Nursing,* 25, pp. 634-642.

Maehr, M. L. and Zusho, A. (2009) 'Achievement goal theory: The past, present, and future', in K. R. Wenzel and A. Wigfield (eds) *Handbook of motivation at school.* (pp. 77–104). New York: Routledge.

Mafura, C. and Charura, D. (2021) ''I then had 50 stitches in my arms…such damage to my own body': An Interpretative Phenomenological Analysis of Izzat trauma and self-harm experiences among UK women of South Asian heritage', *Counselling and Psychotherapy Research,* 00, 1-13. Available at: https://doi.org/10.1002/capr.12464 (Accessed 1 December 2023).

Maltby, J., Williams, G., McGarry, J. and Day, L. (2014) *Research methods for nursing and healthcare.* London: Routledge.

Maqsood, H., Shakeel, H.A., Hussain, H., Khan, A.R., Ali, B., Ishaq, A. and Shah, S.A.Y (2018) 'The descriptive study of imposter syndrome in medical students', *International Journal of Research in Medical Sciences,* 6(10), pp. 3431-3434.

Matthews, G. and Clance, P.R. (1985) 'Treatment of the imposter phenomenon in psychotherapy clients', *Psychotherapy in Private Practice*, 3(1), pp. 71-81. Available at: https://doi.org/10.1300/J294v03n01_09 (Accessed 27 May 2025).

Mears, C.L. (2012) 'In-depth interviews', in J. Arthur, M. Waring, R. Coe and L. Hedges (eds) *Research Methods and Methodologies in Education.* Los Angeles: SAGE, pp. 170-176.

Meleis, A.I. (2010) *Transitions theory: Middle range and situation specific theories in nursing research and practice*. New York: Springer Publishing Company.

Moran, D. (2000) *Introduction to phenomenology*. London: Routledge.

Morris, C., Kadiwal, L., Telling, K., Ashall, W., Kirby, J. and Mwale, S. (2022) 'Restorying imposter syndrome in the early career stage: Reflections, recognitions and resistance', in A. Addison, M. Breeze, and Y. Taylor (eds) *The Palgrave Handbook of Imposter Syndrome in Higher Education.* Cham, Switzerland: Springer International Publishing, pp. 225-240.

Murphy, K. and Mortimore, G. (2020) 'Overcoming the challenges of role transition for trainee advanced clinical practitioners', *Gastrointestinal Nursing*, 18(5), pp. 35-41.

National Health Service (NHS) (2020) *Staff Survey 2020.* Available at: https://www.nhsstaffsurveys.com/Page/1056/Home/NHS-Staff-Survey-2020/ (Accessed 15 August 2020).

Neubauer B.E., Witkop C.T. and Varpio, L. (2019) 'How phenomenology can help us learn from the experiences of others', *Perspectives on Medical Education*, 8(2), pp. 90–97.

Neville, H.A. (2024) *The Imposter Phenomenon: Psychological Research, Theory, and Interventions.* Washington: American Psychological Association.

Nicholson, N. (1984) 'A Theory of Work Role Transitions', *Administrative Science Quarterly,* 29, pp. 172-191.

Noon, E., J. (2018) 'Interpretive Phenomenological Analysis: An Appropriate Methodology for Educational Research?', *Journal of Perspectives in Applied Academic Practice,* 6(1), pp. 75–83.

Nordberg, D. (2023) 'The lens of theory: seeing better or differently?' *International Journal of Organization Theory & Behavior,* 26(1/2), pp. 152-162.

Ogunyemi, D., Lee, T., Ma, M., Osuma, A., Egfhbali, M. and Bouri, N. (2022) 'Improving wellness: Defeating impostor syndrome in medical education using an interactive reflective workshop*', PLOS ONE,* 17(8), Article e0272496. Available at: https://doi.org/10.1371/journal.pone.0272496 (Accessed 12 January 2024).

Olmos-Vega, F. M., Stalmeijer, R.E., Varpio, L. and Kahlke, R. (2022) 'A practical guide to reflexivity in qualitative research: AMEE Guide No. 149', *Medical Teacher*, 45(3), pp. 241–251.

Orbe-Austin, L. and Orbe-Austin, R. (2024) 'Critical Issues of the Imposter Phenomenon and Interventions for Historically Marginalized People', in K. Cokley (ed) *The Imposter*

Phenomenon: Psychological Research, Theory, and Interventions. Washington: American Psychological Association, pp. 269-284.

Owens, R.A. (2018) 'Transition Experiences of New Rural Nurse Practitioners', *The Journal for Nurse Practitioners,* 14(8), pp. 605-612.

Parkes, C.M. (1971) 'Psychosocial transitions: A field for study', *Social Science Medicine,* 5(2), pp. 101-115.

Parkman, A. (2016) 'The imposter phenomenon in higher education: Incidence and impact', *Journal of Higher Education Theory and Practice,* 16(1), pp. 51-60.

Perry, C. (1998) 'Process of a Case Study Methodology for Postgraduate Research in Marketing', *European Journal of Marketing,* 32(9/10), pp. 785-802.

Pleshkan, V. and Hussey, L. (2020) 'Nurse practitioners' experiences with role transition: Supporting the learning curve through preceptorship,' *Nurse Education in Practice*, 42, pp.1-6.

Polgar, S. and Shane, A.T. (1995) *Introduction to Research in the Health Sciences.* 3rd edn. Melbourne: Churchill Livingstone.

Reynolds, F. (2003) 'Exploring the meanings of artistic occupations for women living with chronic illness: a comparison of template and interpretative phenomenological approaches to analysis', British *Journal of Occupational Therapy*, 66(12), pp. 551-558.

Robson, C. (2002) *Real World Research*. 2nd edn. Malden, MA: Blackwell Publishing.

Sakulku, J. and Alexander, J. (2011) 'The Imposter Phenomenon', *International Journal of Behavioral Science*, 6(1), pp. 73-92.

Scheese, C.H., Nerges, J., Sneddon, C.S. and Morton, P.G. (2023) 'Strategies for transitioning from a clinical position to a faculty role', *Journal of Professional Nursing,* 49, pp. 145-154.

Schlossberg, N.K. (2011) 'The challenge of change: the transition model and its applications', Journal *of Employment Counseling*, 48, pp. 159-162.

Schlossberg, N.K. (1981) 'A model for analyzing human adaption to transition', The *Counseling Psychologist*, 9(2), pp. 2-18.

Schoening, A.M. (2013) 'From Bedside to Classroom: The Nurse Educator Transition Model', *Nursing Education Perspectives,* 34(3), pp. 167-172.

Schoening, A.M. (2009) *The journey from Bedside to Classroom: Making the Transition from Nurse to Nurse Educator*. PhD thesis. University of Nebraska at Lincoln.

Schmalenberg, C. and Kramer, M. (1979) *Coping with reality shock: the voices of experience.* 1st edn. Wakefield, Mass.: Nursing Resources Inc.

Scott, D. and Morrison, M. (2006) *Key Ideas in Educational Research.* London: Continuum International Publishing Group.

Shehu, A., Zhilla, E. and Dervishi, E. (2015). 'The impact of the quality of social relationships on self-esteem of children with dyslexia', *European Scientific Journal*, 11(17), pp. 308-318.

Smith, C. and Boyd, P. (2012) 'Becoming an academic: The reconstruction of identity by recently appointed lecturers in nursing, midwifery, and the allied health professions', *Innovations in Education and Teaching International,* 49(1), pp. 63-72.

Smith, J.A. (1996) 'Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology', *Psychology and Health,* 11(2), pp. 261-271.

Smith, J.A., Flowers, P. and Larkin, M. (2022) *Interpretative phenomenological analysis: Theory, method and research.* 2nd edn. Los Angeles: Sage.

Smith, J.A., Flowers, P. and Larkin, M (2009) *Interpretative phenomenological analysis: Theory, method and research*. London: SAGE.

Smith, J.A., Jarman, M. and Osborn, M. (1999) 'Doing Interpretative Phenomenological Analysis', in M. Murray and K. Chamberlain (eds) *Qualitative Health Psychology – Theories and Methods.* Los Angeles: SAGE Publications Limited, pp. 219-240.

