Doctoral Thesis

Hidden Talents: Mental Health Professionals Explore Their Lived Experiences of Mental Health Challenges in the Workplace: An Interpretative Phenomenological Analysis.

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Abstract

Background Lived experience of mental health conditions is becoming valued within mainstream mental health service delivery. This is reflected in the rising employment of Peer Support Workers (PSWs) to support and enhance clients' recovery. However, the lived experience of mental health professionals has been spuriously overlooked in the literature. To date, no studies have explored the influence of lived experience on professionals' roles, identity, work relationships, or its potential clinical utility to enhance clients' recovery.

Methodology This study uses Interpretative Phenomenological Analysis (IPA) to explore the views and reflections of mental health professionals with their own lived experience of mental health challenges. Individual semi-structured interviews were conducted on NHS premises. Data was transcribed and subject to in-depth interpretative analysis by the researcher.

Results Five superordinate themes emerged from the data: "Lived Experience Informs Practice" reveals how having a greater understanding, empathy, and limited self-disclosure enriches the therapeutic relationship; "Stigma" shows that all participants have experienced stigma from others, and some, self-stigma. Half of the participants spoke about the "them and us" between professionals and clients, and one participant, between professionals and PSWs; "Towards a Culture of Openness" captures participants' concerns around social acceptability of their lived experience, and their hopes for greater openness and less shame, akin to that in recovery settings; "Changed Identity" highlights the impact of lived experience on professionals' roles and vice versa; and finally, "Experiencing the Organisation as Unsupportive" reveals that participants feel under pressure to prove wellness, that staff wellbeing is not prioritised, and there exists an ironic lack of understanding and support.

Conclusion The findings showed that lived experience influences mental health professionals' identity and self-care, their clinical practice, and their working relationships with colleagues and the organisation. Participants valued their lived experience, especially in terms of building strong therapeutic relationships with clients.

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1. Introduction

1.1 Chapter Overview

This chapter will begin by defining lived experience and describing its relevance and perceived value in current mental health services. A review and critique of the peer support literature within mental health will be presented, alongside the questions that the peer support movement raises about how lived experience should be used. Peer Support Workers (PSWs) are people who have experienced mental health problems themselves and are employed by mental health services to use their experience to support others on their recovery journey. It will be argued that there is already a substantial amount of lived experience within the traditional professional mental health workforce, and studies will be presented to support this. The lack of peer-reviewed literature on how professionals use their lived experience will be discussed, and the grey literature on this subject will be reviewed. The rationale for this thesis will then be outlined, along with its main research questions.

1.2 Definition of Lived Experience

As yet, there is no universal definition of lived experience. However, within a mental health context the concept of lived experience relates to “the belief that people who have faced, endured, and who have overcome adversity can offer useful support, encouragement, hope, and perhaps mentorship to others facing similar situations” (Davidson, Chinman, Sells & Rowe, 2006, p. 443). Crucially, expertise of lived experience is distinct from clinical expertise, and refers to those who have used services and walked a similar path (Basset, Faulkner, Repper & Stamou, 2010). This lack of a universal definition makes devising job descriptions for people employed on the basis of having lived experience, namely Peer Support Workers (PSWs), problematic (Dyble, Tickle & Collinson, 2014).

1.2.1 Using Lived Experience to Promote Mental Health Recovery

Utilising lived experience to change service culture, reduce stigma, and promote client outcomes has been discussed in the literature for nearly 20 years (Davidson, et al., 1999; Reidy, 1994). The push to introduce PSWs, who have this lived experience, into mental health services in the NHS in England and Wales has been part of the drive to promote more recovery-oriented mental health services (Shepherd, Boardman & Burn, 2010).

Recovery in mental health has been defined in various ways. However, it is generally accepted that recovery refers to a person being able to live a meaningful life alongside symptoms, contrary to the traditional biomedical perspective which aims to eliminate symptoms (Bonney & Stickley, 2008). It is increasingly being accepted that lived experience can be helpful in promoting mental health recovery, but the evidence base for this is neither substantial nor conclusive. Despite this, PSWs represent the quickest growing occupational group in mental health services (Doughty & Tse, 2011).

Although PSWs can bring about reported benefits to service delivery, as will be explored in detail later, the rationale and evidence base for their employment is questionable. Firstly, as mentioned above, a well-developed evidence base to justify their role does not currently exist

(Lloyd-Evans et al., 2014). Secondly, there is no theoretical model of how this lived experience could help. Thirdly, there is a lack of a clear agenda for how lived experience could or should be used. This is important because the prominence of peer support in mental health policy is increasing (Le Boutillier, 2011). The number of PSWs is also rising, with some mental health trusts employing twenty or more (Repper, 2013) and despite sufficient evidence to support this development (Bracke et al., 2008; Lloyd-Evans et al., 2014).

1.2.2 Is Lived Experience Useful in Mental Health Interventions?

There is very little literature about how traditional mental health professions use any of their lived experience. The only literature which examines the question of the utility of lived experience is the literature on peer support interventions. An introduction and critique of the peer support literature will follow.

1.3 Definition of Peer Support

PSWs “are people with personal experience of mental health issues and recovery, who are trained, and then employed to work in support of others in recovery” (Bradstreet & Pratt, 2010, p. 36). Peer-based support aims to provide clients with social and emotional support from people who have experienced mental illness themselves, in order to bring about a desired social or personal change (Solomon, 2004). Peer support is regarded as fundamental to the recovery approach which emphasises the unique journey of an individual living with mental health problems building a life for themselves beyond illness (Shepherd, Boardman & Slade, 2008).

To further explain the concept of peer support, it is worth noting that there are three different kinds: mutual support groups, peer-support services, and peer mental health service providers. These distinctions are important from a service perspective (Daniels, Bergeson, Fricks, Ashenden & Powell, 2012) and have significant implications for research, as will now be demonstrated.

1.3.1 Summary and Critique of the Current Evidence Base for Peer Support

There have been a number of attempts at the systematic review of peer-led mental health interventions. Doughty and Tse (2011) reviewed 29 studies, conducted between 1980 and 2008, to answer the question: can consumer-led mental health services be equally effective? Reviewed studies included a mix of designs with differing levels of rigour. Type and extent of consumer involvement also varied. Services ranged from peer specialists participating within a traditional mental health service, to consumers surveying staff attitudes towards peer support, to entirely consumer-run programmes. The authors concluded that overall consumer-led services produced equivocal outcomes in terms of emotional, social, and symptomatic recovery. However, the authors only assessed the strength of studies based on design type and did not take into account how well the design was implemented. Furthermore, although the majority of studies were considered to be RCT primary research, 10 studies were pseudo-randomised and comparative trials with samples as small as five. This likely introduced considerable bias into the review which the authors did not account for within their conclusions. Manual searching of studies was also not undertaken, perhaps unnecessarily limiting the study’s scope and generalisability. Finally, critical appraisal of the reviewed studies was not integrated within the article making it difficult for the reader to make an informed judgement about the reliability and validity of their conclusions.

A recent Cochrane review (Pitt et al., 2013) reviewed 11 randomised controlled trials involving 2796 people. The quality of these studies was rated moderate to low, with a high risk of bias for blinded outcome assessment and selective outcome reporting. Studies compared the effect of having a consumer-provider in the mental health professional role, or at least in the mental health team, in statutory services only. Equivocal psychosocial, mental health symptom, and service user outcomes for clients were concluded from the review. However, the mode of intervention in the reviewed studies varied widely in terms of aims, structure and content, and there was a considerable risk of bias. Despite this heterogeneity, the authors pooled the results together which is inappropriate when the interventions are heterogeneous (Lloyd-Evans et al., 2014).

A more recent systematic review and meta-analysis of 18 randomised controlled trials including 5597 participants was conducted by Lloyd-Evans et al. (2014). The authors compared evidence from all community-based peer support programmes designed to aid recovery from serious mental illness. The effects of community-based peer-provided interventions on a number of subjective and objective outcomes of overall mental health recovery were measured, including hospitalisation rates, employment rates and mental health symptoms. Measures of quality of life such as recovery, hope, empowerment, and satisfaction with services, were also included. Studies which evaluated mutual support, peer support in addition to treatment-as-usual, and peer-delivered mental health services were all included in their review. Hence there was great heterogeneity of interventions ranging from: access to advice via drop-in centres, manualised self-management skills programmes, befriending and social support, and peer case management within Assertive Community Treatment or Intensive Case Management services. Consequently, similar to previous reviews, the authors also found difficulty in generalising across peer interventions, and the quality of evidence was poor. They identified that the following criteria would make the peer support literature more robust: the utilisation of mixed methods; standard inclusion of objective measures of recovery, such as employment status; reliable and validated self-report measures; manualised interventions which take into account age, culture, and diagnoses of clients; and the use of follow-up data.

With regards to the existing literature, Lloyd-Evans et al. (2014) articulated the following problems. Firstly, studies included in their review which claimed equivalence to treatment as usual did so erroneously, since non-significance of any difference does not equal equivalence in studies powered to find a superiority effect rather than a non-inferiority effect. Secondly, selective outcome reporting due to a lack of formal comparisons may have led to biased results. Thirdly, results of theoretically distinct interventions cannot be pooled together, as doing so compromises validity. Fourthly, poor study design, for example using non-randomised methods, also undermined validity. Gates and Akabas (2007) concur that the majority of evidence in favour of peer support has come from descriptive studies which have placed undue emphasis on positive findings based on poor quality evidence. The authors concluded that the “current evidence does not support recommendations or mandatory requirements from policy makers for mental health services to provide peer support programmes” (p. 10). This is problematic and raises questions about the PSW role, particularly as it remains operationally unclear what peer support work actually involves (Gruhl, LaCarte & Calixte, 2015).

Despite there not currently being a strong evidence base for peer support, there is quite a body of literature seeking to promote its benefits, such as enhancing the recovery of clients and improving clients' relationships with services. Repper and Carter (2011) reviewed 42 studies which also included a range of designs: qualitative, quantitative, and comparative. The quality of studies was not taken into account in their aim for a pluralistic approach which included "a multiple sources of evidence and types of data" (p. 393). They did, however, only include studies which investigated the impact of peers working in statutory or professionally-led services, and not consumer-led services. The authors reported that PSWs appear to be able to promote hope, belief in recovery, increased self-esteem, self-efficacy, self-management of difficulties, social inclusion, engagement, and increased social networks to a greater degree than qualified staff. The lack of critical appraisal and specificity in this review makes its conclusions questionable.

A qualitative metasynthesis was recently conducted by Walker and Bryant (2013). They reviewed 27 qualitative studies investigating peer support in adult mental health. It was not stated what proportion of studies represented perspectives of clients, PSWs, and staff. One fifth of the studies found that clients experienced increased social network, motivation, and hope. A similar number of studies reported that clients built rapport with PSWs more quickly than with professionals. In nearly half of the papers reviewed (44%), PSWs were viewed as role models. Within the two studies which reported that PSWs were not seen as role models, the reason given was due to a lack of confidence in their ability to be effective helpers based on a) not having formal training (Chinman et al., 2008) and b) having a previous diagnosis of mental illness (Doherty et al., 2004). However, it is important to note that, as was the problem in the quantitative reviews, results have been pooled together from very different studies. Therefore caution needs to be applied when interpreting these results. Critically, the studies vary in terms of whose views are being represented: PSWs, professionals, and clients. In Chinman et al.'s study, the participants were consumer-providers only (PSWs) and therefore could not be said to present the views of clients. Overall, much of the literature is derived from clinical prediction or intuition, rather than evidence that peer support leads to better outcomes (Sabin & Daniels, 2003).

1.3.2 Is Lived Experience Reserved Only For PSWs?

It has been claimed that PSWs help to improve relationships through bridging the gap between "them" and "us", thereby enabling greater mutual understanding of client and staff perspectives, and helping some staff have greater hope in recovery (Bradstreet et al., 2010). However, the current study argues that this could be done more directly through utilising the lived experience of professionals. The very nature of creating a separate group of peer support staff leads to unhelpful assumptions that either mental health professionals do not have their own experiences of mental health problems, or that they do not wish to disclose that they do, because it is too stigmatising. This then continues to perpetuate the distinction between "them and us" (Slade, 2009), where clients and former clients are seen as one group, and professionals are seen as another, inadvertently reinforcing the stigma of mental health issues. As such, a dichotomy exists whereby a person working in mental health services is seen as either having clinical or experiential expertise. It is not a great leap to suggest that in reality the two are not so mutually exclusive.

There seems to be another assumption within the literature which suggests that PSWs are uniquely, if not better placed to offer the following contributions: hope through positive self-disclosure, role modelling, empathy, trust, acceptance, and having the ability to better understand a client based on having been there themselves (Davidson, Bellamy, Guy & Miller, 2012). Proudfoot et al. (2012) also claim that PSWs are best placed to offer social support, experiential knowledge, and positive social comparison. Adame et al. (2008) add that PWSs have a “unique understanding of the internal workings of the mental health system” (p. 149). It will be argued it is remiss to assume that PSWs are the only staff group with lived experience who could have these insights and offer these contributions.

Added to this, there is a growing concern that the PSW role is becoming overly professional (Faulkner & Kalathil, 2012) and moving away from its original ethos related to a “mutual and non-hierarchical mode of being” (Adame & Leitner, 2008, p. 148). If it is possible that PSWs are becoming more professionalised, can professionals become more like peers? This might be perceived as a provocative question in view of the traditional culture of professionals being “experts” in mental health. Before this is explored any further, it is first worth reviewing the literature on the prevalence of lived experience in healthcare workers and mental health professionals.

1.4 Lived Experience within the Existing Mental Health Workforce

Peer support work is seen as revolutionary within the NHS but, as previously mentioned, this ignores the fact that many NHS mental health professionals have their own lived experience. In this section, the prevalence and incidence of mental health problems of health care workers will first be described, followed by a more specific investigation of the lived experience of mental health professionals.

1.4.1 Lived Experience of Healthcare Professionals

The following literature has been selected to contextualise this study and by no means is exhaustive. The negative effect of the stressors inherent in health care environments on healthcare professionals, is well-supported by the literature (Shapiro, Astin, Bishop & Cordova, 2005). In fact, emotional distress and burnout has been called the "healthcare professional's occupational disease" (Felton, 1998, p. 237). Twenty years ago, a survey of 389 participants including hospital consultants, general practitioners, and senior hospital managers, was conducted (Caplan, 1994). The authors found that almost half (47%) scored positively on the General Health Questionnaire (GHQ) for high levels of stress. Furthermore, 54% were identified as either being borderline (25%) or likely to be experiencing above threshold clinical symptoms (29%) for anxiety and depression, according to the Hospital Anxiety and Depression Scale. It could be that the staff who did not respond to the survey, 20% of hospital consultants, 20% of general practitioners, and 44% of managers, were too stressed to complete the survey or conversely not stressed at all. Of course there could be a variety of other reasons for not responding, and the relatively small sample size means that the results need to be interpreted with caution. However, in a larger and arguably more representative sample of 11,000 health service workers (Wall et al., 1997), the rate of significant symptoms of mental illness within health professionals was still found to be higher than that of the general population. A more recent survey by the Royal College of Nursing (RCN; Pike, 2006) found that 40% of nurses showed signs of mental illness.

It is well known that general practitioners experience high levels of stress which can lead to physical and psychological distress and burn-out (Bruce, Conaglen & Conaglen, 2005). Fifty physicians completed a confidential postal survey on burn-out (Bruce et al., 2005). The authors used Maslach's definition of burn-out as a syndrome characterised by depersonalisation, emotional exhaustion, and a reduced sense of personal accomplishment (Maslach & Jackson, 1976). They found that 56% were either highly likely to be suffering from burn-out or at least were at great risk of suffering the symptoms. Poorer mental health status not only affects the well-being of the health professional, who is consequently more likely to withdraw from roles involving direct patient care (Williams et al., 2001), but has also been significantly associated with reduced patient satisfaction (Garman, Corrigan & Morris, 2002).

Stress is also a growing problem among healthcare students (Mucci, Giorgi, Cupelli & Arcangeli, 2014). In particular, depression, anxiety, emotional exhaustion, and burn-out are highly prevalent experiences (Jennings, 2009; as cited in Mucci et al., 2014). A recent systematic review of general university students with mental illness highlighted medicine as being "a stand-out discipline" in terms of high levels of stress (Storrie, Ahern & Tuckett, 2010, p. 4). Interestingly, stressors that are specific to the mental health profession have been identified, namely: stigma, challenging interactions with both colleagues and clients, and legal frameworks (Rössler, 2012).

1.4.2 Lived Experience of Mental Health Professionals

As in section 1.4.1 the following literature has been selected for the purposes of this study and is not a systematic review. Although there is some literature related to the mental health problems of mental health professionals where the distress appears to some extent intrinsic to their roles, lived experience in its own right, i.e. extrinsic to the *role* of mental health professional, has received little attention. It appears that studies focussing on work-related burn-out, stress, and vicarious trauma are more common in the literature than studies focussing on outright psychiatric problems. An exception to this is a study which explored the prevalence of auditory hallucinations in nurses working in mental health (Millham & Easton, 1998).

This gap in the literature is perhaps surprising given that individuals with lived experience may be more drawn to working in mental health because of their lived experience (Rippere & Williams, 1985). This can be seen in a survey conducted by Barr (2006), where 73.9% of counsellors and psychotherapists had experienced one or more wounding experiences which had led to their career choice; the majority of which (65%) were personal rather than indirect experiences. It is not possible to elucidate or comment on all of the possible causes for this increased likelihood. However a bi-directional relationship between work and personality has been found which shows that people are drawn to particular occupations which have an effect on them or where they have had a similar experience (Wilhelm, Kovess, Rios-Seidel & Finch, 2004). The decision to study social work for example is often influenced by experiences of loss, psychological difficulties, and other serious life events (Barnett, 2007). The dearth of research in this area may reflect the stigma associated with having a mental illness as a mental health professional. Stigma is a significant issue which will be discussed in more detail later in this chapter.

Stress and emotional exhaustion, however, have been studied in mental health professionals. Prosser et al. (1996) found mean scores representing high levels of exhaustion in a sample of 121 clinical mental health staff, including nurses and nursing assistants, psychiatrists, psychologists, occupational therapists, and social workers. Those working in the community scored significantly higher on the GHQ-12 and higher for emotional exhaustion than did hospital ward staff. A more recent survey (Evans et al., 2006) found mean scores of the GHQ-12 to be almost double those reported by Prosser et al (1996). Evans et al. concluded that mental health social workers feel emotionally exhausted, overstressed, and undervalued. As a result, it has been found that health care professionals, particularly mental health professionals, have higher rates of absenteeism and stress than any other sector (Edwards & Burnard, 2003). It is a concern that lived experience in the mental health profession seems to be increasing as demonstrated by the increase in GHQ-12 score between the two studies, conducted 10 years apart; particularly as this latest finding was a decade ago and many changes to the NHS and mental health services have taken place in that period.

Several Mental Health Trusts have recently surveyed their staff to quantify the amount of lived experience in their workforce. In 2009, The Devon Partnership Trust (DPT) found that

43% of 560 respondents (23% of the workforce) reported personal experience of mental health problems. Half of these respondents reported having lived experience of treatments or services. A third of all respondents said that they would not inform their managers or colleagues for fear of adverse consequences such as rejection and stigma (DPT, 2009).

1.4.3 Self-Disclosure to Colleagues Dilemma

The term self-disclosure refers to verbally communicating information about oneself to another (Cozby, 1973). It is concerning that in the Devon Partnership Survey, a considerable proportion of mental health professionals did not feel able to tell their colleagues and managers that they had personal experience of mental health challenges. However, professionals are increasingly opening up about their experiences of having mental health problems on blogs and websites to get their voices heard. One anonymous professional with bipolar disorder wrote: “The huge stigma I have witnessed mental health professionals attaching to staff experiencing mental health issues is incomprehensible to the point that I've tried vehemently to hide the fact I have mental health problems” (Anonymous, 2012). This desire to hide lived experience is perhaps reflected in the lack of research into self-disclosure of mental health professionals. However, there are studies which have investigated employee self-disclosure in non-mental health settings, and these shall now be outlined.

It has been found that the decision not to disclose may be influenced by employees’ concerns regarding stigma, differential treatment by others, and potential discrimination in terms of opportunities for promotion (Moss & Johnsen, 1997; as cited in An, Roessler & McMahon, 2011). Employees also fear losing perceived credibility and competency in the eyes of others

(Brohan et al., 2012). Medical students in particular perceive that their professional lives would be at risk should it be revealed that they have mental health challenges (Roberts et al., 2001). It could be that people working in healthcare have a greater awareness of the stigma attached to mental illness compared with the general public and peer workers (Stromwall, Holley & Kondrat, 2012), therefore making them less likely to disclose. In addition to public stigma, professionals working in mental health are also exposed to "provider stigma" (Charles, 2013, p. 360) within their organisation, defined as the negative beliefs and behaviours of providers towards clients with mental illness. This then might reduce opportunities for professionals to feel emotionally supported at work by their colleagues, something which is known to facilitate disclosure (Rollins, Mueser, Bond & Becker, 2002).

Personal as well as social and environmental factors are also relevant to general employee self-disclosure. The severity of the mental health condition has been found to influence the decision (Ellison, Russinova, MacDonald-Wilson & Lyass, 2003), as has the type of mental health condition, and gender of the employee. A study found that individuals with mood disorders were significantly less likely to disclose than those with psychosis (Banks, Novak, Mank & Grossi, 2007) and females were less likely to disclose mental illness than men (Bank et al., 2007; Roberts et al., 2010).

A recent systematic review of 48 studies (Brohan et al., 2012) highlighted positive reasons to self-disclose mental health problems at work. These reasons included honesty, having a positive experience of disclosure, in order to gain support and reasonable adjustments, to reduce the stress associated with hiding lived experience, to explain their behaviour, and to be a role model for others. The latter was found to be especially relevant to mental health professionals. It is widely accepted that disclosure also helps to educate others and tackle stigma (Roberts, Rotteveel & Manos, 1995). However, barriers such as stigma and help-seeking hinder self-disclosure of mental health professionals; they can become more isolated and forego the necessary support and treatment as a result (Thornicroft, 2006).

1.5 How Might Mental Health Professionals Use Their Lived Experience With Clients?

Lived experience of professionals is not currently widely acknowledged in the workforce and is overshadowed by a disproportionate focus on staff wellbeing initiatives. Furthermore, the latest research and policies on the use of lived experience and self-disclosure are directed towards PSWs. Walker, Perkins and Repper (2014) emphasise the need to utilise the assets of everyone involved in services, and propose that a strengths-based approach is necessary to draw on professionals lived and life experience, as well as their professional experience and clinical training (Walker et al., 2014). It is promising that the number of articles, opinion papers, and key speakers calling for the need to utilise lived experience within the workforce is steadily increasing. However, the ways in which lived experience influences mental health workers' development has scarcely been explored (Goldberg, Hadas-Lidor & Karnieli-Miller, 2016). To date there is a complete absence of any research on how mental health professionals might currently use their lived experience in their practice and how they experience having lived, as well as clinical, expertise.