Smith, J.A., Osborn, M. (2015) 'Interpretative Phenomenological Analysis', in J.A. Smith (ed) *Qualitative Psychology: A Practical Guide to Research Methods*. 3rd edn. Los Angeles: SAGE, pp. 35-52.

Smith, J.A. and Osborn, M. (2003) 'Interpretative phenomenological analysis', in J.A. Smith (ed) *Qualitative Psychology: A Practical Guide to Methods.* London: Sage, pp. 53-80.

Sousa, D. (2008) 'From Monet's Paintings to Margaret's Ducks', Existential *Analysis*, 19(1), pp. 143-155.

Speer, A.S. and Hutchby, I. (2003) 'From Ethics to Analytics: Aspects of Participants' Orientations to the Presence and Relevance of Recording Devices', *Sociology*, 37(2), pp. 315-337.

Stevens, P.J.M., Schade, A.L., Chalk, B. and Slevin, O.D'A. (1993) *Understanding Research.* Edinburgh: Campion Press Limited.

Stone-Sabali, S. (2024) 'Trends Within the Imposter Phenomenon Literature', in K. Cokley (ed) *The Imposter Phenomenon: Psychological Research, Theory, and Interventions.* Washington: American Psychological Association, pp. 341-362.

Sullivan-Bentz, M., Humbert, J., Cragg, B., Legault, F., Laflamme, C., Bailey, P.H. and Doucette, S. (2010) 'Supporting primary health care nurse practitioners' transition to practice', *Canadian Family Physician*, 56(11), pp. 1176-82.

Taylor, S., Charura, D., Williams G., Shaw, M., Allan, J., Cohen, E., Meth, F. and O'Dwyer, L. (2020) *Loss, Grief, and Growth: An Interpretative Phenomenological Analysis of Experiences of Trauma in Asylum Seekers and Refugees*. Available at: http://dx.doi.org/10.1037/trm0000250 (Accessed: 28 December 2023).

The Quality Assurance Agency for Higher Education (QAA) (2023) *Transition Skills and Strategies: Transition Models and How Students Experience Change*. Available at: https://www.enhancementthemes.ac.uk/docs/ethemes/student-transitions/transition-models-and-how-students-experience-change.pdf (Accessed: 20 February 2024).

Thompson, J.D. (2016*) "I'm Not Worthy!" – Imposter Syndrome in Academia.* Available at: https://theresearchwhisperer.wordpress.com/2016/02/02/imposter-syndrome (Accessed: 19 October 2023).

Thompson, T., Foreman, P and Martin, F (2000) 'Imposter fears and perfectionistic concern over mistakes', *Personality and Individual Differences,* 29(4), pp. 629-647.

Trowler, P. and Knight, P.T. (2000) 'Coming to know in higher education: Theorising faculty entry to new work contexts', Higher *Education Research and Development,* 19(1), pp. 27-42.

Tulshyan, R. and Burey, J-A. (2021) 'Stop telling women they have imposter syndrome', *Harvard Business Review.* Available at: https://hbr.org/2021/02/stop-telling-women-they-have-imposter-syndrome (Accessed: 4 May 2024).

van Gennep, A. (1960) *The Rites of Passage*. Translated from the German by M.B. Vizedom and G.L. Caffee. Chicago, IL: University of Chicago Press.

van Manen, M. (2017) 'Phenomenology in Its Original Sense', Qualitative *Health Research,* 27(6), pp. 810-825.

van Manen, M. (2014) *Phenomenology of practice: Meaning-giving methods in phenomenological research and writing*. New York: Routledge.

Vagle, M.D. (2018) *Crafting phenomenological research*. 2nd edn. New York: Routledge.

Veroff, J., Wilcox, S. and Atkinson, J.W. (1953) 'The achievement motive in high school and college age women', *Journal of Abnormal and Social Psychology*, 48(1), pp. 108-119.

Walker, D.L. and Saklofske, D.H. (2023) 'Development, factor structure, and psychometric validation of the imposter phenomenon assessment: A novel assessment of imposter phenomenon', *Assessment,* 30(7), pp. 2162-2183.

Wenger, E. (1998) *Communities of practice: Learning, meaning, and identity*. 6th edn. Cambridge: Cambridge University Press.

Wilke, M.R. (2018) *Imposter phenomenon: Distinct construct or achievement-related affective experience?* Murray State University.

Willis, P. (2001) 'The "Things Themselves" in Phenomenology', *Indo-Pacific Journal of Phenomenology,* 1(1), pp. 1-12.

Windey, M. (2018) 'Stages of Transition and Transition Shock', *Journal for Nurses in Professional Development*, 34 (4), pp. 228-232. Available at: https://journals-lww-com.yorksj.idm.oclc.org/jnsdonline/citation/2018/07000/stages_of_transition_and_transition_shock.11.aspx (Accessed: 9 March 2024).

World Health Organization (WHO) (2022) *The ICD-11 Classification of Mental and Behavioural Disorders.* 5th edn. Geneva: World Health Organization.

Wright, C.R. (2007) *An investigation into the professional Identities of occupational therapists in higher education.* PhD thesis. Sheffield Hallam University. Available at: https://shura.shu.ac.uk/20707/1/10702805.pdf (Accessed: 23 January 2023).

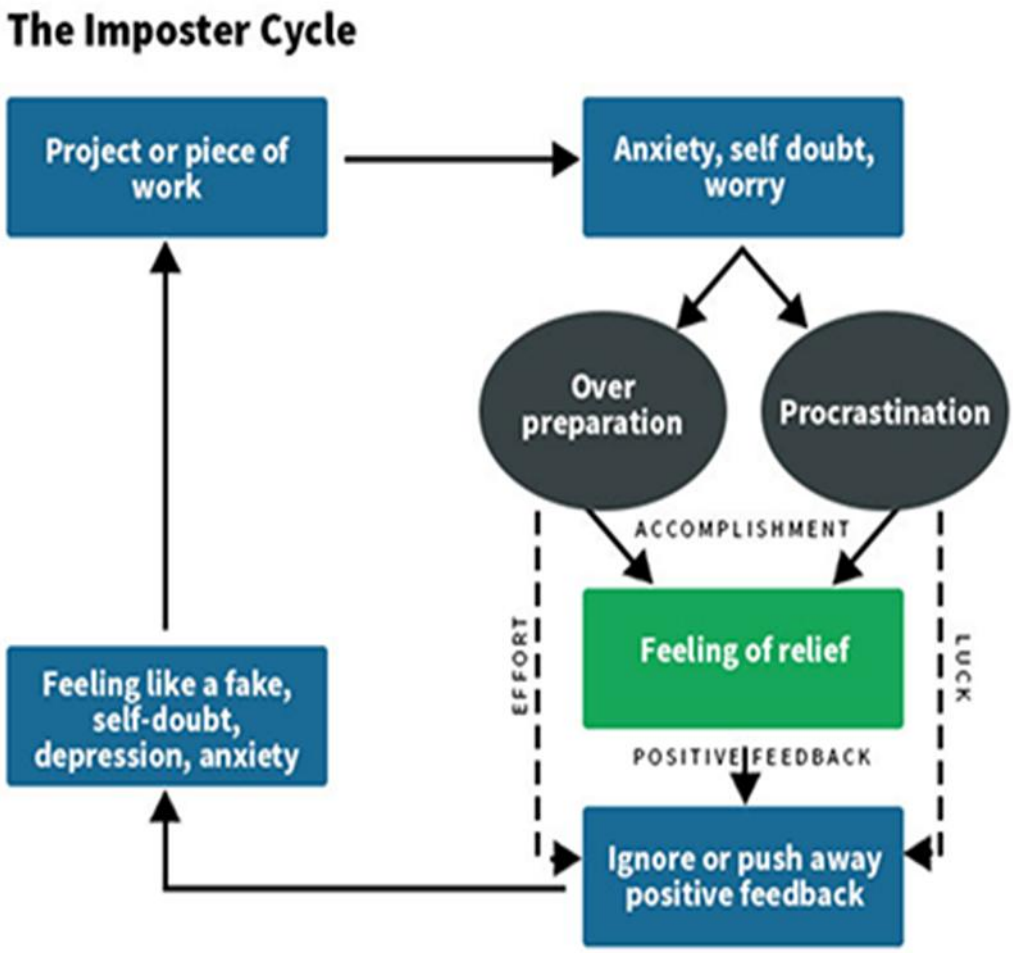
Wu, H.L. and Volker, D.L. (2009) 'The use of theory in qualitative approaches to research: application in end-of-life studies', *Journal of Advanced Nursing,* 65(12), pp. 2719-2732.