Existing knowledge on the use of lived experience with clients is fundamentally based on the psychotherapy literature and is less well recognised in health and social care (Gilbert &

Stickley, 2012). The idea of the "wounded healer" was first presented by Jung in his 1951 book entitled *Fundamental Questions of Psychotherapy* (as cited in Daneault, 2008). The concept of the wounded healer describes "the gift of hope and companionship that people, who have walked a similar path, can give each other" (Basset, et al., 2010, p. 3)**.** It has been argued that wounding experiences can be used positively to engender greater self-awareness, as well as a greater disposition to communicate human warmth in order to facilitate the healing process for patients (McGlone, 1990). This wounding or lived experience enables a connection based on having a shared experience where individuals can *be* with each other (Mead & Hilton, 2003).

Repper (2013) believes that by sharing stories and showing what it is possible to achieve, we can connect and more easily build trust and rapport with our clients. Martin (2010) states that not declaring these wounds or shared experiences is akin to deceit in the name of "professionalism." For in order to be authentic and show one's true self (Laing, 1959) professionals must bring their full personhood to their role, as well as their professional identity (Glover, 2008; as cited in Amering & Schmolke, 2009). A related area of research on the therapeutic use of self is more easily found in the literature. It is generally defined as a therapist's "planned use of his or her personality, insights, perceptions, and judgements as part of the therapeutic process" (Punwar & Peloquin, 2000, p. 285). Its use is highly regarded, especially within certain professions, such as occupational therapy. However, therapists report receiving little postgraduate training on the therapeutic use of self and would like more (Taylor, Lee, Kielhofner & Ketkar, 2009). It is likely that professionals from non-therapy backgrounds may not have received the same level of training on this during pre-qualification.

The sharing of lived experience by mental health professionals is a form of self-disclosure which in itself remains a highly controversial issue, and for which there is a lack of clear guidance or framework on how it should be achieved (Dixon et al., 2001). However, that is not to say that self-disclosure does not happen. It is estimated that 90% of therapists self-disclose on some level to clients, although this is on an infrequent basis (Matthews, 1989; Pope, Tabachnick & Keith-Spiegel, 1987; Edwards & Murdock, 1994).

A recent questionnaire study (Gilbert et al., 2012) investigated the experiences of 30 social work and mental health nursing students with lived experience working in mental health positions. The authors' aim was to see whether the students' experiences shaped their learning and practice, and whether the concept of the wounded healer is still relevant today. The questionnaire included six questions and was subject to thematic analysis. The data was 'coded according to content and significant themes' (p. 36). The results included four distinct themes: personal experience, understanding, empathy, and boundaries. Students expressed having a greater level of understanding of others' experiences on an empathic, as well as intellectual level. They felt that boundaries were important and needed to be maintained, however they also acknowledged that self-disclosure can sometimes help when understanding another's experience and when building rapport. Students emphasised that this should be facilitative and service-user-led and there was evidence that this caused students some apprehension. A number of students also felt that learning about mental health theory and practice had enhanced their understanding of their own mental health challenges. They reported that this gave them the permission to see themselves as effective healers. This is important work and a great start to exploring the influence of lived experience on those working in mental health. However, use of in-depth qualitative interviews instead of questionnaires would have been preferable to generate richer data on the students' experiences.

Another study examining students' "transition from patient to therapatient" (Goldberg et al., 2016) highlighted students' pre-occupation with integrating their identity as patient and therapist. The physical nature of the patient or therapist's chair was particularly salient as students were trying to figure out "whether it was possible to sit in both chairs, whether a chair existed that could contain both roles, and whether this was fair to their own patients" (p. 881).

Henretty and Levitt (2010) conducted a qualitative review of therapist self-disclosure. They found that self-disclosure did not have a negative effect and clients tended to like their therapist more for having disclosed. The results across the reviewed studies suggested that clients exposed to therapist self-disclosure, especially when it was infrequent and of low to moderate intimacy, perceived their therapists as warmer and liked them better. Furthermore, these clients also self-disclosed more to their therapists than other clients did to therapists who did not disclose. The authors concluded that therapist self-disclosure has been found to increase client insight and improve the therapeutic relationship by making the therapist seem more human. Henretty et al. (2010) also make the point that just as caution is required with self-disclosure, the risks and benefits of non-disclosure also need to be considered. The American Psychological Association Ethics Code (2002) cited in their review, states that therapists can no longer choose non-disclosure without reflecting on this carefully.

There are many other reasons to advocate self-disclosure which can be found in the literature. These include: to encourage reciprocity (Jourard, 1971); to normalise unusual experiences

(Ashmore & Banks, 2002); to model effective disclosure (Stricker, 1990); to encourage emotional expression (Riley, 2014); to increase perceived similarity with the client; to improve the therapeutic alliance and provide alternative cognitions and behaviours; and to respond to the client wanting therapist self-disclosure (Edwards & Murdock, 1994; Bender, Geller & Farber, 1997).

A recent discussion paper (Morgan & Lawson, 2015) representing the views of professionals with lived experience, service users, and representatives from different professional bodies, reported that there is hardly any published literature on how professionals can share their lived experience. The paper sought to start the conversation with a view to developing guidelines for sharing lived experience. The authors were involved in the creation of the first Hidden Talents project which was founded six years ago at Dorset HealthCare University NHS Trust. Hidden Talents is a group of professionals with lived experience whose goal is to better understand how services can value, support, and utilise the lived experience of their staff, and tackle stigma of mental health conditions.

1.6 Chapter Summary

It is becoming widely accepted that lived experience is helpful in promoting the recovery of clients with mental illness. There is tentative and preliminary evidence from the peer support literature to support this although, as discussed above, there are myriad problems with the literature from which these conclusions are drawn. The PSW role is not clearly operationalised and they are not the only group of people who have lived experience and understand the inner workings of mental health services. Ironically, their role is becoming professionalised and so they are becoming further removed from the ethos of being a peer.

There is much evidence to suggest that people working in healthcare and mental health services have disproportionately greater lived experience of mental health challenges compared to that of the general population. A link has also been found between having lived experience and choosing to work in mental healthcare (Wilhelm et al., 2004). However, there is a paucity of research on how mental health professionals, who experience a high level of mental health problems of their own, may or may not use their lived experience in their work, or even on how it affects them and their professional lives. Stigma, fears relating to self-disclosure, and a legacy of the traditional "expert" medical model, may account for this.

1.7 Rationale for the Current Study

Overall, there is a great underrepresentation of professionals as clients in the literature. Many mental health workers have their own lived experience and may have their own ideas about how it has influenced their practice, or how they are using lived experience in their work. As yet there are no published quantitative or qualitative studies which explore the experiences of mental health professionals with lived experience, or how it might affect them within their role and practice. In agreement with Walker et al (2014), it is time to stop ignoring the wealth of lived experience held by mental health professionals. This study seeks to explore the reflections and experiences of mental health professionals within a local Hidden Talents group. It seeks to understand the possible impact of lived experience on their relationships with clients and colleagues and their roles within mental health services.

It was hoped that this study would not only provide a description and interpretation of their experiences, but might inform future research and clinical developments in the use of professionals' lived experience in mental health service delivery. In terms of research, a finer grained understanding of the experience of having lived experience and how it is used in clinical work might help formulate research questions and develop models which can then be tested by future studies, and which have wider relevance in terms of peer support interventions. The findings of the study might also help to inform organisational responses in supporting people with lived experience in their roles.

1.7.1 Rationale for a Qualitative Approach

There are several important reasons for choosing a qualitative approach. Firstly, the lack of theory and research investigating the lived experiences of mental health professionals means that it is too early to formulate highly specific research questions. Secondly, quantitative approaches make assumptions in order to test out specific research hypotheses. This would be inappropriate for the current study since there is so little known about mental health professionals with lived experience. Thirdly, qualitative research enables "less tangible meanings and intricacies" (Finlay, 2011, p. 8) of a person's experiences within a particular context to be explored. This is necessary to increase our understanding of the experiences of mental health professionals with lived experience, and is concordant with the research aims and questions of this study.

1.8 Research Questions

The researcher was interested in gaining an understanding of how professionals experience having personal lived experience of mental health challenges in their role and wider organisational context. Due to the phenomenological and discovery orientated nature of this qualitative research there are no predetermined hypotheses to test or prove (Giorgi, 1997). Doing so would lead participants to respond in a certain way rather than speaking freely about their lived experience. Therefore the key research areas of interest are: how mental health professionals with lived experience use their experience professionally, what it adds (if anything) to their practice, and what potential workplace barriers (if any) they may have experienced as a result of having lived experience or disclosing their lived experience.

Reflection 1. Starting the Research

I am excited to begin this research journey. However, I am aware that being a trainee clinical psychologist with lived experience of anxiety and depression no doubt influences my assumptions and pre-understandings about this topic. Having said that, it is fair to say that I am not really sure what to expect although I do somehow expect to be changed by the experience. On the one hand, I anticipate (and selfishly hope) that lived experience will be viewed fairly positively by professionals, yet on the other hand, I think if this is only what I find, I will feel somehow cheated. I imagine that it is a much more complex picture. Therefore, I am slightly apprehensive about the possible negative perceptions and feelings participants may have towards their own and others' experiences. As I am not yet a fully-fledged clinician, I am perhaps not privy to the politics and potential challenges faced by professionals with lived experience who have many years of clinical experience. Taking all of this into account, I hope that I might achieve enough closeness to their experience to gain an insight but also maintain enough distance in order to stay open and curious to their phenomenology.

2. Methodology

2.1 Chapter Overview

This chapter begins by presenting a rationale for using Interpretative Phenomenological Analysis (IPA) and a description of its epistemological position. Information about the methodology will be presented alongside the following: ethical considerations; a description of the participants; study procedure; development of interview schedule; interview process; and an outline of the stages of analysis. Finally, issues regarding quality in qualitative research, especially IPA, are considered.

2.2 Design

2.2.1 Choosing Interpretative Phenomenological Analysis

This study is dedicated to the exploration of mental health professionals' views and reflections regarding their own lived experience of mental health challenges. It is fundamentally interested in how they make sense of having both clinical and experiential expertise, and how these significant life experiences influence them in their practice. Interpretative Phenomenological Analysis (IPA; Smith, 1996) is an experiential and inductive qualitative approach centred in psychology (Smith, et al. 2009) "concerned with the detailed examination of personal lived experience" (Smith, 2011) and giving voice to individuals and their experiences. IPA comes from the standpoint that researchers can learn about a phenomenon by asking key questions of persons who are experts of their own experience. As such it is committed to the idiographic, and attempts to gain an insider's perspective of the phenomenon. IPA considers a person's embodied experience, communication, and interpretation to be all connected (Smith, 2011), and immersed within a particular context. This sets it apart from some qualitative, as well as quantitative methods (Larkin, Watts & Clifton, 2006). The two aims of IPA are to firstly attempt to understand and describe the participants' world, and secondly to develop an interpretative analysis in the contexts of theory, society, and culture (Larkin, et al., 2006). Therefore, this methodology was chosen because it is highly suited to the study's aims and research question. The study's epistemological position will now be described.

2.2.2 Epistemology

Epistemology concerns the philosophical theory of how knowledge is gained and whether it is deemed reliable (Harper & Thompson, 2012). IPA methodology suggests that in order to understand the world, one has to understand experience. It takes the view that people are "embedded and immersed in a world of objects and relationships, language and culture, projects, and concerns" (Smith et al., 2009, p. 21). It is important to consider how mental health professionals with lived experience are embedded within the culture of mental health services, and how this shapes their perceptions and experiences of their lived experience.

IPA assumes that there is a reality, however deems it impossible to directly access another person's reality; instead it is through the "mysterious intersubjective space" where participant and researcher meet and merge, that the participant's relationship to the world can be accessed via interpretation (Finlay, 2011, p. 22). This inter-subjectivity between researcher and participant is embraced, and the corresponding interplay has been likened to a dance (Finlay, 2006). Therefore, IPA adopts a critical-realist position, which is strongly aligned to the interpretative or hermeneutic tradition, and will be discussed in more detail later in the chapter.

IPA views people's sense-making as a process by which they attach personal and existential meaning to their experiences. Consequently, the role of the researcher in IPA is very important in the interpretative analysis of participants' interpretations of their experiences (Smith, 2004), or "double hermeneutic" as it is called (Smith & Osborn, 2003, p. 51). This necessitates recognition and reflection of the researcher's experiences and values, and the possible impact that these may have on the analysis. The researcher's experience of being a trainee clinical psychologist working within the same services as the participants, and having some lived experience of her own, is important material to reflect upon. To this end, the goal of the researcher is to balance being "experience close" and "experience far" (Smith, 2011, p. 10). This is so that their analysis is grounded within the participants' experiences, whilst offering an interpretation to greater reveal the participants' phenomenology.

To summarise IPA's epistemological position, Larkin and Thompson (2012) outline its main assumptions: there is a need to understand experience; individuals are immersed in the context of their world; a focus on the particular is required; others' experience can only be accessed intersubjectively; researchers have to reflect on and be reflexive towards their own assumptions and experiences; and finally researchers need to reflect on their role in data generation, and remain committed to grounding their interpretations in the interview text. The approach is built upon the philosophical foundations of phenomenology, idiography, and hermeneutics, all of which shall now be described.

2.2.2.1 Phenomenology

Without the phenomenology, there would be nothing to interpret; without the hermeneutics, the phenomenology would not be seen. (Smith et al., 2009, p. 37)

Phenomenology is the philosophical study of subjective experience, which "invites us to slow down, focus on, and dwell with the 'phenomenon' – the specific qualities of the lived world being investigated" (Finlay, 2011, p. 3). This study questions what it is like to be a mental health professional with lived experience. Lived experience research can only be deemed phenomenological if it embraces its theoretical and philosophical underpinnings (Finlay, 2011). This next section is devoted to the contributions of the most influential philosophers, namely Husserl, Heidegger, and Merleau-Ponty, whose work influenced IPA.

Husserl, credited as the founder of modern phenomenology, championed going "back to things themselves" (Smith et al., 2009, p. 12), to the "essence" or essential qualities of conscious and human lived experience. This was a reaction against the assumptions within the positivist tradition that natural phenomena can be subject to objective measurement (Danziner & Dzinas, 1997) and empirical investigation. Such quantitative approaches are unable to capture the richness of human experience. In order to study conscious experience, Husserl argued for the need to adopt a special attitude, using a process he called reduction, in order to see things as they really are. This involves detaching oneself from one's own assumptions and understandings about something in order to see it afresh, via a process known as bracketing. This process, Husserl argued, increased the researcher's awareness of their "personal intellectual baggage [that] might distort the description of the phenomenon" and so help identify essences (Finlay, 2011, p. 45).

It is particularly important to acknowledge and attempt reduction, however the possibility of being able to fully bracket one's prior assumptions and knowledge has been challenged by many for not being fully achievable. Moreover, there is a need to be pragmatic when attempting to apply philosophical concepts to research (Giorgi, 2009). Ashworth (1996) suggested that researchers should attempt to bracket the following: their personal views and experiences, the truth of participants' claims, and scientific theories and explanations.

Husserl's greatest legacy is known as the phenomenological attitude. It is the idea that a researcher needs to be open and curious towards the thing under study, and be in a mind-set where they can "be surprised and sensitive to the unpredicted and unexpected" (Dahlberg et al., 2008, p. 98). This is in contrast to the default everyday natural attitude in which things tend to be taken for granted. This concept of being open and curious is more applicable to IPA which prefers building a reflexive, cyclical, and hermeneutic way of acknowledging the influence of prior understandings, to bracketing. According to Smith this relates to engaging in an "enlivened form of bracketing" (Smith et al., 2009, p. 25). He argues that, by adopting a phenomenological attitude, researchers are continuously engaged in the participant's lifeworld anyway, so there is less need to be preoccupied with bracketing (Smith et al., 2009).

Heidegger, a student of Husserl's, diametrically opposed his teacher's assertion that you can separate yourself from the thing under study. Heidegger instead argued that we are inextricably linked to the world and this intersubjectivity is unavoidable. He described this as 'Dasein', which literally means 'being-in-the-world' (Smith, 2011, p. 17); as a result we are always evolving and much of our understanding is dependent on our culture and the time we live in. This is applicable to the current study in that attitudes towards mental ill-health are dynamic, as well as culturally and societally informed.

Heidegger also stated that our observations are always made from our own position and therefore the closest we are able to get is through our own *interpretation* of the phenomena. He asserted that there is a strong association between being and language, and how language reveals phenomena. The choice of words holds great meaning in terms of how a person describes and feels about their experiences. This is evidenced by the way in which participants related to their lived experiences in this study.

Merleau-Ponty also agreed with Husserl that the focus should be placed on our experience and being, but like Heidegger argued that the context of our experience should be emphasised. For Merleau-Ponty, it is necessary to describe our embodied relationship to the world which influences our personal and subjective perspectives. Therefore he claimed that we can never truly know another's experience. Thus attempts to understand another's experience are necessarily interpretative (Smith, 2011).

2.2.2.2 Hermeneutics

Hermeneutics, the theory of interpretation, is a key component of IPA. As such it is important to refer to the work of the philosophers: Schleiermacher, Heidegger, and Gadamer, to set the scene for the significance of hermeneutics in IPA. Schleiermacher posited that interpretation includes psychological as well as grammatical interpretation, allowing the analyst to offer additional insights based on an understanding of the whole text, and of psychological theory. Similarly, Heidegger felt that more could be gained from the text than merely a descriptive surface-level understanding. He espoused that inherent in participants' accounts are implicit and hidden meanings which come forth and appear during the process of interpretation. For the current study, participants described their interpretations of their experience of having lived experience in the workplace. The researcher has used her personal and professional experience, as well as her knowledge of psychological theory and research, to facilitate interpretation of their experiences.

Both Heidegger and Gadamer considered interpretation to be a dynamic process through which the researcher projects their own pre-understandings onto the text, and becomes aware of them in the process. Gadamer's influence also stems from his assertion that interpretation is strongly influenced by context and the time at which it was made. To elucidate this further, Finlay (2011) asserts that context is important because of the following: 1) contextual interpretation generates better understanding of lived experience; 2) interpretation will be subjective and informed by the researcher's own experiences and history; 3) interpretations are viewed through a spatial-temporal lens within specific cultural and historical fields; and 4) the researcher's and participant's interpretations arise in the context of their meeting.

Therefore the findings of this study have been influenced by the researcher's own personal and professional development, the interaction between participant and researcher, the current climate of the National Health Service (NHS), cultural and societal attitudes, and the contemporary evidence base and knowledge of mental health conditions.

One of the most important ideas to come out of hermeneutic theory is the hermeneutic circle. Hermeneutic circling is a term used to describe the whole, either an individual case or all cases, facilitating the interpretation of a part, such as a phrase or an individual case, and the part illuminating the whole. This process is bi-directional in that a single extract or utterance can provide "analytic leverage" (Smith et al., 2009, p. 6) in the context of the whole case and other cases. Therefore it is an iterative, rather than linear process, meaning that "our entry into the meaning of a text can be made at a number of different levels, all of which relate to one another, and many of which will refer to different perspectives on the part-whole coherence of the text" (Smith, et al., 2009, p. 28). The researcher experienced moving around the hermeneutic circle during analysis of an individual case, and when comparing convergence and divergence across the corpus.

2.2.2.3 Idiography

Idiography is the focus on the particular or individual, and is another cornerstone of IPA. The approach is idiographic because it is dedicated to fine-grained contextualised analyses of the phenomenon under study (Eatough & Smith, 2006). It examines how a particular person experiences a particular phenomenon and applies meaning to it. This directly maps onto the aforementioned hermeneutic theory and phenomenology which prioritise the individual's experiences and perspectives. As such it favours the specific over generalities in its utilisation of small homogenous samples. An idiographic approach is important for this current study in order to achieve detailed descriptions and interpretations of how having lived experience influences the role of mental health professionals. The advantage of this idiographic commitment is to question what is known, and open up research about mental health professionals with lived experience. IPA can be argued to have theoretical transferability since by having a deeper appreciation of the particular, one has a closer understanding of the universal (Warnock, 1987; as cited in Smith, 2004). Therefore although the results cannot be generalised as they are situated within a specific sample and time, the findings from this study can be used to question whether similar perceptions and experiences are shared by other professionals with lived experience.

2.2.3 IPA Methodology

As previously mentioned IPA utilises small samples, typically between five and ten participants (Smith, 2004). Any larger sample would risk subtleties of meaning being lost through reduced depth of analysis (Collins & Nicolson, 2002). Participants are purposively sampled in order that they share a common lived experience within a specific context. This is in line with this study's research question. Semi-structured one-to-one interviews are the preferred means to gather data (Reid, Flowers & Larkin, 2005); they are well-suited to in-depth discussion and allow the researcher to use prompts, if needed, in order to address the research question. Semi-structured interviews also enable sufficient flexibility for unanticipated ideas to be followed up and explored. Data is transcribed in full, including notable pauses, utterances, gestures and laughter, which further add to the interpretation.

Smith et al. (2009) offer guidelines rather than instructions on how the data should be analysed. Firstly, the researcher is advised to re-read and actively listen to the audio recording several times in order to become immersed in the participant’s world. Secondly, the researcher engages in initial exploratory noting of the transcript to further reflect on the participant’s words. Smith (2011) states that the researcher has to be open to the phenomenon but also work on the phenomenon iteratively; this is reflected in the three levels of analysis in IPA: descriptive, linguistic, and conceptual. Thirdly, the researcher develops emergent themes throughout the transcript and searches for connections between them to further condense the transcript. Fourthly, the process is repeated with each new case. The researcher is reflexive at all times and reflects upon their position and pre-understandings before analysing each new case. Finally, the researcher rigorously and systematically compares themes across all cases to look for where themes converge and diverge.

The most successful IPA studies are those which are interpretative, transparent, and plausible (Reid et al., 2005). Therefore throughout this study, supervision facilitated the checking of the plausibility of the researcher’s interpretations. The skill in IPA is to try and make sense of what is being said whilst remaining as close to the phenomenology of the participant as possible. A fuller explanation of how IPA analysis was conducted in the current study can be found in the Analysis section.

2.3 Research Procedures

2.3.1 Ethics

The study was granted indemnity insurance and was sponsored by the University of East Anglia (UEA). Ethical approval was obtained from the Faculty of Medicine and Health Sciences (FMH) Research Ethics Committee at the University of East Anglia. This was after the researcher had received reassurance by a local NHS Ethics Committee that the study did not require NHS Ethical Approval due to the sample being mental health professionals. The study was peer reviewed and approved by Norfolk and Suffolk NHS Foundation Trust (NSFT) Research and Development department (R&D). See Appendix A for approval documents.