Young, V. (2024) *All great entrepreneurs have imposter syndrome, and its key to success.* Available at: Linked-in post from Valerie Young about the prevalence of imposter syndrome in entrepreneurs (Accessed 9 June 2024).

Appendices

Appendix 1: The Imposter Cycle

The Imposter Cycle: “A predictable cycle that appears to play a critical role in how IP is maintained” (Clance and Lawry 2024, p. 23):



The Imposter Phenomenon cycle (Clance et al, 1995)

Available at: https://uwaterloo.ca/engineering-wellness-program/blog/changing-discourse-around-imposter-phenomenon. [Accessed 15th June 2025].

Appendix 2: Research Study Information

"Feeling the flow": the experience of Imposter Syndrome in Clinical Educators

My name is Marion Khan, I'm a nurse and previously worked at the Trust in clinical education and development. I am currently undertaking my Doctorate at York St John University, and my area of research is Imposter Syndrome. My focus is the experience of imposter syndrome in individuals who hold clinical registration but also work as teachers, educators or trainers (in any field or specialism).

The term 'Imposter Syndrome' is used to describe an internal, individual experience of self-doubt and fear of being discovered as an intellectual fraud, and is a reaction to certain stimuli and events. That reaction, generally internally hidden, can result in a varying severity of impact on the life, personal development, or career progression of the individual.

The objective of my research is to enable educators to confidentially share their personal stories of living with imposter syndrome when in work environments. The methodology will include confidential discussion, a 1-2-1 interview, and completion by the participants of a freely managed 3-month written/audio diary of their imposter syndrome experiences. The study will be led by the participants, diary entries can be as much or as little as they wish, and can be handwritten (hard copy), computer written (email), or voice recorded. Imposter syndrome is an emotive topic, it can take courage and strength to share experiences of living and working with the situation, and I want to give control over the disclosure and sharing of those experiences to participants.

All data will be pseudonymised, with voluntary informed consent prior to involvement in the study, and no personal information will be included during the research process. Person-identifiable information will be held only by myself, as researcher, on the secure encrypted and password protected York St John University One-Drive system.

If you are interested in being a part of this study, or wish to find out more, please email me at marion.khan@yorksj.ac.uk to have a confidential conversation and discuss the study further.

Many thanks

Kind regards

Marion Khan

December 2021

Appendix 3: The Study Participants - a descriptive summary

(Member Checked)

In Chapter 3, Table 1 provided an overview of the participants' demographics. Appendix 3 enables participants to introduce themselves to the reader to facilitate openness and context:

Annie

Annie qualified as a registered Adult Nurse in her mid-thirties and has worked in her local acute hospital since then. She is married with four children, and because the youngest had significant health issues, Annie took time out of her training to care for her family. Annie worked part-time as a nurse to enable her to maintain childcare commitments to her youngest, the older children now being independent. She always enjoyed supporting, and working with, non-registered staff and student nurses in education and training on the wards. A year ago, she moved from front-line nursing and began a 12-month ward based secondment as a Clinical Educator Team Leader.

Bridget

Bridget is single and has worked in healthcare since she was 17, first as a Health Care Assistant and subsequently as a registered Adult Nurse. Since qualification Bridget has worked in a hospital setting in the Acute Medical Unit and the Emergency Department, before joining the university full-time as a Clinical Teaching Fellow [CTF] in Nursing two months ago. The CTF role combines student nurse teaching in the university (60%) and the provision of practice-based learning opportunities for both nursing students and newly qualified nurses (40%) in hospital wards and clinical departments.

Celia

Celia has always worked in healthcare, including a 3-year period of overseas work. She has worked clinically in hospital frontline settings and supported education and training in ward environments. Celia's career in education developed last year when she was appointed a Team Leader in the education and training department of the hospital. Celia had requested at interview that her healthcare role remain confidential, and that she be described in the study as a 'Registered Healthcare Professional'.

David

When he was 10 years old David was involved in a major road traffic accident and suffered significant injury. Extensive rehabilitation meant that he was absent from Primary School for over a year, returning to education at High School. Following qualification in Adult Nursing, David's clinical career has been in Emergency Care. He has worked in several acute hospitals and then moved into full-time university lecturing on the Nursing programmes after obtaining his MSc. David subsequently achieved his EdD and is also a certified instructor with the Resus Council for Advanced Life Support (ALS), Advanced Paediatric Life Support

(APLS), and Advanced Trauma Life Support (ATLS). He teaches registered healthcare and medical professionals on these courses, once or twice a month, in addition to his university role.

Eric

Eric began his career as a Teaching Assistant before moving into healthcare as a Healthcare Assistant. He completed his BSc in Psychology and began work as an Assistant Psychologist while studying for his MSc. Eric qualified as a Clinical Psychologist (CP) four years ago. He currently works full-time for the Prison Service in a medium secure forensic psychiatric hospital, with his role split between clinical work and as an educator with trainee psychologists. Eric is married with 3 children.

Fred

Fred qualified as an Adult Nurse and worked in cardiology at a local hospital for two years before taking up a Research Nurse role. He moved to the education department of the hospital as a Clinical Education Facilitator, working as a link for student nurses between the university and their hospital placement settings. Fred moved into the university sector a year ago in the full-time role of Associate Lecturer for Nursing Associates and occasionally teaches on the Nursing MSc programme. Fred completed his MSc 2 years ago and is married with 2 children.

Ginnie

After qualifying as an Adult Nurse, Ginnie worked in the Neurosurgery and General Surgery departments of a hospital. She then moved to a community setting, nursing Care of the Elderly patients in a Cottage Hospital. Ginnie joined the Health Visiting team to work with families and children, and after completing her MSc in Public Health moved into School Nursing, which she did for 15 years. Ginnie took up the full-time university post of Associate Lecturer a year ago, teaching Nursing Associate and undergraduate Nursing students in community practice settings.

Heather

Heather is married and qualified as a Midwife. She has worked full time within both hospital and community midwifery settings, finally as Midwifery Sister in a Birthing Centre Unit (BCU). Eighteen months ago, Heather transferred to a part-time midwifery role combined with a part-time teaching post of Clinical Academic Midwife at a nearby university. Heather later moved to another university as a full time Midwifery Lecturer. She teaches on the undergraduate Midwifery programme, and occasionally on the Adult Nursing programme.

Iris

Iris qualified as a doctor, and after her Foundation Years 1 and 2 rotations, chose to undertake the 4-year General Practice Vocational Training Scheme (GPVTS). Iris is married with 3 children and worked part-time in two general practices for 5 years to allow her

to cover childcare commitments. She now works part time as a doctor for a private healthcare provider and also holds a part time role as a Clinical Education Facilitator in the local Medical School, teaching first- and second-year medical students. She has recently completed her Postgraduate Certificate in Medical Education.

Jane

Jane is married and qualified as a Registered Pharmacist. She has spent most of her career working for NHS primary care organisations, but following a part time teaching contract with a university, Jane was offered a full-time contract a year ago, which she accepted. She is teaching on the Non-Medical Prescribing programme, and her student cohorts are registered healthcare professionals (usually nurses) who are required to prescribe medication as part of their role. Jane is currently undertaking the Post Graduate Certificate in Academic Practice programme at the university to support her in her lecturing role.

Khloe

Khloe began her healthcare career as a Healthcare Assistant working in nursing homes before qualifying as an Adult Nurse. She has worked in different parts of the country and in varied fields of practice – Neurology and Neurosurgery; General Surgery; Orthopaedics; Gender Reassignment; the HIV Service; as a Drug & Alcohol Specialist Nurse; and as an Advanced Care Practitioner (ACP) in a hospital setting. A year ago, Khloe was offered the role of Lecturer in Advanced Practice at the university, teaching on the Masters ACP Programme and the undergraduate Nursing Programme. Khloe has completed an MSc in Public Health and occasionally works with a private healthcare provider to keep her clinical skills and knowledge up to date.