2.3.2 Meeting with the Gatekeeper

The researcher met with the Hidden Talents gatekeeper on several occasions and kept in regular contact via phone and by email. The ethos and aims of Hidden Talents is to raise awareness of professionals with lived experience and to challenge stigma. Therefore this study was gratefully received and the gatekeeper was keen to be involved.

2.3.3 Contact with Potential Participants

The Hidden Talents gatekeeper informed the potential participants of the study by emailing the Participant Information Sheet (Appendix B) to the group mailing list of approximately 50 members. The researcher also made a planned appearance at a Hidden Talents group meeting to explain the study. Members contacted the researcher themselves to express their interest providing the researcher with consent to contact. Potential participants were given the choice of contacting the researcher by phone, post, or by email.

2.3.4 Information Provided to Gatekeeper and Participants

The Participant Information Sheet and Participant Consent Form (Appendix C) were given to the gatekeeper in electronic and paper form, and correspondingly passed onto the potential participants to look at. At the interview, participants were also given an optional Demographic Questionnaire to complete (Appendix D).

2.3.5 Informed Consent

Once participants had agreed to take part in the study, care was taken to ensure that they had read and understood the Participant Information Sheet and opportunity for questions was given. Participants were reminded before the interview began that their consent was voluntary, that they were not obliged to participate, and that they could withdraw from the study without giving a reason. Written consent was obtained at the interview.

2.3.6 Confidentiality and Anonymity

Liaison between the researcher and gatekeeper meant that potential participants were informed by the gatekeeper when the researcher would be presenting the study to the group in advance. This meant that members could choose to attend or not and thus preserve their anonymity, if they wished to do so. Confidentiality was maintained throughout the study.

Interview transcripts were anonymised using pseudonyms to protect participants' identities. Personally identifiable demographic information was stored separately from the transcripts. All storage and use of data conformed to UEA policies and the NHS Code of Confidentiality (Department of Health, 2003). Data which was transferred from place to place was stored on encrypted media and in a locked briefcase. The researcher and supervisor were the only individuals who had access to the data. Extracts of transcripts were shared with both supervisors to facilitate data analysis. Care was taken in the write up of the results to protect the anonymity of participants.

2.3.7 Participant Wellbeing

Participants were informed prior to the study commencing that if any risk issues pertaining to themselves or others became apparent the researcher would deal with these sensitively and appropriately. The Participant Information Sheet outlined that if any safeguarding concerns or risk issues arose during the course of the study, the researcher would seek advice from local supervisors, local safeguarding professionals and mental health teams and that confidentiality might be broken.

It was also recognised that due to the sensitive nature of this study, there was a chance that participants might experience distress during the interview. Participants were therefore reminded to share only what they felt comfortable in sharing. It was made clear that should they feel distressed, they had the right to refuse to answer the question, take a break, or terminate the interview. The interviews were conducted in a sensitive manner and the researcher was prepared to utilise her therapeutic skills and signpost the participant to seek support should this have been required. Time and space was given towards the end of the interview to ask how they were feeling and how they had experienced the interview. None of the participants became distressed and all reported having found the interview to be a positive process.

2.3.8 Researcher Wellbeing

Although participants in this study were NHS professionals the researcher adhered to the NSFT and UEA lone working policies. All interviews were conducted in non-clinical meeting rooms on NHS premises within office hours, and the researcher's colleagues knew of her whereabouts during these interviews. The researcher made use of a reflective diary, as well as supervision, to explore her experiences and related personal responses to the interview and emerging data.

2.4 Participant Recruitment

2.4.1 Sampling

Participants were purposively selected based on their membership of a Hidden Talents group in NSFT, which is an NHS Mental Health Trust. The inclusion and exclusion criteria were devised to include qualified mental health professionals from a range of clinical mental health professions, and to minimise any potential distress for participants. The sample was considered homogenous on the basis that participants were all members of Hidden Talents.

All participants met the following inclusion criteria:

- Qualified mental health professional.
- Member of the Hidden Talents group.
- Personal lived experience of mental health challenges i.e. have experienced clinical symptoms of mental health disorders based on self-report and self-diagnosis.
- Aged over 18.
- Good degree of spoken English due to the interview nature of the design.

Participants were excluded if they met any of the following criteria:

- Peer Support Worker (PSW).
- Currently unable to work due to illness or mental health difficulties.

2.4.2 Study Participants

A total of nine participants, four men and five women, were recruited to the study. All participants were white British. The youngest participants were in the 20 - 30 age bracket and the oldest were in the 51 - 60 age bracket. A variety of professions were represented, including: nursing, support work, psychological therapy, occupational therapy, and social work. Years spent in their professions varied from under a year to over 30 years, with a mean of 15 years and 5 months. The majority of participants self-identified with lived experience related to anxiety and mood disorders, although one participant identified as having had post-traumatic stress disorder, and another as having a personality disorder. The duration of lived experience ranged from two years to more than twenty years, with a mean duration of 13 years and 6 months. All participants had sought specialist services which included: Occupational Health, GP, Psychologist, Psychiatrist, Improving Access to Psychological Therapies (IAPT), Electronic Cognitive Behavioural Therapy (E-CBT), private counselling, inpatient services, and community mental health services.

2.5 The Interviews

2.5.1 Interview Schedule

Creating the interview schedule (Appendix E) was an iterative process, informed by Smith et al.'s (2009) recommendations, self-reflection, consultation with supervisors and members of the university's Qualitative Forum, and by the researcher attending a two-day IPA training workshop. The appropriateness of the interview schedule was tested in a pilot interview. The recommended number of questions for a semi-structured interview lasting between 45 to 90 minutes is six to ten questions with prompts (Smith et al., 2009). Therefore four main questions specific to the research question followed by several additional process-related questions were developed to plan for an approximate interview time of one hour. The main questions were:

1. Can you tell me a bit about your journey into becoming a mental health professional? *Prompt: What influenced your decision to work in mental health?*

2. Can you tell me about your lived experience?

3. Can you tell me in as much detail as possible what having lived experience at work is like for you? *Prompts: within the organisation, working with clients, and your relationships with colleagues.*

4. Can you tell me about any times, if any, you feel that lived experience has influenced or been a part of your work in any way? *Prompts: within the organisation, working with client, and your relationships with colleagues.*

2.5.2 Interview Process

All interviews were conducted by the researcher independently. Interviews varied in length from 32 minutes to 92 minutes, the average interview length was 54 minutes. Informed consent was obtained at the beginning of the interview and all participants chose to complete the demographic questionnaire. The researcher explained that the interview would work like a one-sided conversation on the part of the participant, and that obvious or self-evident questions may be asked in order for the researcher to really understand the participant’s meaning. This checking of linguistic variability is an important part of the process (Willig, 2001). The researcher also explained that she was really keen to hear about the participants’ thoughts, feelings, and experiences. Although the perspective of the participant is the fundamental focus (Elliot, Fischer & Rennie, 1999), it was important to use minimal probes to retain focus on the research question. As such, the researcher decided how much movement from the topic guide was acceptable (Smith et al., 2003). The researcher aimed to be participant-led, remaining as open and curious as possible, whilst ensuring that the research questions were being addressed. This balance became easier with each interview.

Question one allowed the participant to open up about their experience, build rapport with the researcher, and become comfortable with the interview process. Often the reason for becoming a mental health professional stemmed from their own direct lived experience or through knowing someone else with lived experience. The first question also set the scene in providing context for the participants' responses. Toma (2000) advocates getting to know your participants in order to elicit greater context and produce better quality data. Some participants were more comfortable than others in sharing examples of their lived experience and its influence. Some of the transcripts were stronger than others, since stigma and avoidance seemed to play a role in the interviews themselves. This is to be expected due to the Heideggerian theory which states that people are embedded and cannot be separated from the culture which they live within. This no doubt affected some participants' awareness, and or willingness, to share their experiences in some cases.

The first two questions built up to questions three and four which explored the participants' lived experience within the context of their work environment to address the research question. The development process of the interview schedule meant that the researcher could follow it and address all of the questions flexibly and as naturally as possible, whilst allowing the participant to take the lead. The researcher was actively engaged with the participant and mindful of her pre-understandings as they came to light, described as an "enlivened form of bracketing" (Smith et al., 2009, p. 25). The researcher did this in several ways, one of which was by asking the participants to further clarify their descriptions and word use, instead of taking for granted their meaning. At first this felt slightly awkward, but the researcher found that this open curiosity enabled richer and more phenomenological meanings to emerge. Another way was to focus as much as possible on the participants' interpretations, rather than the researcher automatically making interpretations from her own frame of reference and experiences.

The purposes of the additional questions were manifold. Firstly, additional questions helped to elicit further topics of conversation which were important to the participant. Secondly, it was useful to know how participants felt about doing the interview, and to also find out what had come to their minds when they had first heard about the study. Thirdly, understanding how they were left feeling at the end of the interview was crucial from an ethical perspective. It was important to check that they felt contained and in no way distressed at the end of the interview. All participants were glad that this study was happening, and felt that the interview had been a positive experience. One participant felt that it had been “therapeutic”. Participants were thanked for their time and their contribution to the study. They were asked whether they would like to see a copy of their interview once transcribed to check for accuracy. None of the participants said yes to this. Some participants did however wish to help co-disseminate the study once it had been completed.

2.6 Data Analysis

Data analysis followed the steps described by Smith et al. (2009), which will follow. As with the interviews, it was important to put aside presuppositions as much as possible, and encompass a phenomenological attitude in order to be fully immersed in the participants’ interpretations. This was facilitated by continuing to work reflexively and the use of a reflective diary, as will be outlined towards the end of this chapter.

2.6.1 Transcription

The researcher transcribed each interview's audio-recording verbatim soon after it had taken place. Transcription took approximately 8 hours per participant. Each transcript had wide margins and numbered lines to enable ease of initial noting and recording of emergent themes. This in itself was a form of interpretative activity (Smith et al., 2009) as the researcher became immersed in the participants' perspectives. The researcher took time to reflect on her own responses to the data which enabled her pre-understandings to become conscious, and tried as much as possible to be put these to one side.

2.6.2 Individual Case Analysis

Following transcription and careful re-reading and listening to the audio-recording, each transcript was sequentially analysed. The researcher started by making free-flow annotations on the right-hand side of the transcript, highlighting and underlining salient parts of the entire text. This process was repeated several times, revealing new insights and interpretations each time. Initial exploratory noting was related to the descriptive, linguistic, and conceptual levels of analysis. At the descriptive level, analysis focused on the content of the participant's words. Linguistic comments related to the participant's choice of language, including tense, pronoun use, tone, hesitations and laughter. At the conceptual level, the participants' words were subject to greater interpretation and interrogation in order to open up the text to a range of possible meanings. For the first couple of interviews, the three levels of analysis were applied sequentially, however as the researcher became more confident and familiar with the process, the three levels of analysis happened simultaneously (See Appendix F for an example). This was an engaging and creative process.

Emergent Themes which captured the essence of the initial noting and transcript were recorded on the left-hand side of the transcript. The researcher was careful to stay as close to the transcript as possible whilst reducing it to approximately 100 themes. The narrative and frequency of the Emergent Themes, as well as what they revealed about the function for the participant, helped with the organisation of themes. These Emergent Themes alongside their relevant quotes and line numbers were put into a separate Theme Summary Table (See Appendix G) producing a chronological list of themes, which were then analysed for connections between them. Themes which were not relevant to the research question were removed from the analysis and the reasons for this were recorded. Similar themes were clustered together under the titles of Main Themes, of which there were 8 - 10 per participant. These Main and Emergent Themes were then organised into a new Superordinate Theme Summary table, so-called because provisional Superordinate Themes were allocated to each cluster (See Appendix H for an example). Superordinate Themes were developed by abstraction (a new title was chosen to identify the cluster) or subsumption (an existing emergent theme became the title for the cluster). Following this, the researcher re-read the transcripts to ensure that nothing had been missed.

Individual case analysis starting from transcription to the generation of Main and Superordinate Themes was an in-depth and iterative process, taking between 4 - 5 days per participant. In line with IPA's idiographic commitment, each transcript was treated as an individual case, before moving on to the next. This meant that new themes could emerge. The researcher was mindful that she would inevitably be influenced by themes within the previous transcript and so tried to mitigate this by immersing herself into each participant's lifeworld and recording her reactions and assumptions separately, so that they could be acknowledged and put aside as much as possible. The researcher utilised supervision with supervisors, as well as peer-supervision with a fellow trainee conducting a different IPA study, to reflect on the process and to check that the themes were plausible and could be seen from the transcript.

2.6.3 Cross-Case Analysis

The researcher then printed and cut out all of the Superordinate Themes per participant and arranged them on an A1 piece of paper to map the connections between them. Similar themes were grouped into five groups representing the sample's five Superordinate Themes. Divergence of themes was also taken into account. Each of the five Superordinate Themes was further sub-divided into 3 Subordinate Themes, totalling 15 Subordinate across the sample. The names of the Subordinate and Superordinate Themes were modified to reflect the whole sample's experiences. The researcher checked these final themes were grounded in the participants' transcripts, initial noting and emergent themes, whilst making sure that the richness had been preserved, thereby completing the hermeneutic circle.

2.7 Reflexivity and Use of Reflective Diary

As previously mentioned throughout this thesis thus far, the processes of reflection and reflexivity are paramount in IPA. This is because the methodology recognises the role of the researcher in co-constructing tentative data (Finlay, 2011) and identifying one's biases through self-reflection. It was necessary for the researcher to consider her background, culture, gender, ethnicity, values, interpersonal style, ad infinitum. Reflexivity helped the researcher recognise her influence before, during and after the interviews, and especially during analysis. Keeping a reflective diary helped to enable this and makes the process visible to the readers (Ortlipp, 2008). Finlay (2011), however, advises caution that researchers do not do so much reflecting on their role that the research becomes about them and their understandings, rather than about the participants'. She advocates a dialectical process of hermeneutic reflexivity, defined as continual reflection on the researcher's own interpretations to move away from their own hypotheses, or hoped-for outcomes.

IPA's Heideggerian approach to reflexivity also centres on the hermeneutic circle and represents that dynamic relationship between part and whole. Parts of the transcript can be better understood in the context of the whole transcript and vice versa. Therefore, the process is non-linear, dynamic, and iterative. We cannot help being influenced by what we have encountered, so there is an acknowledgement in IPA that the researcher will be at a different point on the hermeneutic circle before each new interview. This principle formed many of the researcher's reflections during analysis. An example of this was when participants expressed ambivalence towards their lived experience. This became better understood by the researcher in the context of analysing a participant’s whole transcript, and through becoming familiar with others experiences and interpretations during cross-case analysis.

2.8 Quality

2.8.1 Validity

The volume of qualitative studies has increased exponentially over the last two decades. As the analysis involves subjective interpretation, some have been concerned with the neutrality and rigour of qualitative studies (Stiles, 1993). Numerous guidelines exist to promote good quality studies. In 1999, Elliot et al. produced a checklist of evolving guidelines in order to encourage better quality control. This centred on better self- and other-monitoring to aid scientific reviewers of qualitative research, and to help legitimise and advance the approach. Elliot et al. (1999) proposed that qualitative research shares several guidelines with quantitative research including: scientific context and purpose, ethical and appropriate procedures, and contribution to knowledge. However, the qualitative paradigm also has several additional guidelines: owning one’s perspective, situating the sample, grounding in examples, credibility checks, coherence, general versus specific research tasks, and resonating with the readers.

Smith et al. (2009) refers to the earlier work of Elliot et al. (1999) but specifically recommends Yardley’s (2000) criteria for assessing the quality of qualitative research. More recently Smith (2011) himself outlined what he considers to be the characteristics of good quality IPA. The quality of this study will now be discussed under the headings of Yardley's criteria, with reference to Elliot et al. (1999) and Smith (2011).

2.8.2 Sensitivity to Context

For this study, sensitivity to context relates to the degree of awareness of the relevant literature on recovery and lived experience, and sensitivity to the socio-cultural context of the sample, to ethics, and to data generation. The researcher has attempted to be sensitive to her own pre-understandings, assumptions, and reactions to the data as well as her influence on the research itself, by adopting a reflexive stance. From the beginning, the researcher has shown sensitivity to the choice of IPA methodology and its philosophical underpinnings which have laid the foundations for this study. The researcher has been careful to make sure that the views of the participants are represented and that interpretation has been grounded in their experiences. For Smith, "A good IPA study will always have a considerable number of verbatim extracts from the participants' material to support the argument being made" (2009, p. 180). This allows the reader to check the researcher's interpretations. The researcher included numerous verbatim extracts to meet this quality standard.

2.8.3 Commitment and Rigour

This criterion relates to the care, personal commitment, and dedication that the researcher has invested into the research. In terms of commitment, the researcher was motivated by her passion for the topic and the opportunity to "give voice" to a largely unrepresented population. Along with this came a sense of duty and responsibility to produce a quality study. By adopting a phenomenological attitude, the researcher aimed to pay close and focussed attention on the participants' words, experiences, and sense-making. To a certain extent this was not new to the researcher in her role as a trainee clinical psychologist. However, what was new was attempting not to enter into collaborative sense-making with the participant.

Rigour concerns the thoroughness and appropriateness of the study decisions made by the researcher. Firstly, the sample were purposively selected because they represented a reasonably homogenous group of individuals who self-identified as having lived experience and were part of the Hidden Talents group. Their membership implied a level of acceptance and willingness to talk about their experiences. Secondly, the pilot interview acted as a quality control measure in testing the validity and appropriateness of the interview schedule. Thirdly, the researcher conducted a thorough and systematic data analysis whilst maintaining IPA's idiographic commitment. It was important that researcher learnt to balance the interpretation between being grounded and conceptual whilst remaining plausible. Supervision was used to help "audit" some of the themes and assess the plausibility of the researcher's interpretations. Fourthly, due to the relatively large sample size, care was taken to represent the themes at the level of the individual participant and whole corpus. In order to be "good IPA", proportionate representation of all participants' results is needed (Smith et al., 2009, p. 181). Smith (2011) suggests that for studies with more than eight participants, extracts from at least three participants for each theme plus a measure of prevalence of themes within the sample, or extracts from half the sample per theme, is required. The researcher adhered to this during the process of analysis and write-up.

2.8.4 Transparency and Coherence

The issues of transparency and coherence relate to the clarity of the write-up and presentation. The researcher was mindful to present detailed study procedures in a structured way to enable transparency. This can be seen in the development of the research question, participant selection, formation of the interview schedule, interview process, and analysis. The appendices of this study enable the reader to follow the stages of the study, including analysis. In terms of coherence, the researcher attempted to integrate IPA's philosophical foundations and critical realist epistemology throughout.

2.8.5 Impact and Importance

Yardley's final criterion is a test of a study's impact and utility (Yardley, 2000). This study presents a new development in lived experience research. Instead of being behind the scenes, mental health professionals are slowly speaking out about their own experiences of mental health challenges. However, professionals' experiences of having lived experience had previously not been explored, unlike those of PSWs. The peer support movement has reportedly revolutionised mental health service delivery and helped combat stigma. This study suggests extending this to mental health professionals. Exploring lived experience of mental health professionals helps to deepen our understanding of their experiences at work, how they and peers can be supported, and will potentially inform mental health policy on how professionals might be able to use their lived experience to promote client recovery.

Reflection 2. Conducting the Interviews

During the first couple of interviews I was conscious that I was "digging" for more clarification to really get to the participant's meaning behind what they said. Although this is a skill I utilise in clinical practice with clients, it felt more keenly curious in that I delayed as much as possible in making my own interpretation of what I was seeing and hearing. Interestingly I can see this helping me clinically. Asking numerous self-evident questions initially felt awkward but over time I felt more entitled to ask such questions. I realise that I may have felt a lack of entitlement due to the sensitive nature of the interview and my conscientious concern for the process to be participant-led. However, having done a couple of interviews I feel that I developed a balance between enabling the participant's free expression whilst focusing on their experience of lived experience and being able to interrogate this.

I was aware that at the conclusion of each interview I had moved slightly around the hermeneutic circle. Conscious of this I tried to "bracket off" as much as possible my thoughts and memories of previous interviews when similar comments were made by different participants. One example of this was when I realised that I had previously assumed that clinical knowledge and experience was correlated with years spent training. Having spoken to one of the participants I realised that this was not necessarily the case and reflected that the level of clinical expertise is not everything, rather it is the care given to clients and the approach that matters.

Reflection 3. Personal Impact on the Methodology

*I was moved by the participants' stories and felt a degree of empathy and connectedness with some of what they said. I had not expected this and was careful not to identify my own experiences and opinions with the participants' worlds. I wondered whether the unspoken "sense" or "vibe" that is felt between people with lived experience - a phenomenon described in some of the interviews, was present in the room. However, my whole-hearted curiosity and IPA researcher position of "not knowing" and wanting to know what it's like for that individual, I believe, meant that the focus was solely on the participant. In fact, I got the sense that all of the participants were careful with what they said in terms of "appropriate" self-*disclosure *towards clients, and I wondered whether they wanted to appear to be "doing the right thing" in front of a clinician in training. This made me think that although I was removed from their immediate work context, and so possibly enabled greater freedom of expression, self-conscious monitoring of what felt safe for them to say was also happening, made evident by numerous hesitations, pauses, trying to find the "right words", and nervous laughter.*

3. Analysis

3.1 Overview of Findings

The analysis generated five Superordinate Themes: Lived Experience Helps Inform Practice; Stigma; Towards a Culture of Openness; Changed Identity; and Experiencing the Organisation as Unsupportive. These Superordinate Themes each comprise three Subordinate Themes which emerged from the grouping together the Main and Emergent themes coded from the transcripts. The structure of themes is illustrated in Table 1 (p. 64). The finer detail of the analysis which includes the participants' Superordinate Themes captured within the Subordinate and Superordinate Themes of the sample is presented in Appendix I. Each Superordinate Theme will be discussed in detail and illustrated by each of the Subordinate Themes and linked with individual participant accounts. Within this section potentially identifiable information such as job title and diagnosis have been replaced, for example [job title], to help protect anonymity. Additionally, in order to enhance the readability of some of the quotes utterances such as "er" and "um" have been removed and replaced with "…".