Appendix 4: Pre-interview Information Checklist

Before the interview begins, reconfirm with the participant:

- That everything discussed is confidential, private and pseudonymised.
- That the discussion will be recorded.
- That all data collected from the discussion will be confidential and held in encrypted storage.
- That the participant can ask questions for clarity.
- That the data will not be able to personally identify the participant.
- That the participant is able to withdraw at any time.
- That the study forms the research for my EdD thesis.

20/4/22

Appendix 5: Debrief Form

"Feeling the flow": the experience of Imposter Syndrome in Clinical Educators

V2 22/6/22

Thank you for your participation in my study. Your participation is greatly appreciated.

Purpose of the Study:

We previously informed you that the purpose of the study was to carry out research into the phenomenon called 'Imposter Syndrome' where an individual encounters internal experiences of self-doubt, and fear of being discovered as intellectual fraud. The goal of our research is to enable narration of personal stories of what it is like to feel imposter syndrome within oneself ie to reveal, and then search into, that lived experience. The study will aim to uncover further information and a better understanding of the felt experience of imposter syndrome among Clinical Educators, and potentially form strategies to empower individuals to manage its impact.

I realise that some of the questions asked, and the keeping of the diaries, may have provoked strong emotional reactions. As researcher, I do not provide mental health services or support, and will not be following up with you after the study. However, I want to provide every participant in this study with details of some resources should you decide you need assistance at any time.

If you feel upset after having completed the study or find that some questions or aspects of the study triggered distress, talking with your GP may help.

The following services are also available:

Samaritans
Freephone: 116 123
https://www.samaritans.org
Email: jo@samaritans.org

Counselling Directory
Tel: 0333 325 2500
https://www.counselling-directory.org.uk

Mind
Tel: 0300 123 3393
https://www.mind.org.uk
Email: info@mind.org.uk

The NHS-Every Mind Matters
https://www.nhs.uk/every-mind-matters

And for more information about living with Imposter Syndrome, the following links are available:

https://www.healthline.com/health/mental-health/imposter-syndrome
https://www.kingsfund.org.uk/blog/2019/09/tackling-imposter-syndrome
https://www.leadershipacademy.nhs.uk/imposter-syndrome

*****Please keep a copy of this form for your future reference. Once again, thank you for your participation in this study.**

Appendix 6a: Extracts from 'Ginnie' - IPA Step 3 Construction of Experiential Statements (from transcription)

Exploratory Notes	Original Transcript	Experiential Statements
	1.	
Confident in early role, no sense of IS 'Great team mates around me' Happy in career Changed role – not as confident or comfortable Changed role – found 'niche', confident again 'Vocation' – comfortable/loved working with children, health promotion, teaching	I think in my early career I was quite confident and didn't have imposter syndrome at all, erm.. from qualifying in went into an area I was very confident in, very comfortable in, I had great team mates around me erm.. so I was really quite happy in my career. Erm.. and then I think possibly when I had children and had to move into an area of practice that maybe I wasn't as comfortable and confident in, that knocked my confidence a little bit. 0.49 Erm.. then when I went to work with the health visiting team I kind of found my little niche again and became really quite confident, and then when I went into school nursing I absolutely thought I'd found my vocation because working with children, working with teenagers, doing that public health and health promotion role, going into schools and teaching about health which is an area I was really comfortable with, I loved it.	Confident in past role, no IS Sense of belonging in team. Happy A new practice area, new team, less clinical expertise, less confident Sense of belonging with new team, increased confidence 'Vocation' - establishing professional identity New role, knowledge of clinical area, brought contentment and role enjoyment
	2.	
'Flew', 'thrived', worked in area for 'very very long time' – happy Impact of service review – negative and personal – 'scooping away' 'felt passionate about' Self confident, clinical expert, senior, significant time in role Opinion sought on changes, but felt not genuine as decision made that service not valuable	1.23 And I absolutely flew and thrived in that career. And I worked in that area for a very very long time until erm.. probably about 3 years before I left the service erm.. commissioners came in and started scooping away parts of the service that I felt really passionate about [pause]. Erm.. and I was called into lots of meetings because I was one of the senior nurses by that point because I'd been there for such a long time, and I knew my stuff, and that sounds really arrogant of me but I was really confident and I knew my stuff so….[pause]. They did call me into a lot of these meetings erm.. to get my opinion on things but [pause] in my mind the decision had already been made that our service was no longer valuable, so I felt very	Recall of positive career experience lasting a very long time Personal impact of service changes – painful - sense of betrayal by organisation Senior, skilled, confident in role Value of service, professional role, and confidence taken

Personal impact - undervalued, deskilled, lost confidence, sense of service user impact	undervalued, very deskilled in a way 'cos they kind of pulled away everything that I was confident and comfortable with and felt made a real difference to children and young people.	away – undermined sense of role Felt professional and personal responsibility for loss to service users
Recognised personal career struggle, not delivering deserved service 'Devoted' 15years, 'superfluous', 'surplus' – laughs Confidence down Previously enjoyed/was confident in teaching and student support/interaction – other nurses referred students to *Ginnie*, 'really happy', no IS, 'knew what I was doing', 'give my time to the students'	**3.** 2.32 Erm.. and so I think that's when I started to struggle a little bit in my career because I felt like it wasn't the service that I wanted it to be, the community wasn't getting the service that they deserved, and the service that I had devoted you know the best part of 15 years to was being told, well, it's not needed, you're kind of kind of superfluous to requirements [laughs] surplus to requirements, sorry [laughs]. And, so I think then my confidence went down a little bit [pause] erm.. Throughout my career I've always had students with me erm.. I've loved having students right from first qualifying I went and did my mentor training, I loved teaching, I love having students with me on the ward. They'd be regular times that other nurses would have students and they'd be like 'ugh, a student today, *Ginnie* will you take them?' and I'd go 'yeah, bring them to me'. Erm.. so I think regarding the clinical education part as a nurse I was always really confident, I didn't have the imposter syndrome then because I knew what I was doing in my job and I was really happy to give my time to the students.	Personal and professional loss over service delivery where past 'devoted' service input now felt rejected Feels loss of confidence because of changed situation Skill and confidence in working with students – recognised by colleagues No IS – makes link to high self confidence
Academic achievements to support higher levels students 'loved that', 'thrived on it', felt had a lot to teach but also learn from students New ideas, new people, new energy in team, 'great' Changes due to funding, 'felt squashed', felt previous 15 years 'was a	**4.** 3.54 Erm.. and then after I'd done my Masters in Public Health I did my Community Practice Teacher course so then I had post-graduate students and Masters students with me and they would come with me for a year, they'd be on placement with me for a year and again I absolutely loved that, thrived on it, thought I had a lot to teach, thought I had a lot to learn from them because they were coming through with new ideas which I thought gave real energy to the team 'cos you're getting new people and new ideas coming through which I thought was great. But I had to	Motivated and capable of academic achievement – link to positive teaching experiences High enjoyment, felt valued, and saw team and self benefit from students – new ideas, people, energy

waste of time', knew it was not 'cut, and cut, and cut' 'scary service' due to safeguarding cuts, did not want to be involved in serious case review, 'we're not giving the service', 'not a safe service any more'	say then these changes were made because of funding [pause] erm.. and I think I just felt a bit squashed. And like and I it felt like I was told the last 15 years you've spent doing this job was a waste of time. And I knew it wasn't but that services are cut, and cut, and cut, and [pause] it got to be quite a scary service I felt because I was thinking well they're cutting stuff out of safeguarding as well and I don't want to be a part of a serious case review because we're not giving the service we should be giving and it's not a safe service any more.	Felt crushed - sense of personal criticism because of service changes Significant professional worry about funding cuts for service users and self

Appendix 6b: Extracts from 'Ginnie' IPA Step 4 - Searching for connections across Experiential Statements (Cluster formation)