Table 1. Composition Structure of IPA Themes

Superordinate Themes	Subordinate Themes
1. Lived Experience Helps Inform Practice	1.1 Therapeutic relationship enriched by increased empathy
	1.2 Limited and cautious use of self-disclosure with clients
	1.3 Greater understanding of the client's perspective
2. Stigma	2.1 Others to self
	2.2 Self-stigma
	2.3 "Them and us" narrative
3. Towards a Culture of Openness	3.1 Openness among colleagues reduces shame and promotes help-seeking
	3.2 Social acceptability as a barrier to openness with colleagues
	3.3 Greater acceptability of sharing lived experience in recovery settings
4. Changed Identity	4.1 Impact of lived experience on role identity
	4.2 Positive impact of lived experience on relationship with the self
	4.3 Impact of role identity on lived experience
5. Experiencing the Organisation as Unsupportive	5.1 Staff wellbeing is not prioritised
	5.2 Ironic lack of understanding and support
	5.3 Burden of proof

3.2 Lived Experience Helps Inform Practice

3.2.1 Therapeutic relationship enriched by increased empathy: *'It gives me the ability to empathise with patients and know where they're coming from'* – David

Seven out of nine participants identified increased empathy as a consequence of their lived experience. Patrick and Len commented on having increased empathy and perhaps a more accurate attunement to others. Zoe has also experienced this being perceived by clients:

> ***Patrick:*** *I'm kind of approaching my – that kind of therapeutic interaction so differently now you know, it's that level of empathy I guess… I can have a much better understanding of kind of what they're… feeling, what they've been through…rather than me trying to second guess if you like. (p. 14, 446-456)*

> ***Len:*** *Yeah well I'd like to think I was yeah I sort of flatter myself I was fairly sort of in tune with people and can pick up on things…but I think I'm maybe better placed to be able to say that. (p. 8, 250-252)*

> ***Zoe:*** *I definitely got good feedback from clients or service users that I was a good listener that people felt I was empathic and stuff like that. So I felt it helped me to understand yeah hopefully – I think it got reflected that I put*

> *across that I was an understanding caring practitioner really so I think it definitely helped from that point of view. (p. 9, 268-272)*

David, Maggie, Zoe, and Kerry also shared similar views to those above. David mentioned feeling that this has helped him to become more reflective in his practice. Participants also described that their lived experience helps them to "give [clients] that hope" (Simon, p. 9, 292) that "there is hope of recovery" (Patrick, p. 15, 476).

Jane, Abby, and Kerry described a felt sense in the therapeutic relationship when the client "senses" that the professional may have lived experience. In such situations explicit disclosure is redundant:

> ***Kerry:*** *It's just a sort of vibe that they get that you know that maybe they haven't had depression or – but they have had something which has sort of been a personal experience rather than just a clinical learning experience, something personal that has touched them or affected them in some way… that gives off a certain vibe. (p. 15, 487-493)*

> ***Abby:*** *We just shared a look and it was kind of like she had a sense of it. (p. 8, 228-229)*

It might be that this felt sense is part of connecting more deeply with clients on more of an emotional than a clinical or intellectual level. Maggie and Patrick used the word "deeper" to depict a more emotional way of relating with clients, as compared with a more surface level interactional style:

> ***Maggie:*** *Well I would say it comes from your- it sort of comes in a way from a slightly deeper place… I meant a place of memory and feeling really rather than just you know reading something and thinking 'Well I can see why that would work.' It comes from like you know I suppose you could say you know from your heart… you know maybe more emotional place. (p. 9, 274-279)*
>
> ***Patrick:*** *When people say [pause] about their experience of [disorder] or whatever it is you know, I can engage with what they're saying on a – on a much better level, deeper level. (p. 15, 461-463)*

Kerry's lived experience helped her to focus more on the commonalities, rather than differences, between herself and the client. She also implied that professionals with lived experience may have a greater sense of humility in that they may feel more acutely aware of their own susceptibility to mental illness:

> ***Kerry:*** *Someone with lived experience can end up feeling more like that shared journey… feeling like you don't know all the answers because if you did, if you did know all the answers you wouldn't be getting depressed would you? [laughs]. (p. 21, 663-666)*

3.2.2 Limited and cautious use of self-disclosure with clients: *'It can be about disclosure but it doesn't have to be, and I think mostly it's not' – Jane*

All participants were keen to point out that they are very "careful" with the "small glimpses" (Patrick, p. 15, 489) they disclose to clients about their experiences:

> ***Patrick:*** *I might give a little bit of self-disclosure away but I am very measured with that you know, be very careful with it in terms of what I say (p. 15, 481-483).*

This contrasts with the common misconception which Jane, Kerry, and Abby expressed, that professionals with lived experience disclose everything about themselves to their clients.

Wariness around self-disclosure appeared related to the idea of protecting the clients' interests, for example, by not wanting to be "melodramatic" (Patrick, p. 17, 556) or "hijack the room with my own needs!" (Zoe, p. 9, 291-292). Participants were keen to point out that the focus should not be taken away from the client, and that clients should know that "you're strong enough to help them" (Jane, p. 7, 201). How much time has passed since the experience is a factor in whether or not it feels acceptable to disclose:

> ***Jane:*** *They don't want to hear about some current problem that you're working on (p. 7, 212-213).*

Caution around self-disclosure may also relate to feelings of uncertainty about the consequences for professionals when their lived experience is no longer hidden “because once it’s out there, it’s out there” (Simon, p. 5, 143 - 153). Simon felt lived experience “gets spread, rumoured” like gossip, and that professionals are uncertain about what they are allowed to say. Therefore the decision to disclose is not taken lightly by participants. They suggested it is dependent on the responses of the client, in order to know “when it is worth using” (Simon, p. 7, 228), and “whether that’s going to be therapeutic” (Patrick, p. 15, 487).

An area of lived experience which participants’ felt is easier and more acceptable to disclose, is grief and bereavement:

> ***Maggie:*** *Certainly with grief I could be more – because grieving is something that happens to everybody whereas [disorder] isn’t something that happens to everybody so I wouldn’t be explicit (p. 8, 248-251).*

Zoe used to feel strongly discouraged to disclose any lived experience other than grief before working in a more recovery-focussed way:

> *If you’re in that situation where you’re talking about [disorder] in a culture where you’re not – or you’re strongly discouraged to disclose any personal lived experience, all you can do is not say anything. Do you know what I mean? That’s all you’ve got, talk about it [in] generic terms rather than your*

> *own personal – you know illustrating what you're saying with personal experience (p.10, 321-326).*

She described feeling under pressure to hide her lived experience, but also alluded to there being a more personal reason behind her reluctance to disclose:

> *I wouldn't have shared… [pause] my own – my own difficulties even if there was a really good clinical reason to do it (p. 9, 261-264).*

Other participants did not seem to feel this so acutely and felt more able to disclose small amounts, which some suggested becomes easier over time: "I've done it so many times I feel more comfortable with it" (Simon, p. 5, 159-161). However some participants still remain wary about the possibility of causing harm and are protective of the clients' needs:

> **David:** *I don't want to overwhelm that person or anything to come between us in the therapeutic relationship (p.10, 322-324).*

3.2.3 Greater understanding of the client's perspective: *'It's almost like taking bits from things I've experienced and using them in my own practice' – Kerry*

All participants identified as having a greater knowledge and appreciation of the client's perspective. However they were all careful not to assume that because they have lived experience they know exactly what it is like. The majority of participants mentioned that they actively avoid telling clients that they "understand" their experience. This is because they themselves had experienced this as unhelpful when they were on the receiving end of mental health care. Abby recalls the anger she felt when professionals told her that they could "understand":

> *I hated it when anyone ever told me that they 'understood' because you don't. You can try and understand you can try and put yourself in that position but I'm not you, you're not me, so I'm never gonna fully understand, and if I tell someone that I understand that actually alienates someone a bit more (p. 3, 73-80).*

Instead of saying "I understand" participants try to convey that they are "trying to understand" (Abby, p. 3, 81) and "may not fully" (Simon, p. 4, 117). For Kerry, lived experience has given her an "appreciation as to the hell of it…what a terrible experience it was and how it felt" (Kerry, p. 13, 396-397).

In terms of how this relates to practice, Simon recognises the need for "baby steps with service users and carers, and just trying to build a therapeutic relationship where there's trust" (p. 5, 136-139). This is because of his experience of finding it difficult to trust professionals. Like Simon, David and Maggie also felt that it helps to focus on the relationship and being with the client. They found this personally very helpful in the past from other professionals. This emphasis on being with the client is in contrast to the approach of “doing”, which David perceives as being too simplistic and almost mechanical.

> *It’s interesting the ones that I presume don’t have lived experience who kind of are ‘doers’ and they get very frustrated when patients don’t – it’s almost like ‘well I’ve pressed these buttons but I didn’t get the can of coke out of the machine’, it’s a bit like that (p. 14, 438-442).*

Similarly, Kerry questioned the sensibility of delivering interventions without having lived experience of them:

> *How can you deliver an intervention if you don’t know what it’s like to receive it? I mean you can [pause] but I think it helps. (p. 22, 713-714).*

The idea that lived experienced of the intervention helped to inform the delivery of it was echoed by Jane who felt that this insider knowledge is beneficial:

> *When I’m asking a patient to do something I do know what it’s like (p. 4, 126-127).*

3.3 Stigma

3.3.1 Others to self: *‘I think in mental health services there can be this presumption that mental health is a weakness’ – Kerry*

All nine participants shared experiences of feeling stigmatised in mental health services. Within these accounts there appears to be a common theme of isolation. Despite feeling that "we're supposed to be championing the lack of stigma [laughs]…and trying to normalise mental illness" (Patrick, p. 17, 547-548), participants felt that they are treated differently, and some felt that they have been made to "feel awkward" by colleagues (Simon, p. 12, 393-394). Three participants used evocative language to describe their perceptions of being viewed by others as "toxic", "dangerous", "unsafe" and "contagious":

> ***Abby:*** *I felt kind of like I was a toxic thing that couldn't – that was dangerous to people (p. 12, 383-387).*

> ***David:*** *I thought well it doesn't mean I'm going to go slash all your furniture up and jump out of the window… I very much got the impression of kind of like quite scared quite kind of unsure about the fact that I'm of – m-my mental health issues (p. 24, 765-771).*

> ***Kerry:*** *You know it's not contagious and I think there is this feeling sometimes (p. 5, 147).*

The questioning of trust and ability were also at the forefront of some of the participants' experiences. David was explicitly asked whether he could be trusted, which to him felt to be at the real heart of the matter, and an injustice: 'How do we know you're safe, how can we trust you?' so I thought then no, this is about my illness" (p. 28, 899). He described feeling that his "competency was in question because I had a mental illness, which was discriminatory" (p. 34, 1084-1086).

David and Jane compared how they felt they would have been treated had they been experiencing a physical health problem rather than a mental health problem:

> ***David:*** *I thought I was being treated differently in that if I had a physical problem again, say a spinal problem or anything like that and I'd been off for 7 months, when I came back to work I wouldn't have been asked to do or have an observed session of my practice do you see what I mean? (p. 33, 1039-1043).*

David felt that his mental health problems were the reason he was required to have his initial sessions with clients observed and asked to redo some training. He portrayed a sense of feeling treated differently, and perhaps unjustly, due to having time off for mental health rather than physical health problems.

The difference extended to the way in which mental health and physical health related sick-leave was talked about, or not, by colleagues, once the staff member had returned to work. Jane describes two very contrasting experiences:

> *When I came back off sick from a physical illness there were lots of questions…and I'd been so, I was in hospital for three weeks lots of questions about 'Where were you? What did they do to you?' And it felt like*

> *there was a language around that and a permission to ask questions. When I came back from a mental illness…people were – they weren't unkind at all – but they didn't have a language around it and people didn't ask me things (p. 8, 245-254).*

It appeared to some participants that physical ill-health invited a questioning concern where mental ill-health did not. Jane's colleagues had neither the words nor the sense of "permission" to enquire about her mental illness experience. Although participants sometimes felt that colleagues avoided having conversations with them directly about their lived experience, at other times openly stigmatising attitudes towards their lived experience were also experienced:

> ***Maggie:*** *When sometimes people at work have been talking about a managerial position… it's kind of like been going 'Well you'd be good at that, [name], if only you didn't have your difficulty or whatever' (p. 6-7, 193-196).*

The above quote suggests that some colleagues do not perceive combining lived experience with managerial responsibility as effective, or even possible. However, Maggie is careful not to criticise others or react to it:

> *It might have been out of a sense of I didn't quite fit this sounds so – well it doesn't matter what it sounds like because it's anonymous but I think now and again it's sort of like people can't quite come to terms with 'Ok so*

> *you've got a psychiatric illness… you've been through all this stuff but actually you're quite a good [job title], you hold it together, and you're quite intelligent' and so I think people make jokes because I don't know – I think now and again people have wanted to undermine me and that's ok it's up to them (p. 13-14, 414-430).*

David and Maggie demonstrate different emotional reactions to the stigma they have experienced. David attributed wrong-doing to the ways others have treated him, whereas Maggie seemed more resigned, saying "it's ok it's up to them." Maggie feels grateful to others for the kindness she received regarding her lived experience, however felt bullied nonetheless:

> *I've experienced a lot of kindness… [pause] and some people won't – people are incredibly kind really but I did have a problem where I felt that I was bullied (p. 12, 368-370).*

Zoe's experience meant that she kept her lived experience to herself for fear of being stigmatised by her peers:

> *I mean it did improve over the years but you'd hear people talk about people with any kind of anxiety or depression or anything in really pejorative terms, and you'd think 'Well I'm not saying anything about that'. (p. 3, 83-86)*

Jane describes what it feels like to be stigmatised for her lived experience and how it affects her:

> *It kind of affects you on a sort of visceral level that you're – I mean we all want to be a part of the pack don't we? No one wants to be the one on the outside of the pack so that's what we're talking about isn't it? Like you're dirty, you're on the outside, you're lesser than us. So in an evolutionary point of view if you were the one who was separate you'd die so that's why it is such an important issue, because if you're kind of pushed onto the outside and you're outside of the village and you're up on the mountain on your own then you're dead meat basically (p. 15, 480-491).*

It appears that Jane felt like she was addressing the crux of the issue in this extract by saying "so that's what we're talking about isn't it?" Words like "dirty" and "lesser" portray her sense that mental illness devalues a person's worth and social acceptability. Jane justified her perspective by implying that this happens naturally with reference to evolution and the animal kingdom.

3.3.2 Self-stigma: *'It felt like it was ...some dirty little secret that I was a bit of a fraud for being here when I wasn't very mentally well myself' – Zoe*

Five out of nine participants described experiencing internalised or self-stigma. Patrick implied by his use of "we" that this is endemic to those working in the mental health profession. However he quickly changes it to speak in the first person: “We, you know, I didn’t really want to perhaps admit that there was something wrong” (p. 9, 280-282). Several participants experienced an initial avoidance to acknowledge their own symptoms, at a cost:

> ***Patrick:*** *I ignored the signs and it was getting worse and worse (p. 7, 211-212).*

> ***Len:*** *I think there’s an approach to that which is a mixture of... [pause] shutting down out of work and putting behind you and you know holding it back and then gritting your teeth and going into the working week and getting through [intake of breath]...[pause] which is incredibly unhealthy (p. 10, 305-309).*

Both Patrick and Len found it difficult to differentiate work stress from lived experience – “I thought it was work stress…because the job’s inherently stressful” (Patrick, p. 7, 209-212). They both rationalised their lived experience in the context of their busy roles as mental health professionals. Len had been reluctant to view his experience as going beyond work stress:

> *This makes sense because I’ve got a pretty hard working week, working really hard and feeling a bit stressed, so I didn’t sort of stand out to me as being as something which would be you know recognised as a – as a sort of formal psychological disorder or whatever (p. 2, 46-52).*

Jane also found it difficult to acknowledge that she had had lived experience of a mental health problem. She talked about the length of time it has taken for her to "diagnose" herself as having low self-esteem, which she later said was not actually a mental illness anyway. This ambivalence about formal diagnosis or recognition of mental ill-health may have its roots in the stigma she experienced, because there is the "idea that having a mental illness among staff would be seen as a kind of low thing" (Jane, p. 29, 933-940):

> *What I've recently done is diagnose myself with low self-esteem and…I think it took me a while to come to that. (p. 3, 82-83)*

> *I don't know if you know self-esteem [is] not really necessarily a mental illness. (p. 4, 107)*

The majority of participants described putting up some level of resistance to their lived experience and working hard to prevent the emergence of symptoms:

> ***Zoe:** … you know said 'I'm really sorry, I really didn't want to do this and I tried to sort of - and this is what I did to try and prevent it' (p. 5, 155-157).*

> ***Len:** [I] pick up on what might be lurking in the background to make it [pause] you know… misbehave [laughs]. 'Ah', I think, 'Right I've got to – I better deal with that, I've got to get it cleared out and dealt with. (p. 8, 243-245)*

For Simon, Zoe and Kerry their self-stigma caused them to question themselves and their role in mental health services:

> ***Zoe:*** *[I] couldn't sort of trust myself in a way (p. 6, 178-179).*

> ***Simon:*** *It felt like 'imposter syndrome'…'Should I really be here?' (p. 3, 69-74).*

Across the participants' accounts there was a sense of wanting to distance themselves from the label of mental illness. It appears that participants do this by differentiating their own experience from "real mental health issues" (Jane, p. 2, 34-35). They did this by personalising mental illness to make it their own kind of mental illness, and at times, intellectualised their own lived experience:

> ***Len:*** *I was saying "Ooh blimey! You know I don't, I don't feel depressed [laughs] – it was quite interesting, I was quite surprised by the fact that here I was a mental health worker not recognising in myself maybe what someone else might be recognising as a sort of dep-depressive illness (p. 2, 61-65).*

3.3.3 "Them and us" narrative: *"Imagine the shop counter and we're this side and the patients that side… we feel like we've kind of jumped over to that side and that feels like that kinda you've – that's unacceptable" – Jane*

Seven out of nine participants identified experiencing a “them and us” attitude and a concern with not being seen as the same as “them”:

> ***Zoe:*** *Yeah there was something not quite you know, not quite right about you if you’ve got you know, you’re one of them (p. 4, 112-113).*

Jane and Len describe the feeling that there is a dividing “counter” or “fence” between clients and professionals: “You know we’re this side of the fence, we’re professionals and then there’s patients” (Len, p. 6, 185-187). Jane contradicts herself by firstly saying that she is on both sides, but finding this uncomfortable, decides that she does not want there to be two sides (for her), but this should be the case perhaps for everyone else:

> ***Researcher:*** *Which side do you feel that you’re on?*
> ***Jane:*** *[laughs] Well I suppose I am sort of, well I think I am on both sides I mean I think that the counter shouldn’t be there you know – I mean I think the counter should be there’ (p. 12, 357-362).*

Jane made a particularly graphic analogy to describe how she felt she had crossed the line between us and them:

> *It would be like a policeman coming to work and saying ‘Did a bit of shoplifting at the weekend’ you know you wouldn’t – probably people wouldn’t admit to shoplifting anyway, but it would be like saying well ‘I’m*

> *the criminal I'm over that side and I should be this side so I'm a kinda bent copper'(p.11, 347-353).*

The "bent copper" analogy suggests almost as if having a mental illness is a wrong-doing on the part of a mental health worker, or something illicit. Resistance to being "like them" is also demonstrated by which treatments professionals gravitate to first:

> ***Jane:*** *The GP, he said w-why are you taking St John's wort why don't you take an anti-depressant? And I kind of thought 'we- no I can't because that would make me like them', and then I thought 'oh that's interesting!' [laughs] So there's that kind of thing of like…you've kind of stepped over slightly (p. 10, 320-330).*

To Jane, the act of taking a tablet represents an acceptance or admitting that you have crossed this line:

> *So there's that kind of thing of like you know if you are taking a tablet or not cause it's very physical and it's put into your mouth whereas kind of struggling on you'd nev – you've not admitted it (p. 10, 325-327).*

Other participants also expressed surprise when they were informed by others that their lived experience met clinical levels, as previously mentioned in the Self-stigma section (3.3.2) . This might imply that professionals have a tendency to view their own lived experience of mental illness as perhaps qualitatively different to that of their clients. This might act as a "survival thing" (Maggie, p. 11, 329-331), like a protective function, when working with people with serious mental illnesses. This is propagated by colleagues using different terminology to describe the lived experience of professionals to clients.

> ***Jane:*** *They've said 'Well what do you want me to write'? And you sort of say 'Well write I've got depression' and they're like 'Ooh do you really want me to write that? Maybe I should just write -'... [pause] dunno, they write other things. I mean certainly GPs will write 'neurasthenia'... it's kind of like… almost like a euphemism for mental illness [laughs] (p. 18-19, 588-597).*

Jane further subdivides the professionals into another "them and us" phenomenon: professionals who gained lived experience from working in the profession, and the "newer" peer support workers who are employed on the basis of having previous lived experience and have "come good":

> ***Jane:*** *So there's two groups there's the-*
>
> ***Researcher:*** *Is there?*
>
> ***Jane:*** *Yeah there's in my mind, there's the ones like me who are – who have always been here and we got ill quite often because of the job. Then there's the other ones these newer ones who are – who I think are seen like patients who've kind of gone – come good [laughs] So yeah I think they're seen as different (p. 14, 426-435).*

Jane appears to be suggesting that it is perhaps more acceptable and less stigmatising to have lived experience because of the job, as opposed to being a patient recruited on the basis of having lived experience. In this way, she is positioning herself as closer to the professional in-group, as if on a spectrum, than PSWs. However, Kerry finds the distinction between professionals and PSWs as unhelpful in maintaining the belief that mental illness is not something that is experienced by professionals:

> ***Kerry:*** *[The] whole idea of peer support workers as very separate and that maybe it doesn't acknowledge the fact that you could be a clinician with a mental health problem rather than just a peer worker. (p. 19-605-608)*

The perception that professionals are somehow not as susceptible to mental illness is a popular myth shared by some members of the public, as David encountered first-hand:

> *One patient who has always stuck in my mind said to me, I was normalising it for him saying you know 'We all suffer from things like this and it's temporary and you know you can get better from it' and he said 'but not you surely?' and I said 'Well yeah why do you say that?' and he said 'Well you're a mental health professional'... so that's quite an interesting perspective in that how service users or other members of the public view mental health professionals as perhaps putting them somewhere that you know putting them on the pedestal sort of thing thinking well we must know the answers (p. 6, 181-193).*

Patrick alludes to this same common perception that mental health professionals are invulnerable to mental health problems, and feels that this myth needs to be debunked:

> *We're all potentially [laughs] we're all – we're all prone to it. Perhaps we need to stop-stop kidding ourselves that you know just because we are mental health professionals we're-we're perhaps untouchable in some way. (p. 17-18, 558-563)*

3.4 Towards a Culture of Openness

3.4.1 Openness among colleagues reduces shame and promotes help-seeking: *'If we could be more open with each other about it I think it's a helpful thing because it's you know if we hide it away there's less chance of us trying to get some help [laughs] with it' – Patrick*

Over half of the participants acknowledged the benefit of being more open about their lived experiences. Maggie and Kerry identified that the key speakers and authors in the field of recovery, peer support, and lived experience who are open about their lived experience, had helped to reduce the shame they felt. For Kerry, it felt particularly important that it was not only possible to be a mental health professional with lived experience, but it was possible to be a successful one:

> ***Maggie:*** *...but I think it's to be able to say 'It's ok', the lack of shame I think is really good if you can because that was one of the most debilitating things for me was the feeling of shame or the feeling of being kind of different (p. 16, 519-521).*
>
> ***Maggie:*** *I mean I think that I [pause] I I shouldn't have felt quite so… ashamed as I did at times, now I...I've watched all of the Rachel Perkins stuff on youtube and things (p. 17, 531-541).*
>
> ***Kerry:*** *It's been a massive guiding force in my life… [pause] so… yeah people with lived experience who are working within the field of mental health… that it's possible to be really successful and juggle… those two and them to work together and their lived experience be something that's not shameful (p. 19, 617-626).*

For Patrick and Abby, openness enabled conversations with colleagues which led them to feel more able to disclose to others, and others more likely to disclose to them. Patrick reflects on a situation when two colleagues approached him to ask if he was ok. He felt that this gave him "the push" he needed to seek help. Patrick seems grateful for this and almost pleasantly surprised that they showed this concern for his wellbeing, perhaps reaffirming to him that he is cared for at work:

> *It was nice that they'd taken the time to do that and because they'd said it in such… sort of reassuring and affirming way, they – they you know they were*

> *worried about me [slight laugh] [deep intake of breath] but it gave… me the push that I needed t-to actually go seek and some help. (p. 9, 269-278)*

Patrick and Abby's inclination to be open about their lived experience has increased since they realised how common lived experience is within the workforce. They both suggest that being open creates a ripple effect as more and more people feel able to be open:

> **Abby:** *Sometimes they come to me because I'm so overt with mine. Sometimes they'll then come to me and tell me about theirs… So actually by being open you create a culture of openness which we really need to have more of and that's why I am so open (p. 21, 670-677).*
>
> **Patrick:** *Before I would have never had dreamt of disclosing anything to colleagues. These days I'm more than happy to because I realise it's quite common [laughs] (p. 17, 528-531).*

Len however had a different experience to those mentioned above. His approach was to try to arrange a supportive discussion group with his peers to talk about what was and was not going so well. However this idea was not taken up by his colleagues and he was left feeling unsupported:

> *I remember feeling [pause] I suppose 'well nobody gives a [pause] a damn' you know, at my level and thinking that was rather disappointing and I guess*

> *I've got a level of interest and concern in other people's [intake of breath] work at my level and I was trying to go out and say 'Let's meet' and all these things and I thought it would be helpful but noth- you know nothing so I was – t-that was an issue (p. 6-7, 159-169).*

Len's experience is one of feeling let down by his colleagues. It might be that Len's lack of direct openness with colleagues meant that his personal needs were perhaps not recognised by them, leaving him feeling like nobody cared.