Impact of previous experiences in clinical settings: Previous positive career experience lasting a very long time. p. 2 Senior, skilled, confident in role. p. 2 Skill and confidence in working with students – recognised by colleagues. p. 3 High enjoyment, felt valued, and saw team and self-benefit from students – new ideas, people, energy. p. 4 Confident in ward-based teaching. p. 5 Personal impact of service changes – painful - sense of betrayal by organisation. p. 2 Feels loss of confidence because of changed situation. p. 2 Felt crushed - sense of personal criticism because of service changes. p. 4
How being part of a team felt: Sense of belonging in team. Happy. p. 1 Sense of belonging with new team, increased confidence. p. 1 Confident in professional seniority and knowledge. p. 2 Feel valued and welcomed into university faculty. p. 10
What it means to be a professional: 'Vocation' – establishing professional identity? p. 1 Value of service, professional role, and confidence taken away – undermined sense of role. p. 2 Motivated and capable of academic achievement – link to positive teaching experiences. p. 4 Felt professional identity degraded by changes. p. 7 Felt professional and personal responsibility for loss to service users. p. 2 Awareness of professional knowledge and ability in ward-based clinical teaching. p. 3 Professional loss over service delivery where past 'devoted' service now felt rejected. p. 3
Making connections to imposter syndrome: Confident in past early career role, no IS. p. 1 No IS – makes link to high self-confidence. p3 Aware not a qualified teacher so doubts own ability. p. 5 Felt responsible for shaping the careers of others. p. 5 IS may originate from previous toxic environment. p. 7

Appendix 6c: Extracts from 'Ginnie' IPA Step 5 - Naming the Personal Experiential Themes (PETs) and consolidating and organising into a table

PET 1: PAST EXPERIENCES IN THE CLINICAL SETTING

Positive role experiences:

Previous positive career experience lasting a very long time. p. 2
'And I absolutely flew and thrived in that career. And I worked in that area for a very very long time until erm.. probably about 3 years before I left the service erm..'

Senior, skilled, confident in role. p. 2
'I was one of the senior nurses by that point because I'd been there for such a long time, and I knew my stuff, and that sounds really arrogant of me but I was really confident and I knew my stuff'

Skill and confidence in working with students – recognised by colleagues. p. 3
'They'd be regular times that other nurses would have students and they'd be like 'ugh, a student today, Ginnie will you take them?' and I'd go 'yeah, bring them to me.'

High enjoyment, felt valued, and saw team and self-benefit from students – new ideas, people, energy. p. 4
'I absolutely loved that, thrived on it, thought I had a lot to teach, thought I had a lot to learn from them because they were coming through with new ideas which I thought gave real energy to the team 'cos you're getting new people and new ideas coming through which I thought was great.'

Confident in ward-based teaching. p. 5
'Because teaching what you know in a, in a ward because it's something you do day in and day out is one thing, and that was something I was happy with.'

Impact of organisational changes on self:

Personal impact of service changes – painful - sense of betrayal by organisation. p. 2
'commissioners came in and started scooping away parts of the service that I felt really passionate about [pause].'

Feels loss of confidence because of changed situation. p. 2
'so I felt very undervalued, very deskilled in a way 'cos they kind of pulled away everything that I was confident and comfortable with.'

Felt crushed - sense of personal criticism because of service changes. p. 4
'I think that well if I've been doing a job that wasn't actually needed for the last 15 years then who am I to come in and start teaching other people about how the job should be done?'

PET 2: CONFIDENT AND VALUED IN BEING PART OF A TEAM

Sense of belonging in team. Happy. p. 1
'From qualifying I went into an area I was very confident in, very comfortable in, I had great team mates around me erm.. so I was really quite happy in my career.'

Sense of belonging with new team, increased confidence. p. 1
'Erm.. then when I went to work with the health visiting team I kind of found my little niche again and became really quite confident.'

Confident in professional seniority and knowledge. p. 2
'I was called into lots of meetings because I was one of the senior nurses by that point because I'd been there for such a long time, and I knew my stuff.'

Feel valued and welcomed into university faculty. p. 10
'I think I've found the whole experience of being in the university just so lovely, I mean everyone is so welcoming and so friendly, I mean, you feel valued.'

PET 3: ROLE OF A PROFESSIONAL

Awareness of professional identity:

'Vocation' – establishing professional identity p. 1
'Then when I went into school nursing I absolutely thought I'd found my vocation because working with children, working with teenagers, and doing that public health and health promotion role.'

Value of service, professional role, and confidence taken away – undermined sense of role p. 2
'cos they kind of pulled away everything that I was confident and comfortable with and felt made a real difference to children and young people.'

Motivated and capable of academic achievement – link to positive teaching experiences. p. 4
'after I'd done my Masters in Public Health I did my Community Practice Teacher course so then I had post-graduate students and Masters students with me… and again I absolutely loved that.'

Felt professional identity degraded by changes. p. 7
'I think that well if I've been doing a job that wasn't actually needed for the last 15 years then who am I to come in and start teaching other people about how the job should be done?'

Responsibility of professional role:

Felt professional and personal responsibility for loss to service users. p. 2
'cos they kind of pulled away everything that I…felt made a real difference to children and young people.'

Awareness of professional knowledge and ability in ward-based clinical teaching. p. 3
'I've loved having students right from first qualifying I went and did my mentor training, I loved teaching, I love having students with me on the ward.'

Professional loss over service delivery where past 'devoted' service now felt rejected. p. 3
'because I felt like it wasn't the service that I wanted it to be, the community wasn't getting the service that they deserved, and the service that I had devoted you know the best part of 15 years to.'

PET 4: MAKING CONNECTIONS TO IMPOSTER SYNDROME

Confident in past early career role, no IS. p.1
'I think in my early career I was quite confident and didn't have imposter syndrome at all.'

No IPS – makes link to high self confidence. p. 3
'regarding the clinical education part as a nurse I was always really confident, I didn't have the imposter syndrome then because I knew what I was doing in my job.'

Aware not a qualified teacher so doubts own ability. p. 5
'And I think – what if I'm not putting the right things in, I mean I'm not a qualified teacher, what if I'm not putting it across to them in the right way.'

Felt responsible for shaping the careers of others. p. 5
'And it's a huge responsibility to have I think because, you know, this this is other people's careers that we're talking about.'

IS may originate from previous toxic environment. p. 7
'And I don't know if it's come from the very toxic environment I worked in before where I was basically told that my role was superfluous and that I'd wasted…I mean they never said that I'd wasted the last 15 years, but that's how it made me feel.'

Appendix 7: Study 2 Interview Questions

v 2.4 4/9/24

Question 1:

Reflecting on our first interview over two years ago, where you described experiencing imposter syndrome as a clinical educator, how do you recall those feelings now?

Question 2:

Have your feelings of imposter syndrome persisted, or have they evolved in any way over the past two years?

Question 3a:

As those feelings have remained unchanged, do you continue to experience imposter syndrome in your current role?

OR

Question 3b:

As your feelings have changed, how would you describe your current emotions regarding your role?

Question 4:

What factors do you think have influenced these feelings?

READ: HYPOTHESIS DISCUSSION DOCUMENT

Question 5:

Having discussed the hypothesis from Study 1, I am wondering what this could mean for you. Are you able to tell me what you feel about my hypothesis in relation to your own imposter syndrome experiences?

Appendix 8: Study 2 Interview Discussion Document

V3 8/9/24

STUDY 1 FINDINGS:

- For most participants, unexpected feelings of imposter syndrome first arose when they commenced role transition into the clinical educator post
- Most participants had begun the clinical educator role within the last 12 months
- Analysis and interpretation of the data indicated that the key features described by participants as significant to their experiences of imposter syndrome were:
    - relationships with others
    - the challenges of the dual-professional role
    - meaningful recollections
- Due to the imposter syndrome feelings experienced during role transition, all participants found orientation into the new clinical educator post difficult.

WHAT IS STUDY 2 ABOUT?

From these findings I undertook a second literature review into the impact and outcomes of role transition. From the literature I learned about Duchscher's model of Transition Shock (2008) which sat within her Stages of Transition Theory (2008) and centred on role adaptation into clinical settings by newly qualified Registered Nurses.

The theory identified that transition shock arose because of the different relationships, roles, responsibilities, knowledge, and performance expectations now required in the transitioned environment.

The impact of transition shock on an individual was identified as:

- feelings of anxiety, insecurity, inadequacy and instability
- fluctuating states of emotional, sociocultural, intellectual, and physical well-being
- and was described as an occurrence which arose within the first few months of orientation into a new role.