3.4.2 Social acceptability as a barrier to openness with colleagues: *'I suppose people have misconceptions of what they're allowed to say without it coming back on them' – Simon*

Six of the nine participants identified not feeling able to be open about their experience with colleagues. Kerry, Jane, and Maggie talk about needing to display an "acceptable" rather than an "unacceptable" level of lived experience, which inhibits complete openness. However, this can depend on the team and the type of professional background one has:

> ***Kerry:*** *It depends on the team but there's sort of – there's things that you would share and things that you wouldn't… there's maybe a level of what you would share…that sort of feels socially acceptable (p. 10, 312-316).*

> **Jane:** *I think within the therapists it's perhaps a little more ok cause there's something about being a therapist where…you've often had to have therapy to get through…so there's kinda understanding that you do look at yourself and look at your own issues (p. 9, 263-270).*

They also describe there being an implicit hierarchical structure of what is and is not ok to share "in terms of coping strategies":

> **Jane:** *I think there's a kind of hierarchy of what's accepted in terms of coping strategies so it would be perfectly acceptable to talk about large amounts of drinking…I don't think somebody would come into work and say 'I'm worried about my drinking'…but they might come in a go 'Oh I got wasted' (p. 9, 274-290).*
>
> **Jane:** *If you were to kind of talk about not coping or using a sort of – like if your strategy was cutting that would be completely [laughs] unacceptable. (p. 10, 300-303).*

It is suggested that through sharing these safer, more "acceptable" coping strategies one might hint at having a degree of lived experience, without raising concerns to others that "you are an actual patient". Kerry felt that to be open about having spent time in hospital might not feel so socially acceptable and might incur judgement and labelling:

> ***Kerry:*** *[It's] sort of an acceptable thing to talk about how you know you're struggling and you have a large glass of wine or that you've felt depressed or anxious but I think it's very different if you say like 'I've been in hospital' or you know that there's still there's – there's sort of what feels safe - socially acceptable level of lived experience to talk about and maybe one that's 'Ooh! Maybe you are an actual patient' (p. 10, 320-327).*

Jane spoke of the two faces of mental illness: an acceptable face and a non-acceptable one. However, she pointed out that masking lived experience with an "acceptable face" can lead to a person's experience not being validated and supported:

> *What she was doing was bringing the acceptable face of mental illness into the office by saying she wasn't sleeping that's what I think, but we kind of ignored it…and I think now I would kind of learn from that (p. 17, 553-556).*

While some participants talked about disguising their lived experience or presenting the "acceptable face" by hiding some of their lived experience, Zoe described her experience of needing to keep her lived experience a "secret", so as not to arouse suspicion or be seen as having "something wrong" with her:

> *There was a feeling of being really suspicious, which is where maybe that 'dirty little secret thing' came from. It's like you know if you've…had any*

> *kind of emotional problems and you've gone for counselling or you know anti-depressants, there is something wrong with you… But it's changing, it's changing definitely, definitely feels like it's changing definitely yeah (p. 11, 327-330).*

There was some hope from participants that things were changing with respect to disclosure. Len and Patrick pointed out that people in the organisation were becoming more aware of lived experience and there was a growing sense of being able to "be open about it and to be honest about it and say actually 'yes' [laughs]" (Patrick, p. 9, 284-288):

> ***Len:*** *I have picked up on a sense of…when one acknowledges it, talks about it, has a sense of 'Ooh' you know we've got permission to actually start talking about it a little bit (p. 6, 208-209).*

Although they describe feeling a sense of permission to "start talking" about their lived experience, it continues to feel restricted and conditional by it only being "a little bit."

3.4.3 Greater acceptability of sharing lived experience in recovery settings: *'It feels like we're equal really…they all support each other' – Maggie*

All three participants who spoke about working with the Recovery College identified a greater acceptability of sharing lived experience in this setting. Abby described it as feeling more equal and less restrictive. Zoe felt that it enabled her to be more honest and authentic. Maggie felt able to share her diagnosis and felt freed up to support clients differently:

> ***Abby:*** *I think because the Recovery College is very much co-facilitated, it's very much recovery focused, everyone's on a level platform, everyone's working together on this. And because it is everyone working together to make this course, that feels different because I am not necessarily having management breathing down my neck saying 'Why are you doing this, why are you doing that?' (p. 8, 251-256).*
>
> ***Zoe:*** *I have my own lived experience… and you know I find practising mindfulness and doing blah-blah-blah actually helps, helps with my wellness and is part of my wellness plan… It feels really honest actually, it feels really good (p. 9, 283-296).*
>
> ***Maggie:*** *I've been able to say 'Oh yes I have [disorder]' and there I am as a [job title] facilitating the group, and maybe at times being able to support people in a way that wouldn't have been possible (p.14, 446-466).*

Participants described coming across novel situations around disclosure which present them with dilemmas. For example, Maggie described a situation when clients who know her in her role as professional outside of the Recovery College, attend recovery courses which she is also co-facilitating or attending. In these instances, Maggie does not feel able to disclose her diagnosis unprompted, but feels it should be acceptable if it were to come up naturally in conversation. Maggie's tone and insistence implies that she feels strongly that it should be ok to share her lived experience with those clients who also know her in her role as mental health professional.

> S*o if somebody from my ward was to come to that group I wouldn't you know be able to – I wouldn't specifically say 'Oh by the way so and so I'm [disorder] that's why' but if it comes up in that group and they're part of that group then that's ok it's gonna have to be ok (p. 15, 475-479).*

Maggie experiences her role within the recovery setting as less about her professional status and more about her status as a person with similar experiences to the clients she is supporting. However, she does not altogether dismiss her professional qualification. She feels that it is useful because 'I know what to do' when it comes to responding to clients:

> *I'm not really there as a professional I am there as facilit- I'm not there as a [job title] I'm just kind of – it's useful that I have a [profession] qualification because I know what to do I know the different – and that's important but I never feel I am there as a [job title], I feel like I'm there you know as somebody…who knows what it's like (p. 16, 499-504).*

3.5 Changed Identity

3.5.1 Impact of lived experience on role identity: *'I'm certainly not better than anyone else because of it but I'm a different kind of [job title] because of it' – Maggie*

Four of the nine participants felt that their lived experience affected how they and others viewed themselves within their role as a mental health professional. Of these four, Maggie and Zoe chose to focus on the positive aspects:

> ***Maggie:*** *I think I am one of the probably one of the calmer people you know in a crisis or whatever… I think I kind of just stay in the time in the now and I'm not…you know some – some people are incredible perfectionists or whatever I think I am just kind of like well this is how it is, this is how we'll carry on… I suppose. I don't know I think maybe you know this sounds like I'm just trying to make a virtue of it like you know but when you – perhaps when you have had… a trauma when you are quite young you know somehow you – it's never going to be that bad again (p. 7, 202-214).*

Maggie feels that her lived experience has prepared her for other people's crises because she has lived through some of her own and survived them. She is careful not "to make a virtue out of it". Other participants also did not want to be viewed as "better" than other professionals without lived experience, although they felt that their experience added something:

> ***Kerry:*** *…validating basically I suppose…it's not to say that without lived experience you can't do that, but it feels quite natural (p. 15, 461-463).*

Zoe also highlighted perceived authenticity as a result of having lived experience. She felt that clients found disclosure of lived experience more authentic when done by a professional, rather than a peer support worker:

> *I know that they sort of reflected back actually they felt there was something more authentic about having a member of staff, a non-peer support – a peer member of staff who actually had that lived experience, they felt there was something more authentic about that really (p. 10, 310-305).*

In contrast, Jane and Kerry felt that their professional confidence was diminished due to their lived experience negatively distorting their self-perceptions of their ability to do the role. Jane implies that her capability to evaluate her own effectiveness is biased because of her "you know" (lived experience):

> *There's always a challenge that you have where you feel very uncertain about whether you're any good… if your kind of internal dialogue is…if it's hard for you to measure how good you are at something because you're – because of like…you're you know (p. 34, 1074-1079).*

> ***Kerry:*** *It's how the mental health problem affects my perception of myself as a clinician which I suppose is a bit different…[pause] in that in that I feel not*

> *good enough and it triggers these thoughts of 'I shouldn't, I shouldn't be doing this job, maybe I'm harming my clients'. There's no evidence that I'm harming my clients but that's a big big worry that I have…that I think is more related to my [disorder] that other people's – well definitely not other people's experiences that I've had where they've said that it's just a feeling that I have that's – that's my [disorder] can be very enmeshed with m-my confidence in my clinical role (p. 17, 530-541).*

Both had an awareness of their mental health problems negatively biasing their internal dialogue, sometimes to the extent where they would experience self-doubt about their entitlement or capacity to perform the role. Kerry was aware that her fears were neither substantiated by evidence nor by other professionals' opinions. She countered her distorted self-perceptions with a self-reassuring statement: *'My mental health affects my role in the same way that it would affect any role' (p. 17, 545-546).*

Kerry, like the majority of participants, demonstrated some ambivalence towards her lived experience; she sees it as only having a positive influence when she is well:

> *When I'm self-managing it feels like a real gift I suppose that's something that adds on to other skills and experiences that you have but ask me when I'm [disorder] it feels like a terrible thing [laughs]. I suppose that's the nature of fluctuating mental health conditions… triggers all of these like*

> *feeling – feeling ashamed of having a mental health problem feeling like i- it's a curse or feeling like it's a really bad thing thinking that nothing positive will happen from it (p. 16, 506-523).*

3.5.2 Positive impact of lived experience on relationship with the self: *'It's good to have an insight into, you know, I feel more able to detect what my needs are and more easy to [intake of breath] understand other peoples' perspectives as well' - Len*

Five out of nine participants expressed that their lived experience had benefited them personally. For some participants this relates to being more mindful of their own experience and mental wellbeing. For others, it helps them take a less critical view of themselves and feel more accepting of their lived experience as a result. Len, David, and Simon describe how their experiences have helped them become more reflective and connected to themselves, which in turn helps them take appropriate action in terms of self-care:

> **Len:** *I know there's stuff worrying me and I think 'What is it that's worrying me?' and I think 'Ah yes I am – that thing is on the back of my mind I am – I have got that particular issue [pause] eating away at me I will deal with it', so it has made me more…I sort of attend more to my emotional pulse…I procrastinate less than maybe I used to (p. 8, 238-246).*
>
> **David:** *I think lived experience does put you in mind of it again - reflective, looking back at your life and what led you to become unwell or the issues*

> *that made you unwell and then taking them forward and using it in your daily life (p. 15, 487-490).*
>
> ***Simon:*** *I listen to myself a lot more, I listen…mentally, physically, and I use coping strategies (p. 24, 752-754).*

Similarly, Abby experiences a much greater self-awareness which she has developed through therapy and self-help over the years. Her intimation that she is "too self-aware" might suggest that it is not always conducive to her well-being however she did not go into detail on this:

> *I'm ridiculously self-aware, probably too self-aware in some ways. I check in with myself loads, but I – because I've spent so much time in therapy and in self- working in myself and all that kind of thing (p. 20, 639-642).*

This increased self-awareness helps Simon and Maggie to feel a greater sense of compassion towards themselves and their experiences. Although Simon continues to have high expectations, he is kinder towards himself by allowing himself to have his inner emotional experience.

> *I suppose my lived experience does help me. I-It yeah, yeah I suppose when I do lose my temper, or get wound up which apparently doesn't look like I am*

> *losing my temper or getting wound up [laughs] I get annoyed with myself internally because I've allowed myself to do that [pause] so I'm harsh on myself as I probably always have been just due to expectations but I'm just a bit kinder to myself as well (p. 25, 779-785).*

For Maggie, it was being given a diagnosis of mental illness that was "really helpful" as it meant she could let herself "off the hook a little bit" from her own self-criticism and self-blame about having lived experience. The diagnosis gave her permission to see her experience as an illness:

> *Diagnosis was really helpful actually in the end ...it sort of... [pause] it made me sort of...what's the word?...Well just to not beat myself up about it really, just to think actually it's an illness I sort of let myself off the hook a little bit (p. 3, 77-85).*

3.5.3 Impact of role identity on lived experience: *'It probably wasn't until I started working with more of the CBT model that I recognised that I had all of these unhelpful cycles going on for me' - David*

Three participants recognised their role as helping them to identify their difficulties and to “deal with them differently” (Simon, p. 7, 214). Maggie sees her professional role and lived experience as impacting on each other reciprocally:

> *Maybe being [disorder] makes me a sort of different kind of [job title] but being a [job title] made me a different kind of [disorder] sufferer (p. 9, 289-293).*

Having a greater understanding of psychological models and interventions was commonly cited by participants as being personally beneficial to their recovery in helping them to become more conscious of their own thinking styles. One participant, Patrick, however did not feel that this was the case. Simon explains how as a professional, he now uses the self-help techniques he used to view as ineffective and pointless when he used services:

> *[The] well-being stuff and the breathing and the guided visualisation and - it was a load of pants and rubbish. However, I was using it without realising I was using it. Which is quite interesting, cause since I have revisited it as a clinical member of staff, a lot of the stuff, I-I’ve used without realising I’m using it, it’s subconsciously, because the seed was planted, placed there (p. 6-7, 196-203).*

Simon attributed his change in attitude to subconscious processes. He suggests that “the seed was planted” by professionals which enabled a new way of thinking to grow and take root without him being aware of it. Becoming a mental health professional has served as a conscious reassuring reminder of the well-being techniques shown to him.

David feels that learning to deliver CBT principles has helped him to understand the "unhelpful cycles" he had "going on" (p. 7, 215), enabling him to manage his lived experience more effectively. His partner was the first to recognise this positive change, which to David felt like a revelation:

> *I'd reach for a bottle you know if I'd had a stressful day… she said 'that started to change quite a bit once you started doing the CBT…course' (p. 9, 268-274).*
>
> *You don't use think about psychology so much just basic nursing and it was sort of like 'I never knew, yeah you're right!' (p. 8, 241-243).*

However for Patrick, his role had not prepared him for experiencing mental illness. Instead it gave him a false sense of security – "I know about mental illness! I can't you know I can't be suffering from it! [laughs]" (p. 18, 566-567). Similarly, Len was surprised that his role as a mental health professional had not equipped him to recognise his own symptoms of mental illness – "It was illuminating not to recognise in myself what I might have recognised in others" (p. 4, 108-109).

For Zoe, it was not so much the techniques or strategies that her role equipped her with which positively impacts on her lived experience. Rather it is the current initiatives in mental health services towards valuing lived experience that helps her to now feel "really comfortable" with it. Her experience of being a professional is now positively impacting on her sense of self:

> *It wasn't until the whole you know Hidden Talents, Recovery, valuing lived experience that I felt really really comfortable about it (p. 3, 64-67).*

3.6 Experiencing the organisation as unsupportive

3.6.1 ***Staff well-being is not prioritised:*** *'More should be done about the well-being of the staff at times, and that sometimes is forgotten… They are probably making themselves as ill' – Simon*

Four out of nine participants identified feeling that there is a lack of attention paid to staff well-being in the organisation. Jane and Simon suggest that "we" in terms of the organisation and society in general, do not promote the ethos of "looking after yourself":

> ***Jane:*** *The culture of the organisation is not about looking after yourself so I think it's…the idea of – I think culturally it's happened everywhere it's not*

> *just [Trust] but culturally we don't – we aren't a society that takes lunch breaks any more so it's seen as an extravagance (p. 23, 745-749).*
>
> **Simon:** *We look after the service users, but we don't look after the staff in the same way (p. 23, 707-709).*

Simon experiences a disparity between how "we" look after clients and staff. The use of "we" in both accounts suggests that Simon and Jane perhaps realise that they have a role in promoting their own and other staff members' well-being, rather than it being solely the responsibility of the managers, or the organisation alone.

Abby and Zoe felt worried that a greater number of staff would experience mental illness as a consequence of a lack of attention to staff wellbeing:

> **Abby:** *They don't take care of their staff properly and because they don't do that more staff are gonna end up having lived experience I think (p. 19, 603-605).*
>
> **Zoe:** *I think more and more staff are going to get lived experience unless they do something radically different in terms of people's stress levels (p. 13, 397-399).*

Zoe, on the other hand, held more hope that things might change for the better. However this was on the condition that considerable changes are made to improve the situation for staff and managers:

> *I do feel managers have sort of had their hands tied to a certain extent. People have been wanting to be understanding, for example the last time I was off sick, it was just before I started this job and I knew I was becoming unwell and I did go to my manager and say 'Look I can't- I can't do clinical work at the moment, I don't want to go off sick it doesn't help me' and he was really sympathetic really – but just couldn't I mean the war- it was just so busy he couldn't actually take me out of clinical practice so I was – sort of soldiered on for a while. I just thought 'No I can't, I'm going to make, I'm gonna make a huge mistake, I'm not safe, I'm taking myself out', so I had to go off sick (p. 5, 141-151).*

Zoe felt that she had no other option than to take sick leave as a matter of professionalism and self-care. Zoe went on to advocate that a break from clinical practice might be helpful for a member of staff who was struggling with their mental wellbeing:

> *Maybe recognising that there are times when actually it's still good to be at work but maybe needing to step back from clinical practice because there's a*

> *difference between writing a report or working in an office and actually listening t-to somebody's distress – there's – there's a huge difference to how you cope with that really but again maybe that should be for all staff as well [laughs] (p. 14, 433-439).*

Simon and Jane agreed that better self-care at work is what is needed, for example, mandatory breaks and wellness planning, to encourage staff well-being. They put the onus on staff to be "kinder to themselves" and practice wellness at work. Zoe believes this should be formalised into a "wellness at work plan" for all staff, not just staff with lived experience:

> **Simon:** *Staff need to be kinder to themselves (p. 23, 717).*
>
> **Simon:** *Mandatory breaks 'you WILL leave your computer!' (p. 23, 724).*
>
> **Jane:***...people aren't having proper lunch breaks and that's a kind of basic healthy living thing to have a break and have something to eat to you know look after yourself (p. 22, 718-720)*
>
> **Zoe:** *I think all staff should have some kind of wellness at work plan because the kind of things we are listening to we don't – you know over a period of time the impact that that has on you it's difficult to know so I think…you know a wellness at work plan for everybody a-and particularly if you've got lived experience (p. 13, 403-408).*

3.6.2 ***Ironic lack of understanding and support:*** *'It's the most crazy thing ever that you can't be openly mentally ill in an organisation that's treating mental illness. It's just wrong.' – Jane*

Five out of nine participants emphasised the irony that they felt unable to be open about their lived experience to employers, and did not feel adequately supported by an organisation treating mental illness. Jane and David experienced the organisation to be unprepared and lacking in expertise when it comes to supporting professionals with lived experience. Jane felt managers' clinical training did not necessarily translate directly to supporting staff with mental illness:

> *I mean managers they just don't know what to do, I think…they think they should know what to do because they've been psychiatric nurses quite often so – but they actually don't because actually – nobody's actually – people they know how to help a patient who's mentally ill but they don't know how to help a staff member who is mentally ill cause it's not the same thing (p. 19, 598-603).*
>
> **David:** *It's crazy to say that although we're a mental health trust it seems from the feedback that we're getting that a lot of managers don't really [pause] whether it's because of the pressure, they haven't got enough time, but they don't show that much insight or empathy into the nature of mental health issues in staff and I'm sure a lot of them flounder around and actually don't know quite what they should be doing (p. 1, 8-15).*

David clearly felt that the organisational pressures that managers were subjected to impacted negatively on their availability to staff with mental health problems, in addition to not knowing how to respond. He also wondered whether there was associated or unrecognised distress for them as a result:

> *I'm the person who's come back with a mental health problem but she's actually the one who's really falling to bits about it all (p. 31, 989-994).*

Rather than experiencing a positive and collaborative approach to his return to work, David experienced a prescriptive attitude towards him:

> *[It is] very much the tone of you will do this rather than we'd like to support you back into work (p. 25, 791-792).*

Both David and Abby imply the rules around returning to work and recommencement of certain responsibilities, such as duty and one-to-one client work, were arbitrary and unclear. Both felt that their fitness to work was judged on how busy the service was rather than an actual assessment of their needs:

> ***David:*** *I can't believe that the nerve after two weeks ago saying to me…that I must be observed in order to be safe to practice and now you're actually saying 'Yeah you can just start work…and by the way, can you do an extra one? (p. 30, 942-946).*
>
> ***Abby:*** *It's kind of like when it suits them it's alright because within two weeks 'Oh no, we don't have anyone on duty, shit we need someone to do the duty. '[Name] do you feel up to doing duty?', 'Yeah of course I do because I was up to do duty the first day I was back', 'So we can put down that you're well enough to do duty now?', 'Because you needed me to do duty' that's what's happened here (p. 12-13, 388-393).*

As a result of her experiences, Abby feels it would be better to say nothing than go through the return to work process again:

> ***Abby:*** *[It] makes you want to be less open it makes you not want to tell them if you're starting to get ill again, it makes you not want to say anything (p. 14, 432-433).*

Abby went on to describe feeling 'trapped' and almost in a no-win position:

> *It makes you feel trapped because you feel trapped by whether you say anything or don't say anything because it's just like being in a position where you're feeling like they want to know everything about you, all about*

> *you like they want to diagnose you themselves [laughs] and they want to come up with a plan to keep you well (p. 14, 434-438).*

This seemed more redolent of the kind of formulation and intervention approach that you might take with a client, rather than a return to work meeting. Abby suggested a more collaborative approach would have been more useful in her return to work:

> *It needs to be a lot more about what do you feel you need, what is it that you want rather than we need this and we need that, we want this, and we need this from you and we think this is right because no one actually said to me 'What do you want from this?', 'What do you feel you need?'. Didn't get that question asked of me and that should have been the first thing said (p. 15, 463-470).*

David warned that many people would not have been able to cope with the experience he had in returning to work. He emphasised the need for services to support people:

> *In my case I was well enough to weather the storm, but a lot of people would have just thought 'I can't cope with this, I wanna go – I wanna go off sick again' or 'I'm gonna leave I'm just gonna leave, or get – look for another job' or whatever you know so I think that's the price that you know services will pay if they're not being proactive in supporting people (p. 32, 1016-1021).*

3.6.3 ***Burden of proof:*** *'I feel like I always have to really really emphasise it to anyone when you're disclosing a mental health experience that you know I am totally fit for work' – Kerry*

Four out of the nine participants identified feeling that they need to prove to others that they are mentally well and fit to practise. Kerry felt very pre-judged about this:

> *There's this real assumption that because you've got a lived experience that it's going to make you really unprofessional or that you're not- you're not fit for- that it's a fitness to practise thing and it I have never and I make pains in saying this that I've never been judged as unfit to practise but there can be this assumption that having that mental health experience lived experience makes you unfit in some way (p. 6, 179-185).*

Within the interviews, there was evidence of participants perhaps feeling the need to prove to others that they are well and in control of their lived experience. There was also a sense of pride in overcoming or at least managing their lived experience. On more than two occasions, Jane digressed from the topic of conversation to point out that she had not had any time off work for a number of years and has never been sectioned:

> *I haven't been sectioned I haven't kind of had to be given medication against my will or been so unwell that I've been off for more than like six weeks or something (p. 30, 963-966).*
>
> *I haven't been off sick for 10 years or something (p. 8, 260).*

David emphasised that he was "very well at the moment" by repeating this statement twice, even though he was not asked directly about this. Also he described his lived experience as being in the past with his use of past tense for example, "I say had". However, he sees his lived experience as not gone, but as possibly "coming back" and affecting him in the future:

> *I say had because I'm very- I'm well at the moment, I have to try and think to myself you may get elements of this coming back still over the years but I am very well at the moment [deep intake of breath] (p. 10, 302-305).*

Abby repeatedly emphasised how she has "managed", saying it as she does four times in the next quote. It suggests a sense of personal achievement with her repeated use of "I" and explanation of how "difficult" it is to prevent a relapse. She described it as being "quite a feat to do" implying therefore that her ability to self-manage is quite remarkable:

> *I've managed to prevent [disorder] episodes I've managed to prevent [disorder] episodes – they're really difficult to prevent but I've managed to catch it right at the start and even though I'm starting to go [disorder] I've managed to reduce it back down and do all my techniques that I know help with [disorder] episodes which seem to curb it quite well which is quite a feat to do, very difficult when your thoughts are going everywhere (p. 20, 644-650).*

Reflection 4. Personal Impact on the Analysis

The process of analysis was both challenging and rewarding; it involved discipline, concentration, time, and focus, which culminated in a sense of achievement after each individual analysis. I enjoyed fully immersing myself in the participants' worlds, being open and curious to the data. I found that I gleaned further insights as I moved from individual to cross-case analysis, and around the hermeneutic circle. However it was also emotive at times and I took these opportunities to reflect on the reasons for this using my reflective diary. In Heideggerian terms, I was becoming aware of some of my own fore-understandings as a result of conducting the analysis. Inevitable though these are, I tried as much as possible to separate them from colouring my interpretations and stay grounded in the participants' words, rather than getting caught up in my own phenomenology.

4. Discussion

4.1 Chapter Overview

This chapter will review the main findings in the context of the study's research question. As described in the first two chapters, the research question was derived from a dearth of literature concerning the lived experience of mental health professionals. Therefore the research question was kept as open as possible and was simply to explore the experiences of mental health professionals with their own experience of mental health problems. To date, there has been no research into mental health professionals' experiences of having lived experience in the workplace, how it might influence their role, or how it might be used with clients. Data was analysed using Smith's (1996) Interpretative Phenomenological Analysis (IPA), and quality guidelines for qualitative research were adhered to. Five Superordinate Themes emerged: Lived Experience Helps Inform Practice; Stigma; Towards a Culture of Openness; Changed Identity; and Experiencing the Organisation as Unsupportive. These findings shall be summarised and discussed in relation to relevant psychological theory and previous research. Strengths and limitations of this study will be examined. Theoretical, clinical, organisational, and research implications will be outlined. Directions for future research will be suggested, followed by an overall conclusion of the study.

4.2 Lived Experience Helps Inform Practice

4.2.1 Therapeutic relationship enriched by increased empathy

All participants felt that they possess greater empathy as a result of their lived experience. This helps them to connect more deeply and emotionally with clients, build rapport and give them hope. Greater humility and humanness, in terms of focusing on the commonalities as opposed to differences between themselves and clients, was also found to improve the therapeutic relationship. This is supported by clients' perspectives on therapist self-disclosure (Henretty & Levitt, 2010). Previous research has shown that empathy is considered to be crucial in helping relationships (Reynolds, 2000, as cited in Mercer & Reynolds, 2002). In fact, "common factors such as empathy, warmth and the therapeutic relationship have been shown to correlate more highly with client outcome than specialised treatment interventions" and "clients often attribute their positive therapy outcome to the personal attributes of their therapist" (Lambert & Barley, 2001, p. 357 & p. 358). Therefore, rather than purely intellectual understanding, it is the emotional connection between client and professional which may be at the centre of clinical empathy (Halpern, 2001).

This study also supports Gilbert et al.'s (2012) findings that mental health students with lived experience feel that they have a greater level of understanding of others' experiences on an empathic, as well as intellectual level. Within services, a general assessment of care will need to include "the human dimension of the clinical encounter, of which empathy is a key part" (Mercer et al., 2002, p. 11). However, empathy is a skill which, for some, requires training and clients are well-placed to advise professionals on how to offer empathy (Mercer et al., 2002). Professionals with lived experience might also be in a good position to offer such training as not only does their lived experience give them greater insight, but they also have a greater exposure to, and possibly influence over, other professionals.

4.2.2 Limited and cautious use of self-disclosure with clients

All participants emphasised their careful and limited use of self-disclosure. Some participants reported experiencing a felt sense or knowing between themselves and the client, where the client realises that the professional has lived experience without the professional disclosing it. It appears that this can sometimes be communicated through their empathic approach. Therefore, verbal self-disclosure can be redundant in some situations, where a mutual acknowledgement is shared and the client does not ask for further disclosure.

Participants felt that it was important to consider the context, the setting, the reason for any self-disclosure, and whether or not it would be helpful for the client and the therapeutic relationship. Careful consideration of the reasons behind self-disclosure and the possible risks and benefits has also emerged as a theme in a recent mixed-methods study investigating peer self-disclosure (Marino, Child & Campbell Krasinski, 2015). Again, this supports Gilbert et al.'s (2012) findings and demonstrates that having these apprehensions related to self-disclosure is not due to student status or inexperience. Rather, professionals who have worked for decades continue to struggle with this uncertainty. This highlights a need for increased guidance and support regarding self-disclosure.

Some participants in this study differed as to whether or not they would share their diagnosis with clients; one feeling that it was irrelevant and another feeling that it was permissible as long as it came up naturally in conversation and within the recovery college setting. This seems to be a matter of personal choice and is perhaps dependent on the individual's relationship to having a diagnostic label. There is evidence to suggest that labels dehumanise people and evoke stigma if not contextualised (Martinez, Piff, Mendoza-Denton & Hinshaw, 2011). It is questionable whether diagnostic labels are relevant in a recovery model which champions individuality and wellness, particularly as many participants themselves resisted having a diagnosis of mental illness.

The majority of participants felt that the recovery movement has helped them to value their lived experience and that they have felt more able to self-disclose as a consequence. This might be because within the context of recovery, with its focus on equality and co-production, the "professional" role is less powerful. Therefore we need to question what being a recovery-orientated professional means (Borg & Kristiansen, 2004). Borg et al. (2004) found that the characteristics of professionals deemed as most helpful by clients included a willingness to stretch the boundaries of their professional role and thus become more human. This included friendly gestures such as touching the client's hand when upset. These "boundary crossings" serve to affirm clients' self-worth and are effective as long as it is intentional and managed appropriately (Green et al., 2008, p. 15). The findings concur with existing research which suggests that self-disclosure can be used in the following ways: to normalise unusual experiences, to increase perceived similarity with the client, to improve the therapeutic alliance, to provide alternative cognitions and behaviours, and to respond to the client wanting therapist self-disclosure (Ashmore & Banks, 2002; Edwards & Murdock, 1994; Geller & Farber, 1997). Support was not found in the current study for self-disclosure being used to encourage reciprocity (Jourard, 1971) or to model effective disclosure (Stricker, 1990).

4.2.3 Greater understanding of the client's perspective

All participants described having greater knowledge and understanding of the client's experience in appreciating what it is like to have mental health challenges. However, they were strong advocates for every person's experience being unique. Many of the participants expressed discomfort about the phrase "I understand" being used by colleagues or professionals due to having been on the receiving end of this in the past and having found it unhelpful. Some participants emphasised that they would now never say "I understand" to a client because they feel it is neither authentic nor possible. The participants emphasised that their lived experience enables them to focus on being with the client and the therapeutic relationship. Their direct experience of having received some of the interventions they deliver was felt to be beneficial in that they can anticipate and empathise with some of the challenges.

4.3 Stigma

4.3.1 Others to self

All participants experienced stigma from others in the workplace. This included direct bullying, as well as indirect “provider stigma”, where colleagues openly stigmatised people with mental illness (Charles, 2013, p. 360). Across the sample, there was evidence of participants having different reactions to stigma. Three main reactions to stigma have been identified in the literature: diminished self-esteem, righteous anger, and indifference (Corrigan & Watson, 2002). The majority of the participants expressed diminished self-esteem, two demonstrated righteous anger, and one showed indifference. Some described feeling that their mental illness was perceived as a weakness, and even as toxic or dangerous. Participants felt that they were less trusted by colleagues and managers to do their job well. The results of this study support those found elsewhere that employees fear losing perceived credibility and competency (Brohan et al., 2012), differential treatment by others, and potential discrimination in terms of opportunities for promotion (Moss et al., 1997; as cited in An, Roessler & McMahon, 2011). However, the findings from this study add another important dimension: the impact of self-stigma on non-disclosure, which is perhaps more striking as it is within a mental health service which espouses the reduction of stigma as one of its activities and values.

A couple of participants who had had the experience of taking sick leave for physical as well as mental health reasons, had experienced greater support from colleagues and a less stressful return to work following physical ill-health. One participant described that colleagues and managers did not have a language for discussing or talking to colleagues about their lived experience, which is highly surprising given their job roles. The return-to-work process following episodes of mental illness for two participants was felt to be discriminatory, arbitrary, and non-collaborative. Stigma from others contributed to feelings of isolation for many participants and, as a result, it was felt this directly contributed to not getting the right support or treatment, as has been previously mentioned (Thornicroft, 2006).

4.3.2 Self-stigma

Internalised self-stigma was also widely experienced by participants. Male participants in particular described not recognising, disbelieving, and avoiding their symptoms, preferring instead to categorise them as stress-related and do their best to carry on. This gender difference has been reflected in the literature in that females tend to have more positive attitudes towards help-seeking than males, a greater recognition of need for help, and a greater degree of interpersonal openness (Leong & Zachar, 1999). Leong et al. (1999) suggest that men may have more restrictive attitudes towards mental illness which leads them to become defensive and less open. The two aforementioned male participants in this study wished that they had sought support sooner and had not tried to do it alone. Participants generally expressed self-criticism and self-blame towards themselves for having lived experience, and several questioned their ability and trust in themselves, and even whether they should be working in mental health. Rusch, Angermeyer & Corrigan (2005) suggest that this process is the result of an individual accepting the common prejudices and turning them inwards causing self-stigmatisation and loss of confidence.

4.3.3 "Them and us" narrative

Three participants explicitly identified experiencing a "them and us" phenomenon. Words like "counter", "line", and "fence" were used as a way of describing the felt separation of professionals from clients, and professionals from Peer Support Workers (PSWs). This supports Slade's (2009) point that the employment of PSWs continues to maintain the distinction rather than challenge it. The separation described by participants was suggested to have a protective quality when working with others' mental distress. Within the literature, so-called social distancing by professionals keeps the status quo, i.e. the power is maintained by those who are most invested in the system (Richards, 2010). However, this artificial separation also serves to make professionals feel a sense of wrong-doing should they have their own mental health challenges which in turn increases feelings of shame and isolation. Some participants argued that all professionals need to view themselves as equally susceptible to mental illness.

4.4 Towards a Culture of Openness

4.4.1 Openness among colleagues reduces shame and promotes help-seeking

All participants identified a need for mental health professionals to be more open about their experiences. For some, this has been helped by going to events and conferences, or by watching videos of well-known and eminent clinicians speaking publically and openly about their own lived experience. One participant described these individuals as a guiding force in her life, and as giving her hope that she can have lived experience and be successful. Another participant felt less ashamed about having lived experience as a result of the openness of others. This reduction of shame following self-disclosure to colleagues was also found in Marino et al.'s (2015) study. Participants who are open with colleagues found that colleagues are in turn more open about their own lived experiences with them. For another participant, having another colleague ask after his wellbeing made him feel cared for and gave him the motivation to seek professional help. Some participants expressed surprise at discovering that a greater number of professionals in the workforce have lived experience than they had expected.

4.4.2 Social acceptability as a barrier to openness with colleagues

Several participants felt that there is a limit to which lived experience of professionals is acceptable. Serious mental illness or the use of certain coping strategies such as self-harm, alcoholism, and prescription medication, it was suggested, would be seen as unacceptable. Participants felt the need to either disguise or play down the extent of their lived experience or more dysfunctional coping mechanisms so that they became acceptable, for example saying they had a large glass of wine or could not sleep. Other participants even felt the need to hide their lived experience from colleagues and managers altogether. Although a couple of participants experienced this issue of social acceptability as getting better, it was still very much an issue and a preoccupation for them.

4.4.3 Greater acceptability of sharing lived experience in recovery settings

Those participants working in recovery settings described feeling more honest and authentic as a result of sharing more of themselves with clients. Participants valued the practice of co-facilitation and being able to share their own coping strategies with those they support. One participant described being there as a person first and a professional second. Her qualification helped her know what to do in a given situation, but she was not there strictly as a “professional”.

4.5 Changed Identity

4.5.1 Impact of lived experience on role identity

Some participants felt that they are better equipped emotionally to deal with other people’s distress and are calmer in a crisis as a consequence of having their own lived experience. This growth from adversity has also been described by mental health students (Gilbert et al., 2012) and supports the wounded healer phenomenon. One participant commented that clients have reported experiencing her self-disclosure as more authentic and influential than self-disclosure from PSWs. However, several participants felt that their lived experience was unhelpful in negatively distorting their perceptions of their own ability and confidence to fulfil their role. One participant explicitly stated her ambivalence towards her lived experience. This ambivalence was also alluded to by the majority of other participants. Similar to previous research (Goldberg et al., 2016), participants showed a preoccupation with integrating their role identity with lived experience.

4.5.2 Positive impact of lived experience on relationship with the self

All participants felt that their lived experience had benefitted them personally. Benefits included: greater mindfulness towards their wellbeing, being less critical and kinder towards themselves, and being more reflective. One participant experienced less shame after being given a diagnosis.

4.5.3 Impact of role identity on lived experience

For some participants, learning about psychological theory, models and interventions for use with clients also increased their understanding of their own experiences and helped to enhance their self-management skills. This is also supported by Gilbert et al. (2012). For two male participants, their role as mental health professionals gave them a false sense of security that they would not be affected by mental illness. As a consequence, they took longer to recognise and address their symptoms. The recent recovery focus in services has helped one participant feel more comfortable with her own experience. This suggests that professionals from non-psychology backgrounds may benefit personally as well as professionally from learning psychological theories and formulations of mental illness.

4.6 Experiencing the Organisation as Unsupportive

4.6.1 Staff wellbeing is not prioritised

The majority of participants felt that staff wellbeing is not prioritised in the workplace. As a consequence several shared a concern that a greater number of professionals will have lived experience and will need to take time off work. Suggestions made by participants to ameliorate the situation included staff taking greater care of themselves at work by taking breaks, and for all staff to have a wellness at work plan. Although mental health organisations do support and provide wellbeing initiatives, these are currently taken up on a voluntary basis.

4.6.2 Ironic lack of understanding and support

As was found in a large-scale survey of mental health professionals (DPT, 2009), participants expressed reluctance to disclose their lived experience to colleagues and managers, and several participants commented on the irony of this. Although the pressures on management were recognised by participants, they felt that there is an unpreparedness and lack of expertise with regard to managers meeting the needs of staff with mental illness. Two participants experienced negative and stressful return to work processes which they felt were arbitrary and prescriptive as opposed to meaningful and collaborative. This suggests that further training for managers to support employees with lived experience is required.

4.6.3 Burden of proof

All participants demonstrated a need to prove their wellness to others. Either by explicitly stating the pressure they feel under to constantly prove that they are well enough to do their role, or by implicitly informing the researcher, without prompting, how well they are. Some participants did this, for example, by describing how well they can self-manage, pointing out treatments they have not had to have and how many years it has been since they were last off sick.

4.7 Strengths of the Study

This novel study is at the forefront of opening up communication around mental health professionals with lived experience. A homogenous, purposively-selected sample was recruited for the study as required for IPA. There was a balance of male and female participants. All participants were motivated and engaged to take part. A pilot interview was useful in checking the validity of the interview schedule and the interviews were conducted sensitively. The researcher's questioning style improved after the first couple of interviews as she grew in confidence in her ability to be interrogative whilst being fundamentally participant-led. The analysis was thorough and the researcher adhered to IPA and quality guidelines as recommended by Smith et al. (2009). The researcher attempted to embody IPA's philosophical cornerstones of phenomenology, idiography, and hermeneutics throughout her work, and kept a reflective diary of the process. The study's emergent themes were well supported. Several transcript extracts and emergent themes were checked for face validity at various points during analysis by supervisors and a peer conducting a separate IPA study. This study has wide-ranging clinical, organisational, and research implications which will be discussed later in this chapter. All participants asked for feedback on the study's results and the majority also wanted to be involved in the dissemination of results.

4.7.1 Limitations of the Study

The sample included mostly professionals with a nursing qualification. It might have been useful to include a range of professionals to compare and contrast experiences from different professions. There was also a lack of ethnic diversity since all participants were white British. However, this was a self-selecting sample, nurses represent the majority of the mental health workforce, and the majority of employees are white British. The sample criteria excluded professionals who were not well enough to be at work, maybe for mental health reasons or stress. These professionals may have a different experience to the sample included in this study. However, it would have been unethical to contact them while they are on sick leave. The nine participants who were pooled from the Hidden Talents group are not representative of the wider workforce. Firstly the sample size is too small to be representative, and secondly professionals belonging to the Hidden Talents group value lived experience and provide some support to each other via this group, which may not be the case for other professionals with lived experience. Other professionals with lived experience may not feel as empowered or accepting of their lived experience.

It is recognised in IPA that data is co-constructed between the participant and the researcher. However, my role as trainee clinical psychologist may have influenced their responses in that I may be working with participants as colleagues in the future, or they may have affiliations with the university I attend. Therefore there is reason to suggest that a researcher not working in the same mental health services, and perhaps conducting the interviews away from their typical work setting, would have been beneficial. Having said that, professionals were able to say things without needing to be explicit because they knew the researcher would understand: things that they might not otherwise have said to someone outside of the system.

Nine participants was a relatively large sample for IPA, although still within the range of what is recommended. Fewer participants would have enabled a deeper analysis of responses. However, this was the first qualitative as well as IPA study of its kind, so including a greater number of participants was useful in generating as much data as possible. It was difficult to proportionately represent all of the participants' views in the results write up. This was due to word count restrictions and the fact that some participants were more self-disclosing than others.

4.8 Clinical, Organisational, and Research implications

4.8.1 Clinical Implications

Professionals with lived experience may have much to offer the recovery approach and client recovery. Their expression of increased empathy and greater understanding of clients may enhance their therapeutic relationships with clients and consequently improve outcomes. In addition to these personal and therapeutic factors, participants described using their lived experience to good effect in a practical way. This included the administering of interventions, normalising and validating clients' experiences, and by giving an inclination or self-disclosing having experienced something similar. As previously stated, the recovery college setting enables professionals to utilise their lived experience to a greater degree than in mainstream mental health services. It seems odd that this disparity should exist when mental health services also adopt a recovery focus. There is a need to review policy and guidelines on self-disclosure so that professionals feel supported to be more open and authentic with clients whom they support. Professionals should perhaps stop trying to present a perfect, infallible image of themselves, and instead they should aim to be human.

4.8.2 Organisational Implications

Professionals with lived experience should be recognised and valued by the organisation for their experiential and clinical understanding of mental health challenges. They are best placed to advocate and balance the needs of the service and client, since they have direct experience of both. Integration of PSWs into mental health services has been problematic. Gates et al. (2007) identified five main problems which interfere with integration according to PSWs: 1) stigmatised attitudes of staff towards the possibility of recovery, 2) role conflict and confusion, 3) issues around self-disclosure, 4) poorly operationalised roles, and 5) lack of social support and networking opportunities. Kemp and Henderson (2012) found that PSWs reported feeling excluded, under pressure due to high work load expectations, and received a lack of supervision.

The number of professionals with lived experience already embedded in the workforce is likely to far outweigh the number of PSWs entering the workforce. In order to make the most of this largely unacknowledged resource, mental health services need to tackle the iatrogenic stigma and extend the growing appreciation for lived experience to professionals, not just PSWs, and work with professionals with lived experience in order to become really recovery-focussed. One way to address stigma could be for professionals with lived experience, including the Hidden Talents group, to speak at team meetings, conferences, and produce articles through Trust communications. The most effective way of tackling stigma is through education and contact with those who are stigmatised against (Rusch et al., 2005). The integration of PSWs promotes this contact however professionals would be able to do this on a bigger scale and would therefore cause other professionals to question the false separateness between clients, PSWs, and professionals. Professionals with lived experience therefore have the power to help change the negative stereotypes of mental illness and raise awareness. Part of this is to recognise the benefits of lived experience and the potential for personal growth as a result. There is the possibility to also lead the way in other areas, such as promoting reflexivity and reflective practise, as well as by running group supervisions or workshops for colleagues. Clearer guidelines on self-disclosure and legislation would facilitate this process and help ease the anxiety that comes with the current uncertainty felt by professionals.

As emphasised by many of the participants in this study, mental health organisations may also need to address the mental illness of professionals in the workforce in order to avoid high rates of burnout, absence, and greater lived experience. Suggestions from participants included for all professionals to create a wellbeing at work action plan. This would endorse the importance of wellbeing for all and therefore not become a possible source of stigma if only attached to those with lived experience. Men are particularly at risk of either failing to recognise symptoms or not help-seeking. Therefore this approach, if made mandatory, would promote self-care and open up the conversation. This could be done within supervision, appraisals, or through a buddy system. Training is required to help managers best support professionals with lived experience in a collaborative and positive way, and to become more vigilant to stigmatising behaviours and how to address them. Other suggestions were for all staff to take proper lunch breaks and to learn greater self-compassion. This could be achieved through the organisation providing self-compassion or Acceptance and Commitment Therapy (ACT) workshops, and could be co-produced and delivered by clients and professionals.

Respite from clinical work could also prevent staff absence due to sickness, whilst at the same time promoting their recovery. One participant felt that if she had been allowed to take a break from her clinical role and replace it temporarily with administration or working within the recovery college, she would not have needed to take sick leave. This highlights the need for greater flexibility on the part of the organisation in how they support their staff. The subsequent return-to-work process needs to be made more standardised and structured so that both managers and professionals feel supported, whilst enabling professionals to play an active role in the process.

4.8.3 Research Implications

There are many exciting possible directions for future research in this area. Firstly, a similar IPA study exploring the experiences of professionals with lived experience unaffiliated with Hidden Talents might offer a very different perspective. Or indeed a larger scale quantitative study to find out whether the phenomena of stigma and self-stigma are experienced in a more widespread way by mental health professionals with lived experience. Secondly, how clients experience mental health professionals with lived experience would fill an important gap in the literature. Recent research investigating clients' views of PSWs suggest that they are seen as role models (Walker et al., 2013) which may or may not be the case for professionals. Capturing the views of clients is vitally important in assessing the real value of professionals with lived experience. A qualitative study using IPA for rich and idiographic understandings, or to a lesser extent thematic analysis, would open up this research area. The latter could be conducted with greater numbers. Thirdly, it would be advantageous to investigate whether professionals with lived experience also help promote self-esteem, self-efficacy, self-management of difficulties, social inclusion, engagement, and social networks as it is claimed PSWs can (Repper & Carter, 2011). This would require a larger scale study using a quantitative or mixed-methods design. Fourthly, there is a need for research to examine whether the impact of self-disclosure is mediated by the role of the professional or the client's perceptions of the role, as suggested by one participant in this study. This would help inform guidelines on self-disclosure and use of lived experience. Fifthly, there is a need for more research into self-disclosure in a mental health context as current research falls within a psychotherapy and counselling context. Sixthly, a more ethnically and culturally diverse sample recruited for a similar IPA study would highlight specific issues which need to be addressed to support professionals. Finally, further research is needed to identify the specific ways in which professionals from different disciplines can be best supported, since it is possible that lived experience is considered more or less acceptable depending on the role. Greater attention perhaps needs to be paid to professions where lived experience is not inherently valued, unlike the therapy professions, as these professionals may be more likely to hide their lived experience and suffer in silence.

4.9 Conclusion

Over the past two decades there have been numerous studies focused on exploring the effectiveness of peer support, making PSWs the quickest growing occupational group in mental health services. However, there is a fundamental lack of evidence to support this trend. Furthermore, professionals with their own lived experience have been largely overlooked; a spurious oversight when it is well-known that health-, including mental health professionals, experience higher rates of stress and emotional distress than the general population. This study has shed light on the views and experiences of mental health professionals with lived experience in the workplace. The findings related to the influence of lived experience on the professionals' identity and self-care, their clinical practice, and their working relationships with colleagues and the organisation. Participants valued their lived experience, especially in terms of building strong therapeutic relationships with clients. It will perhaps one day be unthinkable that the lived experience of professionals was not always valued and utilised to enhance clients' recovery; after all, it is the lived experience of professionals which might close the gap between "them and us", which PSWs help to bridge.

Reflection 5. Final Reflection

Throughout the research my understandings grew as I moved around the hermeneutic circle. The similarities and differences within the corpus helped illuminate the meanings made by individual participants, as well as the whole, facilitating my interpretations of them. I found myself in a constant process of hermeneutic circling throughout the study and write up, as I became more embedded in the data and wider research, which I enjoyed. It has been a great learning opportunity for many reasons. Firstly, I have become aware of the issues faced by professionals with lived experience, with whom I also identify, which will be useful in my career as a clinical psychologist. Secondly, I have learnt many research skills and now have a greater appreciation and interest in the significant philosophical origins of qualitative methodology. Thirdly, I feel I have improved my reflective practice through consistent and focused reflexivity, beneficial for my clinical practice and future research endeavours.

At this final point in the study I cannot help but feel an array of mixed emotions. The main emotion which strikes me is a feeling of sadness that mental health stigma still exists in organisations treating mental illness. It was also surprising to me that some participants also held stigmatising views. This I had not expected. However, I also feel cautiously optimistic about the future of professionals with lived experience.

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Appendices

Appendix A. Ethical Approval Documents

Norfolk and Suffolk NHS
NHS Foundation Trust

Research and Development
The Knowledge Centre
Hellesdon Hospital
Drayton High Road
Norwich
NR6 5BE

Telephone 01603 421255
E mail: RDofficemailbox@nsft.nhs.uk

Miss Harriet Gough
Room 2.30 Postgraduate Office
Elizabeth Fry Building
University of East Anglia
Norwich NR4 7TJ

27th April 2015

Dear Miss Gough,

Re: RD #15 168637: Mental health staff's lived experiences of mental health challenges

Thank you for submitting the above project for local research governance approval. I am pleased to inform you that your project has been given full approval and you may begin your research at the following site:

- Norfolk & Suffolk NHS Foundation Trust

I have enclosed two copies of the Standard Terms and Conditions of Approval. Please sign both copies returning one copy to the Research and Development office, at the above address, and keeping the other in your study file. Failure to return the standard terms and conditions may affect the conditions of approval. Under the agreed Standard Terms and Conditions of Approval you must inform the R&D department of any proposed changes to this study and submit annual progress reports to the R&D department.

Any researcher(s) whose substantive employer is not the Norfolk & Suffolk NHS Foundation Trust must have a Letter of Access or Honorary Research contract and evidence of Good Clinical Practice (GCP) training before coming on site to conduct their research in this project. Please note that you cannot take part in this study until you have this documentation. If a Letter of Access / Honorary Research Contract has not been issued – please contact us immediately.

If you have any queries regarding this or any other project, please contact, Tom Rhodes, Senior Research Facilitator, at the above address.

The reference number for this study is: **RD #15 168637,** and this should be quoted on all correspondence.

Yours sincerely,

Bonnie Teague
Research Manager

Chair: Gary Page
Chief Executive: Michael Scott
Trust Headquarters: Hellesdon Hospital,
Drayton High Road, Norwich, NR6 5BE
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Appendix A. Ethical Approval Documents (continued)

Faculty of Medicine and Health Sciences Research Ethics Committee

University of East Anglia

Harriet Gough
MED

Research & Enterprise Services
West Office (Science Building)
University of East Anglia
Norwich Research Park
Norwich, NR4 7TJ

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8/5/15

Dear Harriet,

**Project title: Exploring the experiences of mental health professionals with personal lived experience of mental health challenges:
A qualitative study**

Reference: 2014/2015 - 55

The submission of your above proposal has been considered by the Faculty Research Ethics Committee and we can confirm that your proposal has been approved.

Please could you ensure that any further amendments to either the protocol or documents submitted are notified to us in advance and also that any adverse events which occur during your project are reported to the Committee. Please could you also arrange to send us a report once your project is completed.

Yours sincerely,

Mark Wilkinson
Chair FMH Research Ethics Committee

CC Deirdre Williams, Paul Fisher

Appendix B. Participant Information Sheet

v2 11.03.15

University of East Anglia

Doctoral Programme in Clinical Psychology

Participant Information Sheet

Study title

Exploring the experiences of mental health professionals with personal lived experience of mental health challenges:

A qualitative study

Part 1

Invitation and brief summary

Hello. We would like to introduce you to the Chief Investigator (CI) and the study. The CI is Harriet Gough. Harriet is studying to become a Clinical Psychologist at the University of East Anglia (UEA). She has an interest in mental health professionals own experiences of mental health challenges and will be carrying out this piece of research as part of her training course. This study is supervised by Clinical Tutors and Researchers, Dr Deirdre Williams and Dr Paul Fisher at UEA.

We would like to invite you to take part in our study which aims to explore the experiences of mental health professionals who identify as having their own personal experience of mental health challenges.

Before you decide, we would like you to understand why the research is being done and what it would involve for you. So please consider this leaflet carefully.

Why are we doing this research?

There is a rapidly growing movement towards greater recovery-orientated practice in mental health care on local as well as international levels. Recovery focuses on building a meaningful life with or without the presence of mental health symptoms, with the emphasis being on hope, self-determination and self-management (Shepherd et al., 2008). The recovery approach is being supported by organisational change through recovery colleges and the growing numbers of peer support workers who are employed on the basis of their experience of mental health challenges. Although there is a growing appreciation for the value of lived experience there is very little research on the personal lived experience of mental health professionals. This study seeks to address this gap. There are several important clinical implications for this study. Firstly, the findings may help inform advisory guidelines on how to use lived experience. Secondly, it may help identify issues on an organisational level which may impede the implementation of the recovery approach, such as stigma. Finally, it may help formulate any challenges in having this kind of dual role which could help develop training and support for mental health professionals and peer support workers.

Why have I been invited to take part?

You have been invited to take part because you are a member of Hidden Talents. We hope to involve a minimum of 8 to a maximum of 10 mental health professionals in this research. For the purpose of the study, we define lived experience as having your own personal experience of having mental health challenges.

Do I have to take part?

No, it is up to you. If you do not wish to take part, this will not affect your medical care, legal rights or job role in any way. If you agree to take part, we will ask you to meet the CI to have a semi-structured interview on NHS premises local to you. You are free to withdraw from the study at any time and without giving a reason up until the data has been analysed. This is because individual responses cannot be easily removed once anonymised.

What would taking part involve?

The study involves a one-off interview which will last between 60 to 90 minutes. The interview will take place in a quiet confidential room in a non-clinical area on NHS premises at a time convenient to you. The interview will be audio recorded as it is important that the information from the interview and your experiences are accurately represented. After the interview you will be given the opportunity to arrange to meet with the CI again to read the interview transcript to check its accuracy. This is optional, however if you would like to, a date and time will be arranged for this short meeting to take place within one month of the interview.

Once you have read this leaflet and feel that you would like to take part in this study, you can contact the CI to arrange a time for the interview.

What will I have to do?

The interview will involve the CI asking you a few open-ended questions relating to your experiences of being a mental health professional with your own lived experience. We would also like you to fill in a short demographic questionnaire. This is so that we can describe the background of the participants taking part in the study, for example job role and age bracket. It is important to note however that the demographic information is to give context for the study and your anonymity will not be compromised. Also, you do not have to answer all of the questions on the demographic questionnaire if you do not want to and you will still be able to take part in the study.

What are the possible benefits of taking part?

In the current climate of NHS mental health services there is a growing awareness that lived experience is helpful in facilitating a recovery-orientated approach when working with clients in promoting hope and engagement. Peer support endeavours are a vital part of this. However, there is no research to date which has looked into what it is like to be a mental health professional with lived experience of personal mental health challenges. As such, little is known about what it is like to have both clinical and lived experience and how this can be utilised and supported. Also there is much to learn about how lived experience of qualified mental health professionals can contribute to recovery-focussed services.

It is hoped that by taking part in the study, you may like the opportunity to share your views and experiences all of which will be written up anonymously and disseminated to a wider audience.

If you are still interested, please go to Part 2 of the information sheet or contact the researcher for further information.

Contact details

Thank you for reading so far. If you have any questions or are interested in taking part, please feel free to contact the CI: **Harriet Gough, Trainee Clinical Psychologist.**

You can call 07718 202334 and speak to Harriet Gough, CI for this project.

Alternatively, you can write to Harriet at: C/O Postgraduate Research Office, Room 2.30, Elizabeth Fry Building, Faculty of Health and Medical Sciences, University of East Anglia, Norwich, NR4 7TJ.

Part 2

Will anyone else know that I am taking part?

We will only tell those who have a need or right to know that you are involved in this research. All contact will be made through the CI and the gatekeeper of the Hidden Talents group who has agreed to support this study. Also should you wish to speak to the primary research supervisor you are welcome to do so. Their contact details can be found at the end of this leaflet.

Will my responses be kept confidential?

Extracts from the interview will be used for educational purposes, for a doctoral thesis project and in any related publications. Demographic information will not be able to be linked with direct quotes used in the write up of the thesis and participants’ quotes will be anonymised using a number. Therefore, any personally identifiable data will not be used during the course of analysing the data or in any reports in order to protect your anonymity.

The CI will have access to data which identifies you from the study. Your demographic information will be stored separately from your responses you give in the interview, which only the researchers have access to. All storage and use of data will conform to UEA and NHS policies. The data will be held securely and retained for a 10 year period under locked conditions at the University of East Anglia, after which the study data will be disposed of securely in line with NHS procedures.

The CI has a duty of care and as such confidentiality may be broken in cases where risk of harm to the participant or others has been identified. In the event of this happening, concerns will be raised with research supervisors and external agencies where appropriate.

What will happen to the results of the research study?

The results of the research will be used for a doctoral thesis project and may be published in the future. Should you wish to be receive a copy of the findings you will be able to do so by ticking a box on the demographic questionnaire.

What if I decide I do not wish to carry on with the study?

If you do not wish to continue with the study, you are free to withdraw from the research at any time up until the point of data analysis and without giving a reason. Your medical care, legal rights and job role will not be affected in any way.

What will happen if I become upset during the interview?

If you become upset or distressed during the interview, we will discuss whether we are able to continue or whether you would like to stop the interview or withdraw from the study. The researcher will remind you of the support options available to you should you wish to seek them.

What if there is a problem?

If you have a concern about any aspect of this study, you should call 07718 202334 and ask to speak to Harriet Gough, CI, or contact the research supervisors, Dr Deirdre Williams on 01603 593581 or Dr Paul Fisher on 01603 593084.

We will do our best to answer your questions, however if you remain unhappy about the study, the normal NHS complaints mechanism is available to you if you wish to complain about any aspect of the study.

Independent information and advice about taking part in research studies is available from the Patient Advice and Liaison Service (PALS) office. To contact PALS please phone: 01603 421191 or email: pals@nsft.nhs.uk

Who is organising the research?

The organisers of this project are the University of East Anglia.

Who has reviewed the research study?

This study has been reviewed by NSFT Research and Development Department and the FMH Ethics Committee at UEA.

Thank you for reading this leaflet.

Appendix C. Participant Consent Form

v2 11.03.15

University of East Anglia

Centre Number: Participant Identification Number for this trial:

CONSENT FORM

Title of Project: Exploring the experiences of mental health professionals with personal lived experience of mental health challenges: A qualitative study.

Name of Chief Investigator: Harriet Gough

Please initial box

1. I confirm that I have read the information sheet dated 11/03/2015 (version 2) 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 the project supervisors will have access to anonymised data purely for the purposes of training and learning. ☐

3. I understand that my participation is voluntary and that I am free to withdraw any time up until the point of data analysis without giving any reason and without my medical care or legal rights being affected. ☐

4. I give my consent to take part in a semi-structured interview and for an audio recording of this to be made. I understand that this is for the purposes of transcribing information and that recordings will be stored under locked conditions. ☐

5. I understand that publication of quotations will be anonymised using a number and quotes are not associated with demographic information. ☐

6. I understand that I do not need to complete all of the demographic information questionnaire to take part in the study. ☐

7. I agree to take part in the above study. ☐

________________	________________	________________
Name of Participant	Date	Signature
________________	________________	________________
Name of Researcher	Date	Signature

When completed: 1 for participant; 1 for researcher site file;

Appendix. D Participant Demographic Questionnaire

University of East Anglia

v2 11.03.15

Centre Number: Participant Identification Number for this trial:

Study Title: Exploring the experiences of mental health professionals with personal lived experience of mental health challenges: A qualitative study

Demographic Form

1. Please **state** your job role
   ……………………………………………………
2. Please **circle** your age bracket: **20 – 30** **31- 40** **41 – 50** **51 – 60** **61+**
3. Please **state** the **nature and duration** of your lived experience
   E.g. depression, 12 years

   ……………………………………………………………………….
4. Did you receive a formal diagnosis by a clinician? **Yes / No**
5. Please state the **type(s)** of mental health service you have received
   e.g. IAPT, in-patient, community, private counselling etc.

   …………………………………………………………………………………………..
6. Please **circle** how long you have been working for the Trust?
   0 – 11mths 1 – 2 yrs 3 – 5 yrs 6 – 10 yrs 11 – 15 yrs 16 – 20 yrs 21+ yrs
7. Please state how long (in months or years) you have worked as a mental health professional

   …………………………………….

- I wish to receive a copy of the results from the study once the study has ended ***(please tick).*** ☐
- I wish to be involved in the dissemination of the study's results ***(please tick).*** ☐

Appendix E. Interview Schedule

Interview Schedule

'I am really keen to hear about your experience, thoughts and feelings, so I will say very little, so that you can do most of the talking – it will be like a one-sided conversation. If it's ok with you, I may write down notes while you're talking to help me remember things you've said.

Some questions might seem obvious or repetitive, but that is because I will be trying to get to grips with how you understand things as everyone has different ways of understanding things.

Feel free to only share what you want to. Also there are no right or wrong answers.

Please see this as a space and an opportunity for you to tell your story. Please take your time, there is no rush. Do you have any questions?'

Interviewer questions

1. **'Can you tell me a bit about your journey into becoming a mental health professional?'**
   - *Prompt: What influenced your decision to work in mental health?*

2. **'Can you tell me a bit about your lived experience?'**

3. **'Can you tell me in as much detail as possible what having lived experience at work is like for you?'**
   - *Prompts: within the organisation, working with clients, and your relationships with colleagues?*

4. **Can you tell me about any times - if any - that you feel lived experience has influenced or been a part of your work/role in anyway?**
   - *Prompts: within the organisation, working with clients, and your relationships with colleagues?*

During interview

- **Can you give me any examples of that? Describe times/instances when that has happened? What was that like?**

Questions to ask towards the end

a) **I am aware my questions have shaped about what we have talked about. I would like to know if there are things that I haven't asked about that you would like to talk to me about?**

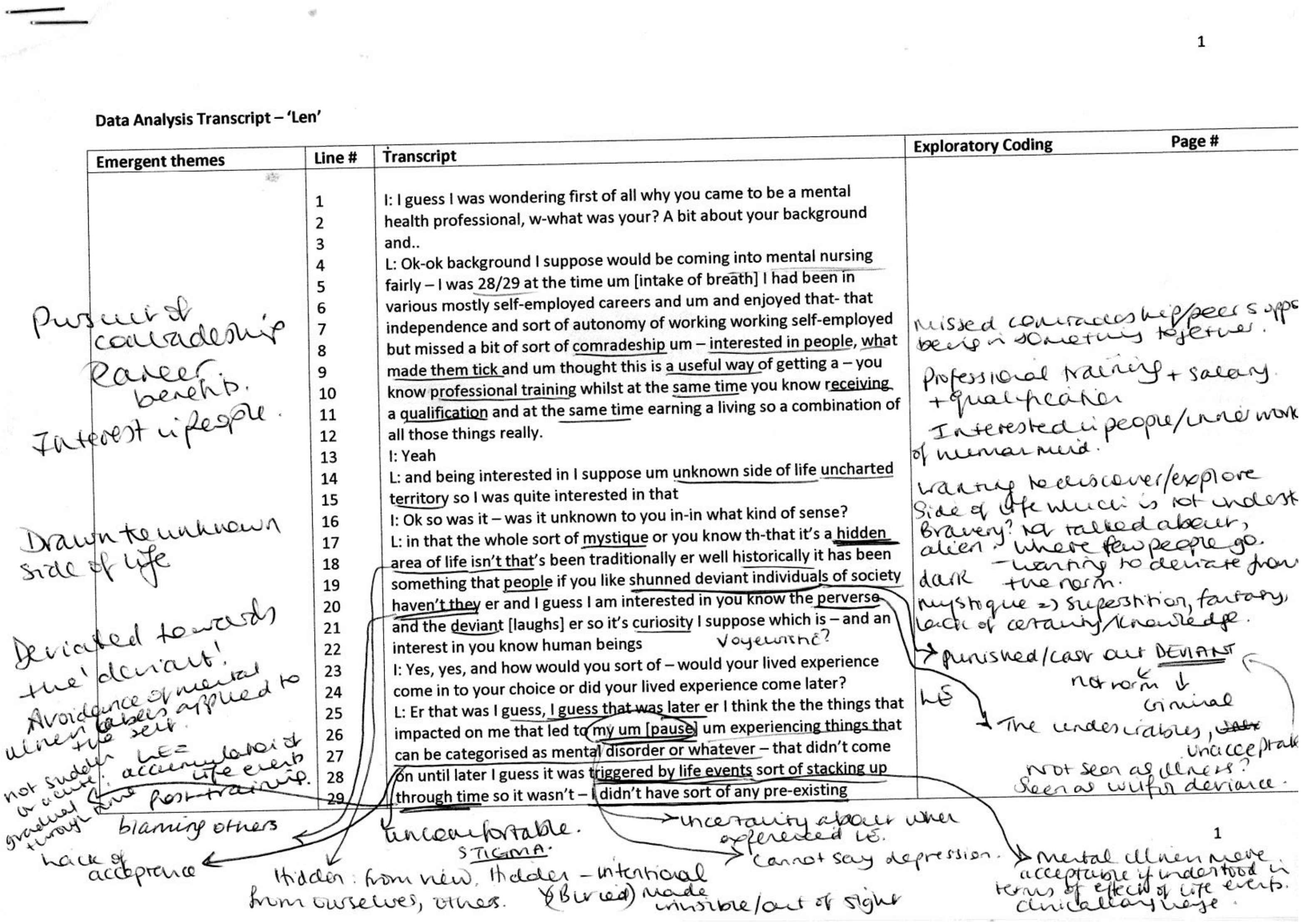
b) **Before/when you signed up for the interview, were there any particular things that you wanted to say?**

c) **How did you feel when you knew about this study?**

d) **What has it been like talking to me about your experiences? How are you feeling now?**

Thank you very much for sharing your views and experiences with me.