My review of the Study 1 findings of the imposter syndrome experiences of participants showed many similarities with the researched experiences of new nurses in Duchscher's transition shock studies.

As a result of this thinking, I carried out a piece of comparative work from the literature to review the defining features of imposter syndrome and transition shock.

While there were similarities between the two, there were also significantly different features attributed to transition shock which appeared to align with the study findings.

KEY SIMILARITIES BETWEEN IMPOSTER SYNDROME AND TRANSITION SHOCK:

- Negative views of own current competence
- Feelings of intimidation in professional relationships
- Fear of being unable to live up to the expectations of others
- Influence of the socio-cultural context

KEY DIFFERENCES BETWEEN IMPOSTER SYNDROME AND TRANSITION SHOCK

Imposter Syndrome	Transition Shock
Aetiology of imposter syndrome is understood as a reaction to a cumulation of experiences and negative messages that occur in personal, professional, and sociocultural domains across a lifetime.	Transition shock is presumed to be influenced by the histories and contexts that cultivate expectations about professional roles and responsibilities, work ethic, and culture.
The literature indicates feelings of imposter syndrome will be experienced across a lifetime.	Transition shock occurs unexpectedly within the first stage of role transition, emerging from a contrasted reality between former and current roles.
One of the most dominant characteristics of imposter syndrome is that individuals are unable to hear and believe received compliments, despite objective evidence regarding their success or intellectual ability.	Supportive statements from colleagues are greatly valued and have a significantly positive impact on individuals experiencing transition shock.
Individuals with feelings of imposter syndrome believe their achievements are a result of luck or chance, and not genuinely deserved. They have continual expectations therefore that others will find out they are the intellectual fraud they believe they are.	An individual experiencing transition shock has meaningful intellectual confidence in their former role, it was the transition into the new role that had created feelings of doubt and anxiety.
The continued existence of the Imposter Cycle where individuals fear role failure, work extremely hard to succeed, discount evidenced success, believe they lack competence, then fear future role failure.	These feelings will, over successive months, evolve through a process of adjustment to enable professional orientation into the new role. The negative feelings arising from transition shock will thus diminish.

I reviewed these similarities and differences against the discussion in this chapter, and subsequently developed the hypothesis that:

> *On moving from the clinical to clinical educator role, participants may have experienced transition shock rather than imposter syndrome*

Appendix 9: Participant Information Sheet

V10 1/6/22

Pseudonymised Name:

Title of Project: "Feeling the flow": the experience of Imposter Syndrome in Clinical Educators

Research Student: Marion Khan, York St John University, Lord Mayor's Walk, York YO31 7EX

Email: marion.khan@yorksj.ac.uk

Supervisor: Dr Joan Walton, York St John University, Lord Mayor's Walk, York YO31 7EX

Email: joan.walton@yorksj.ac.uk

Date:

Dear Participant

I am carrying out research into the phenomenon called 'Imposter Syndrome' where an individual encounters internal experiences of self-doubt, and fear of being discovered as an intellectual fraud. Imposter syndrome is not perceived as a mental disorder but a reaction to certain stimuli and events. That reaction can result in a negative impact on the life, personal development, or progression of the individual. Research has shown that many individuals experience imposter syndrome throughout their lives, to varying degrees, and depending on context – for example within an educational setting, commercial or business organisation, or with a profession.

Following my open discussion with colleagues about my research project you expressed a personal awareness of imposter syndrome in your own life, and I am therefore writing to see if you are willing to be part of this project as a participant. This will first consist of a semi-structured interview to hear your imposter syndrome 'story' and give you the opportunity to explore the history, experience, triggers, feelings, and impact of imposter syndrome as situated in your own life. The interview will last around 1-2 hours and will take place either online, or face to face if Covid restrictions allow and you prefer. If face to face is preferred, I would arrange for private office one-to-one discussions in an appropriate setting, agreed by both parties, where conversation can be held comfortably and in private.

Subsequently you will be required to keep a diary of your personal lived experience, feelings, and thoughts on imposter syndrome for 3 months. It will be your choice whether you keep a written diary document, or use a hand-held tape recorder (supplied) to orally keep your diary record. Guidance on confidential collection and safe storage of your diary entries (written or recorded) will be given to you before data collection commences.

Before you make a decision on whether you wish to take part in this study, you will need to consider why the research is being done and what it would involve for you. Please read the following participant information carefully, you are free to discuss this study with your family

and friends. If there is anything you would like further information on, or if something is not clear, please contact me on:

marion.khan@yorksj.ac.uk

What is this study about?

The focus of this research project is to explore the lived personal experiences of the participants, and how and what they internally 'feel' regarding imposter syndrome. The term 'Imposter Syndrome' or 'Imposter Phenomenon' is used to describe an internal, individual experience of self-doubt, and fear of being discovered as an intellectual fraud. It is not perceived as a mental disorder but a reaction to certain stimuli and events, and that reaction can result in a varying severity of impact on the life, personal development, or career progression of the individual. Research has shown that many individuals experience imposter syndrome throughout their lives, sometimes to a greater or lesser extent, and may be dependent on context – eg within an educational setting, commercial or business organisation, or within a profession.

The focus of this research will explore, with a small cohort of Clinical Educators, their personal lived experiences, thoughts, and feelings of imposterism. Anecdotal and informal evidence I have collated, and a small pilot study I undertook last year with Clinical Educators, indicated that experiences of imposter syndrome do occur among this professional group.

The aim of this research is to enable narration of personal stories of what it is like to feel imposter syndrome within oneself ie to reveal, and then search into, that lived experience. The phenomenological approach to this study will aim to uncover further information and a better understanding of the felt experience of imposterism among Clinical Educators.

As I explained at the open discussion, this project is a study for my EdD thesis and I will be discussing progression on the study with my Supervisor, Dr Joan Walton. All data will be anonymised, and your identity will be protected throughout. If this research leads to an unexpected disclosure of information that I believe could require notification or other follow-up action, I shall immediately advise you that I will be contacting my academic supervisors for advice, support, and guidance, and will let you know the steps that have been taken as a result.'

Why have I been selected as a participant?

You have been invited to take part in the study as you expressed an awareness of imposter syndrome in your own life. Your personal experiences and individual story about imposter syndrome, how it feels for you, and the impact it can and may have on your life, are important to enable me to develop a greater understanding of the role imposter syndrome can play in the life of an individual. You alone know how it feels, what can bring such feelings to the fore, the impact it can or may have on your life, and possible supporting or coping strategies that may help you – I cannot feel as you do, so the discussions you are able to share with me will enable me to get as true a picture as possible of your relationship with imposter syndrome.

What will I have to do?

Following the 'cooling-off' period of 7 days subsequent to your consent to participate in the study, I will have a confidential discussion with you (online or face to face if possible and preferred) to go through the methodology and procedure in detail, and talk through interview format, and diary structure and design (written or recorded). Either following, or on another date, I will undertake an individual semi-structured confidential interview with you, again either face to face or online.

The semi structured interview will take around 1-2 hours and will consist of me talking with you. With your permission I will video/audio record the interview to enable me to transcribe our discussions more accurately. You will be able to select whether the interview is either video, or audio recorded. If you select video recording, the .mp4 recording will be immediately converted into an .mp3 audio recording, meaning only I will have seen the video recording. If you select audio recording, the .mp3 recording will be preserved in this format. All recordings will be pseudonymised and securely and confidentially uploaded to my account on the encrypted and password protected University OneDrive system. My Academic Supervisors will only have access to the .mp3 audio recording.

The interview is my opportunity to hear your imposter syndrome 'story' and give you the opportunity to explore the history, experience, triggers, feelings, and impact of imposterism as situated in your own life. The interview will take place either online, or face to face if Covid restrictions allow and you prefer. If face to face is preferred, I would arrange for private office one-to-one discussions in an appropriate setting, agreed by both parties, where conversation can be held comfortably and in private.

Subsequently you will be required to keep a diary of your personal lived experience, feelings, and thoughts on imposter syndrome for 3 months in your role as a Clinical Educator. It will be your choice on how you structure this diary and whether you keep it as a written document (either hard-copy or on your computer), or use a hand-held voice recorder. I will supply a hard-copy diary, or the voice recorder, if you choose one of these methods to keep your diary record. It is your decision how often you make diary entries, and the depth/breadth of detail you give. Transcription data I obtain from your diary will be pseudonymised to ensure confidentiality. Guidance on confidential collection/storage of your diary entries (hard copy, computer, or voice recorder) will be given to you before data collection commences.

During the 3 month data collection period I will liaise with you to arrange regular contact meetings to talk through any concerns, queries, or questions you may have and also ensure you are happy to remain in the study. As part of my preparation for this study I have reviewed the literature concerning the possible impact on participants involved in researching stressful or affective experiences, such as Imposter Syndrome. Some individuals may feel that involvement in the study gave them the opportunity to share their experiences, and this brings clarity or understanding. There was recognition in the literature that, as with any method that encourages participant reflection of their experiences, the very act of completing a diary (verbal or written) may contribute to perceptual changes of the experience being considered, some of which may trigger reduced or low mood, or feelings of inadequacy. In researching about such a personal experience, I must share these issues with you, and I would encourage and support you to talk with me about any responses or emotions you may feel or be aware of during the study. As researcher I do not provide mental health services or support, and will not be following up with you after the study. However, I want to provide you with details of some resources should you decide you need assistance at any time. At the end of the study therefore, I shall offer you the opportunity for

a debrief using a Debrief Form to signpost services you can access if you feel a need for additional support.

At our contact meetings I will also collect diary data:

- If you have chosen the hard-copy diary record I will collect the latest pseudonymised diary document at this time, and issue a new one to you. I will store this diary securely in a locked draw in my office and it will be confidentially accessed solely by me for transcription. The transcriptions will be uploaded to the secure OneDrive system of the University. Over the 3 month study period the diaries will be stored securely in my personal locked cabinet, located in the YSJU Graduate Centre entered by keypad admittance, and accessed solely by me. Upon completion of the research study the hard copy of the diaries will be destroyed.

- If you have chosen to use the voice recorder, I will collect the latest pseudonymised memory card at this time, and give you an empty card to replace in your recorder. I will store this memory card securely in a locked draw in my office and it will be confidentially accessed solely by me for transcription. The transcriptions will be uploaded to the secure OneDrive system of the University. Over the 3 month study period the memory cards will be stored securely in my personal locked cabinet, located in the YSJU Graduate Centre entered by keypad admittance, and accessed solely by me. Upon completion of the research study the memory cards will be destroyed.

- If you have chosen to keep your diary record on your computer, I will ask you to email it to me using the University SafeSend system. With SafeSend your diary data is encrypted at both sender and receiver ends, I "request a drop-off" from you, and forward a password to you separately to enable this. Files are automatically deleted from SafeSend 14 days after they are uploaded. I will show you how to use SafeSend, including a trial run, before you email any diary data to me. Over the 3 month study period your pseudonymised emailed diary records will be saved on the password protected University's Microsoft Office 365 Suite and confidentially accessed solely by me for transcription. The transcriptions will be uploaded to the secure University OneDrive system. Upon completion of the research study the emails will be deleted and removed.

What will you do with the information I tell you?

All information, and data I collect during discussions, interview, and transcribed from your chosen diary format, will be kept totally confidential, pseudonymised, and safely data managed to protect your identity in the research writing, and to ensure data will not be able to personally identify you. All pseudonyms will be securely stored and kept by myself on the encrypted and password protected OneDrive system of York St John University.

The data may be kept for up to ten years after completion of the thesis as per university requirements. Written data will be stored on the encrypted and password protected systems of the University. Audio recordings will be deleted from portable media and stored on the York St John University OneDrive where it will be encrypted. You can request to review the field notes or listen to the audio at the end of the interview, and any parts that you are unhappy with can be deleted and removed from the data collection process.

The data gathered during this study may be used for future journal articles and conference presentations, but the same levels of confidentiality, privacy and pseudonymity will be

applied, and the data may be required for up to ten years. If the research data is to be made public this would be using the YSJU system RaYDaR. After this period, all data will be destroyed.

Do I have to take part?

No, you do not have to take part in this study – your participation is entirely voluntary. If you do not wish to participate, please let me know. You can withdraw at any time during the study, there is no obligation on you to continue once you have started, and there is no penalty of any kind should you wish to withdraw. There will be a 7-day 'cooling off period' prior to the interview and diary keeping – during this time you can withdraw from the study and your data will be disregarded. After the 7 days, however, you can still withdraw but the pseudonymised data will remain part of the study.

Can I see the study results?

A summary of the study results will be made available to you upon completion of the thesis. You will have the option for the summary to be emailed or posted to you.

Who can I contact for further information or if I have any concerns?

If you would like further information on this project, or the EdD Thesis for which the project is being undertaken, please contact me:

Marion Khan, York St John University, Lord Mayor's Walk, York YO31 7EX

Email: marion.khan@yorksj.ac.uk

If you have any concerns about the project or my conduct as a researcher, please contact my main thesis Supervisor:

Dr Joan Walton, York St John University, Lord Mayor's Walk, York YO31 7EX Email: joan.walton@yorksj.ac.uk

If you have any issues or complaints re data/data breaches, please contact the University's Data Protection Officer:

Dr Amanda Wilcox, University Secretary, York St John University, Lord Mayor's Walk, York YO31 7EX.

Telephone: 01904 876844 Email: a.wilcox@yorksj.ac.uk

If you wish to contact someone independent to the study project about any issues or concerns, please email:

Dr Scott Cole, Chair of Ethics Committee, School of Education, Language and Psychology, York St John University, Lord Mayor's Walk, York YO31 7EX.

Email: s.cole1@yorksj.ac.uk

Many thanks for giving up your time to be part of this study. Your contribution to the phenomenological approach of this study will support the research aim to advance understanding of the felt experience of imposter syndrome among Clinical Educators.

Thank you for reading this Participant Information Sheet

Privacy Disclosure

The Sponsor for this study is **York St John University**, and is referred to as 'we' in this Privacy Disclosure document. In this research study we will use information from you. We will only use information that we need for the research study. We will let very few people know your name or contact details, and only if they really need it for this study. Everyone involved in this study will keep your data safe and secure. We will also follow all privacy rules. At the end of the study, we will save some of the data in case we need to check it. We will make sure no-one can work out who you are from the reports we write. The Participant Information Sheet tells you more about this.

How will we use information about you?
We will need to use information from you for this research project. This information will include your:

- Name
- Contact details [telephone and email]

People will use this information to do the research or to check your records to make sure that the research is being done properly. People who do not need to know who you are will not be able to see your name or contact details. Your data will have a code number instead. We will keep all information about you safe and secure. Once we have finished the study, we will keep some of the data so we can check the results. We will write our reports in a way that no-one can work out that you took part in the study.

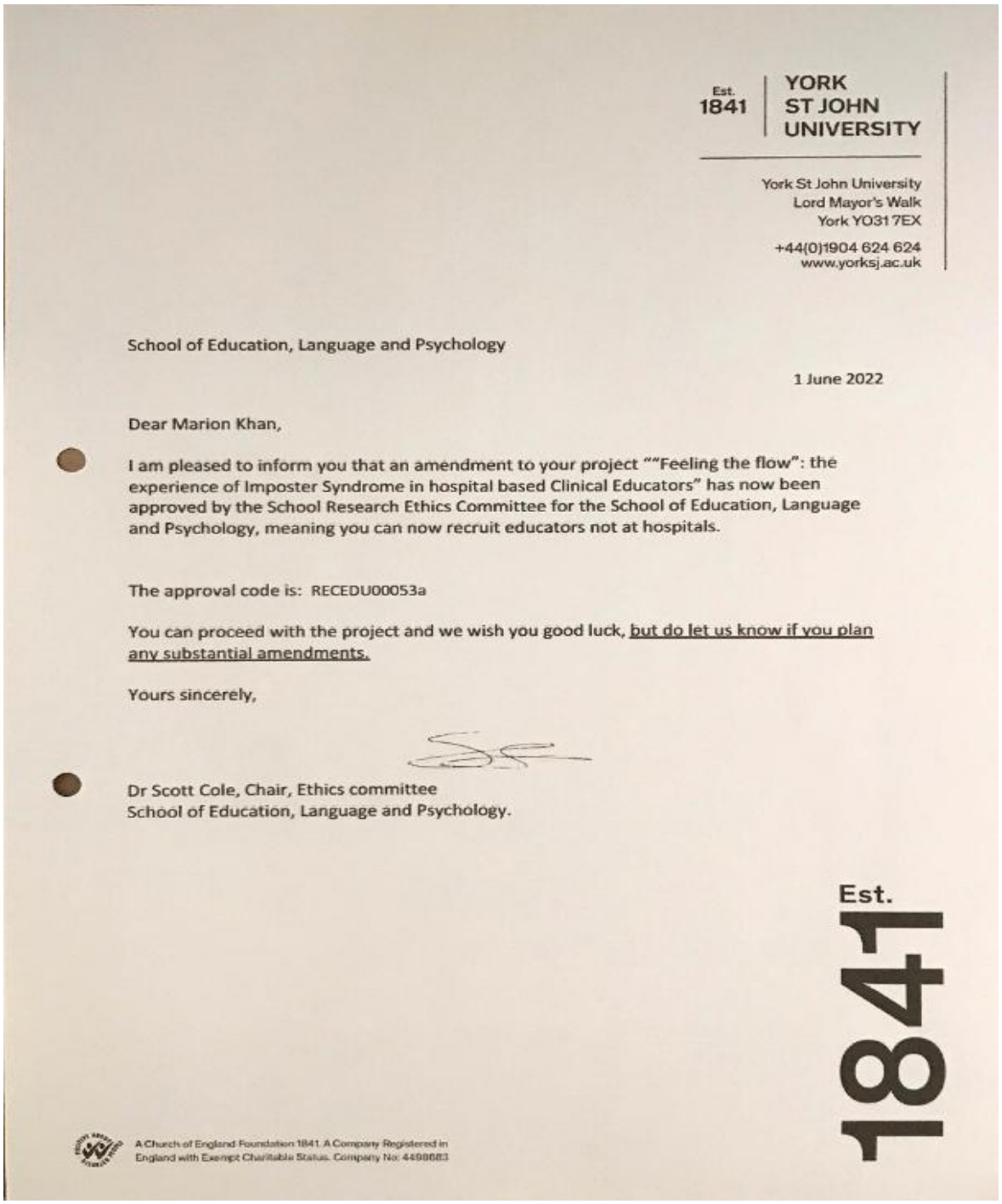
What are your choices about how your information is used?

- You can stop being part of the study at any time, without giving a reason, but we will keep information about you that we already have.
- We need to manage your records in specific ways for the research to be reliable. This means that we won't be able to let you see or change the data we hold about you.

Where can you find out more about how your information is used?
You can find out more about how we use your information:

- at https://www.hra.nhs.uk
- our leaflet available from Marion Khan [Researcher]
- by sending an email to marionkhan@yorksj.ac.uk
- by contacting the University's Data Protection Officer, Dr Amanda Wilcox, York St John University by telephone on 01904 876844 or email to a.wilcox@yorksj.ac.uk

Appendix 10: University Ethics Approval following Participant Amendment



Est. 1841 | YORK ST JOHN UNIVERSITY

York St John University
Lord Mayor's Walk
York YO31 7EX
+44(0)1904 624 624
www.yorksj.ac.uk

School of Education, Language and Psychology

1 June 2022

Dear Marion Khan,

I am pleased to inform you that an amendment to your project ""Feeling the flow": the experience of Imposter Syndrome in hospital based Clinical Educators" has now been approved by the School Research Ethics Committee for the School of Education, Language and Psychology, meaning you can now recruit educators not at hospitals.

The approval code is: RECEDU00053a

You can proceed with the project and we wish you good luck, but do let us know if you plan any substantial amendments.

Yours sincerely,

Dr Scott Cole, Chair, Ethics committee
School of Education, Language and Psychology.

Est. 1841

Appendix 11: Guidance on confidential collection and safe storage of your diary entries

V5 28/6/22

[Czechowski, K., Sylvestre, J. (2018) *Manual for Ensuring Privacy, Confidentiality, and Secure Data Storage, for the Centre for Research on Educational and Community Services.* Ottawa, University of Ottawa]

Your diary for this study, whether written or as a voice recording, contains confidential and sensitive personal information, and if it is accidentally disclosed the information may cause you some private or reputational embarrassment. To mitigate this risk, I have prepared the following guidance for you to consider regarding confidential collection and safe storage of your diary entries.

Collecting Diary Entries:

1. When making diary entries using a computer or handheld voice recorder, please ensure that your device is password protected with a strong password. The voice recorder I supply can be password protected, and I will show you how to set up your own password on it.
2. Try to ensure that your diary entry work will not be overlooked or overheard to maintain confidentiality of the content.
3. Passwords should not be easy to guess and should be kept confidential.
4. When making diary entries ensure that devices, or diary hard-copies, are not left 'open' and unattended.
5. If possible, try not to use identifying information (eg name, job title, etc) when completing diary entries. Use of 'I' or 'me' will be sufficient for my transcription. If it is absolutely necessary to include identifying information in a diary entry, this will be removed during transcription and your pseudonym inserted.
6. Only use the handheld voice recorder for the purposes of diary entry. If used for other purposes there is a great risk that confidential diary data could be either accidentally accessed, or accidentally deleted.

Safe Diary Entry Storage

1. If using a computer for your diary entries, it is recommended that the computer is up-to-date and has a firewall system to scan for malware and give virus protection (eg Norton) to protect against data breaches and computer hacking.
2. It is suggested that all diary entries held on a password protected computer or voice recorder be stored and named with the study pseudonym to anonymise the diary data.
3. It is suggested that all diary entries held in a hard-copy diary format be written and named with the study pseudonym to anonymise the diary data.
4. Only store diary entries on a single password protected computer file or on the voice recorder. Moving data across different files and devices increases the risk of accidental confidentiality breaches.
5. Do not share the user-IDs or passwords etc related to the devices storing diary entries as this increases the risk of accidental confidentiality breaches.
6. Avoid, where possible, moving the hard-copy diary, computer, or handheld recorder to different sites or locations to reduce the risk of accidental confidentiality breaches.
7. Do not leave devices or hard-copy diaries unattended or in non-secure locations (eg a locked car) as this increases the risk of accidental confidentiality breaches.
8. When not in use, devices and hard-copy diaries should be stored in a secure location.

Appendix 12: Consent Form

V5 1/6/22

Confidential

Consent Form

Study: "Feeling the flow": the experience of Imposter Syndrome in Clinical Educators

Researcher: Marion Khan, York St John University

	Pseudonymised Name:	**Please initial to agree**
1.	I confirm that I have read and understood the Participant Information Sheet dated 1 June 2022 for the above study. I have had the opportunity to consider the information, ask questions, and have had these answered satisfactorily.	
2.	I understand that my participation in this research study is voluntary. If for any reason I wish to withdraw during the study, I am free to do so without providing any reason, and without incurring any penalty.	
3.	I consent to the interview being audio/video recorded, and for my preferred diary format to be either written or voice recorded.	
4.	I understand that my contributions to an interview and diary will be part of the data collected for this study, and my anonymity will be ensured. I give consent for all my contributions to be included and/or quoted using a participant code pseudonym in this study.	
5.	I understand that I will be offered a 7-day 'cooling off period' after my consent to participate in the study. Once data has been collected, I can still withdraw, but my pseudonymised data will remain in the study.	
6.	I understand that the information I provide will be used for an EdD research thesis, and the pseudonymised combined results of the study may be published, or included in conference, professional, or educational presentations.	
7.	I understand that I have the right to review and comment on the information I have provided, or ask for it to be disregarded, during my participation in the study.	
8.	I understand that if I lose capacity to consent before or during the 7-day 'cooling off period' I will be withdrawn from the study and any data already obtained will be destroyed. If I lose capacity to consent during the study, I will be withdrawn from the study. No further data collection would be carried out under the study protocol, but any pseudonymised data already collected will remain part of the study.	
9.	I agree to take part in the above study project.	
	Signature: Date:	