Appendix F. Example Extract of Initial Analysis: Coding and Emergent Themes



Data Analysis Transcript – 'Len'

Emergent themes	Line #	Transcript	Exploratory Coding	Page #
	1–3	I: I guess I was wondering first of all why you came to be a mental health professional, w-what was your? A bit about your background and..		
Pursuit of camradeship Career benefits. Interest in people.	4–12	L: Ok-ok background I suppose would be coming into mental nursing fairly – I was 28/29 at the time um [intake of breath] I had been in various mostly self-employed careers and um and enjoyed that- that independence and sort of autonomy of working working self-employed but missed a bit of sort of comradeship um – interested in people, what made them tick and um thought this is a useful way of getting a – you know professional training whilst at the same time you know receiving a qualification and at the same time earning a living so a combination of all those things really.	missed camradeship/peers suppo being in something together. Professional training + salary + qualification Interested in people/inner work of human mind.	
	13	I: Yeah		
Drawn to unknown side of life	14–15	L: and being interested in I suppose um unknown side of life uncharted territory so I was quite interested in that	wanting to discover/explore side of life which is not underst	
	16	I: Ok so was it – was it unknown to you in-in what kind of sense?		
Deviated towards the 'deviant'!	17–22	L: in that the whole sort of mystique or you know th-that it's a hidden area of life isn't that's been traditionally er well historically it has been something that people if you like shunned deviant individuals of society haven't they er and I guess I am interested in you know the perverse and the deviant [laughs] er so it's curiosity I suppose which is – and an interest in you know human beings Voyeuristic?	Bravery? not talked about, alien. Where few people go. dark –wanting to deviate from the norm. mystique => superstition, fantasy, lack of certainty/knowledge. → punished/cast out DEVIANT not norm ↓ criminal → The undesirables, ~~dark~~ unacceptable	
	23–24	I: Yes, yes, and how would you sort of – would your lived experience come in to your choice or did your lived experience come later?		
Avoidance of mental illness labels applied to the self. not sudden or acute; gradual through time LE= accumulation of life events post-training.	25–29	L: Er that was I guess, I guess that was later er I think the the things that impacted on me that led to my um [pause] um experiencing things that can be categorised as mental disorder or whatever – that didn't come on until later I guess it was triggered by life events sort of stacking up through time so it wasn't – I didn't have sort of any pre-existing	LE not seen as illness? Seen as wilful deviance.	1

blaming others

lack of acceptance

uncomfortable.

STIGMA.

Hidden: from view, Hidden – intentional from ourselves, others. (Buried) made invisible/out of sight

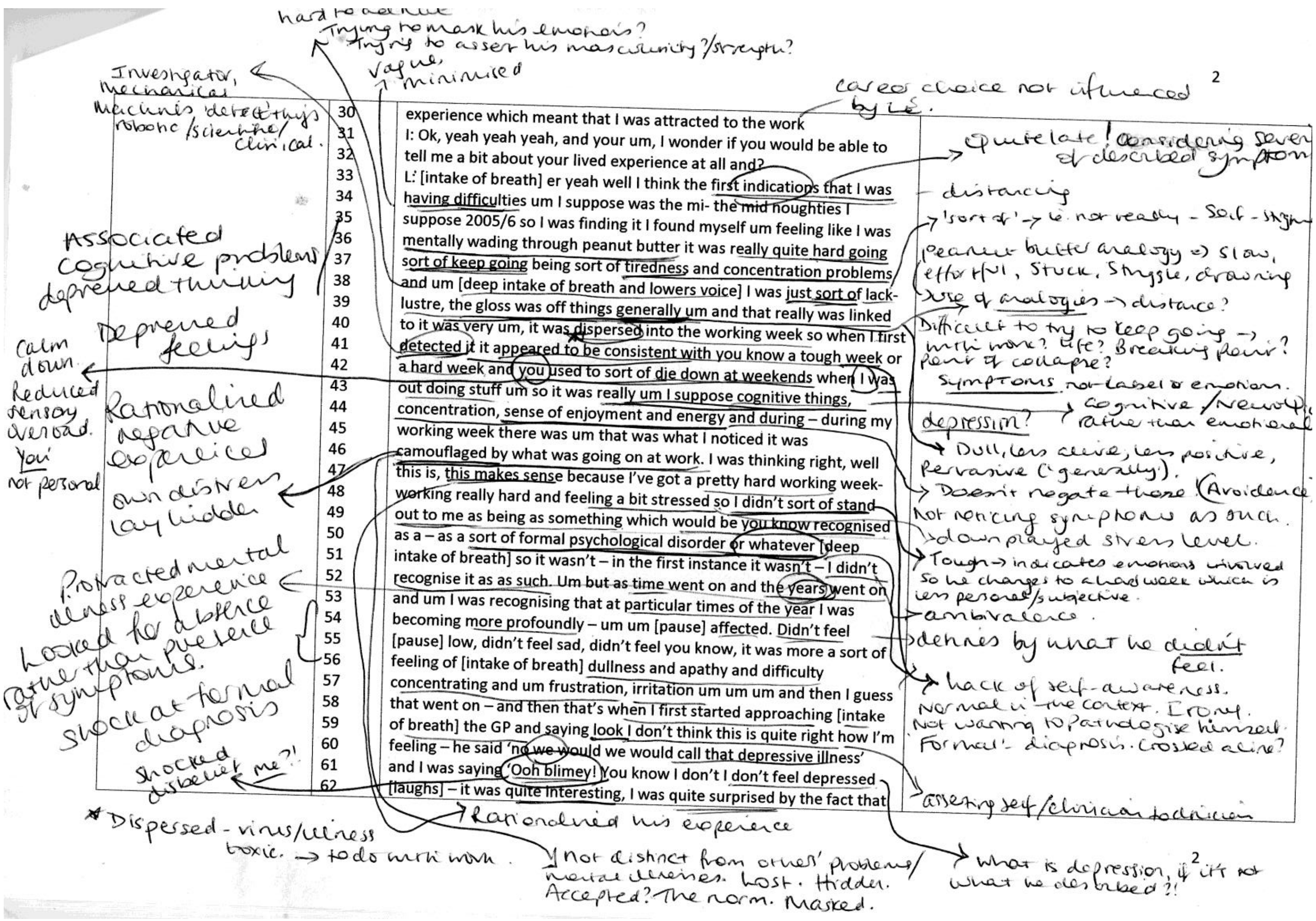
→ uncertainty about when experienced LE.

→ cannot say depression.

→ mental illness more acceptable if understood in terms of effects of life events. clinically vague.

1

Appendix F. Example Extract of Initial Analysis: Coding and Emergent Themes (continued)



experience which meant that I was attracted to the work

I: Ok, yeah yeah yeah, and your um, I wonder if you would be able to tell me a bit about your lived experience at all and?

L: [intake of breath] er yeah well I think the first indications that I was having difficulties um I suppose was the mi- the mid noughties I suppose 2005/6 so I was finding it I found myself um feeling like I was mentally wading through peanut butter it was really quite hard going sort of keep going being sort of tiredness and concentration problems and um [deep intake of breath and lowers voice] I was just sort of lack-lustre, the gloss was off things generally um and that really was linked to it was very um, it was dispersed into the working week so when I first detected it it appeared to be consistent with you know a tough week or a hard week and you used to sort of die down at weekends when I was out doing stuff um so it was really um I suppose cognitive things, concentration, sense of enjoyment and energy and during – during my working week there was um that was what I noticed it was camouflaged by what was going on at work. I was thinking right, well this is, this makes sense because I've got a pretty hard working week-working really hard and feeling a bit stressed so I didn't sort of stand out to me as being as something which would be you know recognised as a – as a sort of formal psychological disorder or whatever [deep intake of breath] so it wasn't – in the first instance it wasn't – I didn't recognise it as as such. Um but as time went on and the years went on and um I was recognising that at particular times of the year I was becoming more profoundly – um um [pause] affected. Didn't feel [pause] low, didn't feel sad, didn't feel you know, it was more a sort of feeling of [intake of breath] dullness and apathy and difficulty concentrating and um frustration, irritation um um um and then I guess that went on – and then that's when I first started approaching [intake of breath] the GP and saying look I don't think this is quite right how I'm feeling – he said 'no we would we would call that depressive illness' and I was saying 'Ooh blimey! You know I don't I don't feel depressed [laughs] – it was quite interesting, I was quite surprised by the fact that

hard to define
Trying to mask his emotions?
Trying to assert his masculinity?/strength?
vague, minimised

Investigator, Mechanical
Machines, detecting things
robotic/scientific/clinical.

Associated cognitive problems
depressed thinking

Depressed feelings

Calm down.
Reduced sensory overload.
'You' not personal

Rationalised negative experience

own distress lay hidden

Protracted mental illness experience

Looked for absence rather than presence of symptoms.

Shock at formal diagnosis

Shocked disbelief me?!

career choice not influenced by LE.

2

Quite late! considering sever of described symptom

– distancing

→ 'sort of' → i.e. not really – Self-stigm

Peanut butter analogy ⇒ slow, effortful, stuck, struggle, drowning

Use of analogies → distance?

Difficult to try to keep going → with work? Life? Breaking point? Point of collapse?

Symptoms not label or emotion.

depression?

→ cognitive/Neurol rather than emotional

→ Dull, less alive, less positive, Pervasive ('generally').

→ Doesn't negate those (Avoidance

Not noticing symptoms as such.

→ down played stress level.

→ Tough → indicates emotions involved so he changes to a hard week which is less personal/subjective.

→ ambivalence.

→ defines by what he didn't feel.

→ Lack of self-awareness. Normal in the context. Irony. Not wanting to pathologise himself. 'Formal' diagnosis. Crossed a line?

→ asserting self/clinician to clinician

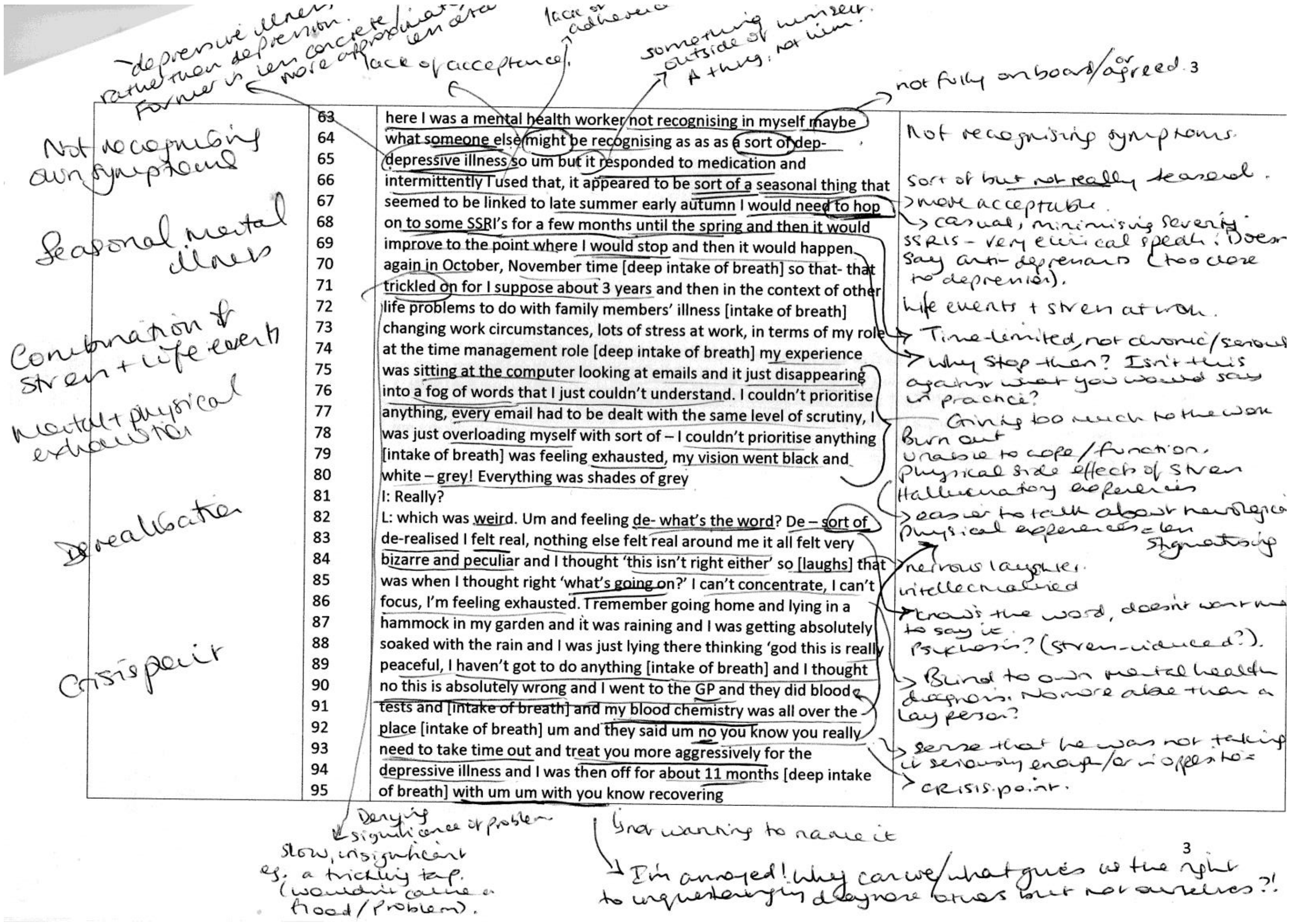
* Dispersed – virus/illness toxic. → to do with work.

→ Rationalised his experience

→ Not distinct from others' problems/mental illnesses. Lost. Hidden. Accepted? The norm. Masked.

→ What is depression, if it's not what he described?!

Appendix F. Example Extract of Initial Analysis: Coding and Emergent Themes (continued)



—depressive illness, rather than depression. Former is less concrete/ more approximate, less direct

lack of acceptance.

lack or adherence

something within self. outside of
A thing; not him.

not fully onboard/or agreed. 3

Not recognising own symptoms Seasonal mental illness Combination of stress + life events Mental + physical exhaustion Derealisation Crisis point	here I was a mental health worker not recognising in myself maybe what someone else might be recognising as as as a sort of dep- depressive illness so um but it responded to medication and intermittently I used that, it appeared to be sort of a seasonal thing that seemed to be linked to late summer early autumn I would need to hop on to some SSRI's for a few months until the spring and then it would improve to the point where I would stop and then it would happen again in October, November time [deep intake of breath] so that- that trickled on for I suppose about 3 years and then in the context of other life problems to do with family members' illness [intake of breath] changing work circumstances, lots of stress at work, in terms of my role at the time management role [deep intake of breath] my experience was sitting at the computer looking at emails and it just disappearing into a fog of words that I just couldn't understand. I couldn't prioritise anything, every email had to be dealt with the same level of scrutiny, I was just overloading myself with sort of – I couldn't prioritise anything [intake of breath] was feeling exhausted, my vision went black and white – grey! Everything was shades of grey I: Really? L: which was weird. Um and feeling de- what's the word? De – sort of de-realised I felt real, nothing else felt real around me it all felt very bizarre and peculiar and I thought 'this isn't right either' so [laughs] that was when I thought right 'what's going on?' I can't concentrate, I can't focus, I'm feeling exhausted. I remember going home and lying in a hammock in my garden and it was raining and I was getting absolutely soaked with the rain and I was just lying there thinking 'god this is really peaceful, I haven't got to do anything [intake of breath] and I thought no this is absolutely wrong and I went to the GP and they did blood tests and [intake of breath] and my blood chemistry was all over the place [intake of breath] um and they said um no you know you really need to take time out and treat you more aggressively for the depressive illness and I was then off for about 11 months [deep intake of breath] with um um with you know recovering	Not recognising symptoms. Sort of but not really seasonal. > more acceptable. > casual, minimising severity: SSRIs – very clinical speak. Doesn't say anti-depressants (too close to depression). Life events + stress at work. > Time-limited, not chronic/serious > Why stop then? Isn't this against what you would say in practice? Giving too much to the work Burn out Unable to cope/function. Physical side effects of stress Hallucinatory experiences > easier to talk about neurological physical experiences = less stigmatising > nervous laughter. intellectualised > Knows the word, doesn't want me to say it Psychosis? (stress-induced?). > Blind to own mental health diagnosis. No more able than a lay person? > sense that he was not taking it seriously enough/or in opposite = > crisis point.

Denying significance of problem

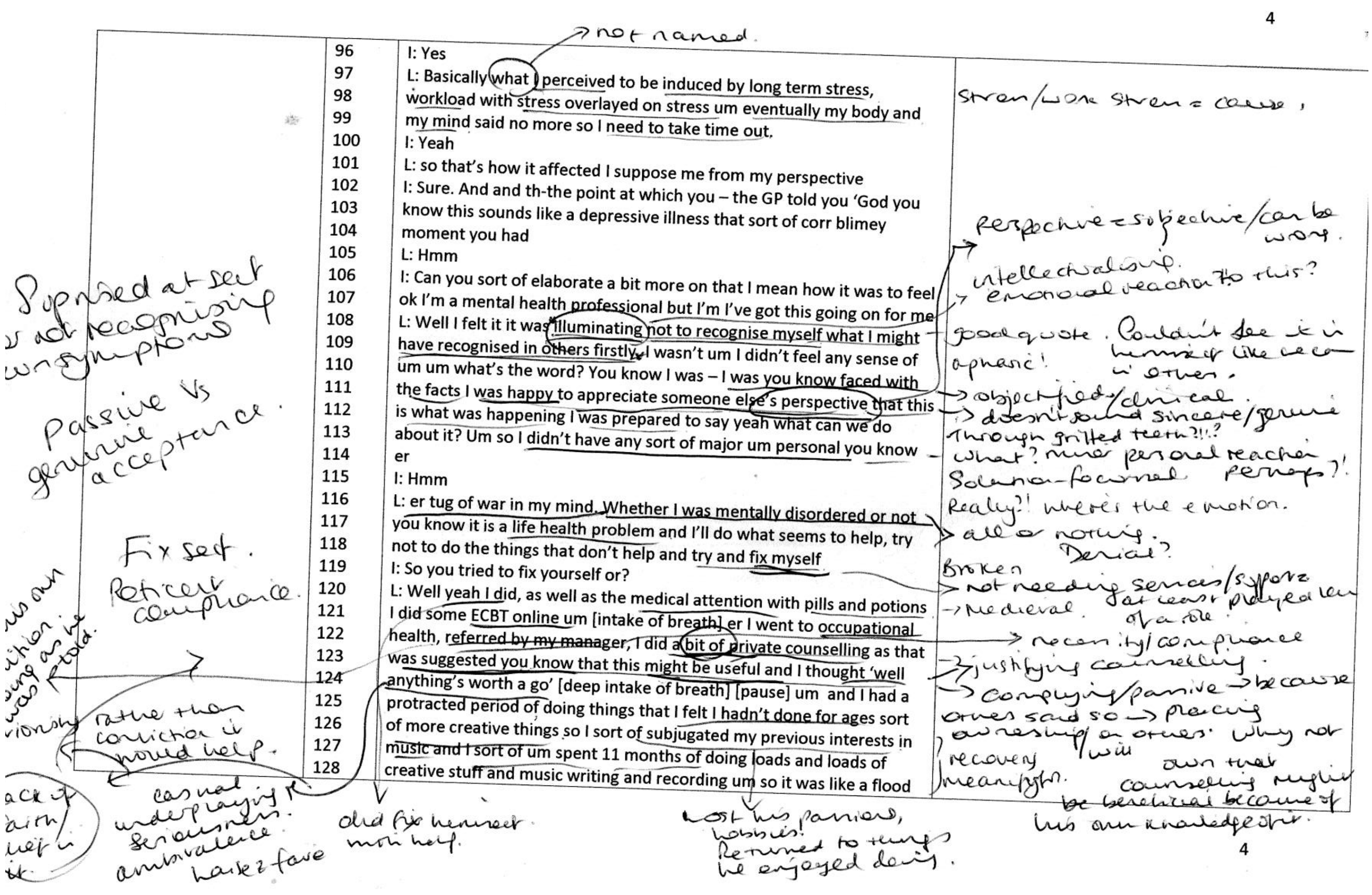
Slow, insignificant
eg. a trickling tap.
(wouldn't cause a flood/problem).

Not wanting to name it

I'm annoyed! Why can we/what gives us the right to unquestioningly diagnose others but not ourselves?!

3

Appendix F. Example Extract of Initial Analysis: Coding and Emergent Themes (continued)



4

→ not named.

	96	I: Yes	
	97	L: Basically what I perceived to be induced by long term stress,	Stress/work stress = cause,
	98	workload with stress overlayed on stress um eventually my body and	
	99	my mind said no more so I need to take time out.	
	100	I: Yeah	
	101	L: so that's how it affected I suppose me from my perspective	
	102	I: Sure. And and th-the point at which you – the GP told you 'God you	
	103	know this sounds like a depressive illness that sort of corr blimey	Perspective = subjective/can be wrong.
	104	moment you had	
	105	L: Hmm	
Suprised at self for not recognising own symptoms	106	I: Can you sort of elaborate a bit more on that I mean how it was to feel	intellectualising.
	107	ok I'm a mental health professional but I'm I've got this going on for me	→ emotional reaction to this?
	108	L: Well I felt it it was illuminating not to recognise myself what I might	good quote. Couldn't see it in
	109	have recognised in others firstly, I wasn't um I didn't feel any sense of	epiphanic! himself like he can
	110	um um what's the word? You know I was – I was you know faced with	in others.
Passive vs genuine acceptance.	111	the facts I was happy to appreciate someone else's perspective that this	→ objectified/clinical.
	112	is what was happening I was prepared to say yeah what can we do	→ doesn't sound sincere/genuine
	113	about it? Um so I didn't have any sort of major um personal you know	Through gritted teeth?!!?
	114	er	What? minor personal reaction perhaps?!
	115	I: Hmm	Solution-focused
	116	L: er tug of war in my mind. Whether I was mentally disordered or not	Really?! where's the emotion.
	117	you know it is a life health problem and I'll do what seems to help, try	→ all or nothing.
Fix self.	118	not to do the things that don't help and try and fix myself	Denial?
	119	I: So you tried to fix yourself or?	Broken
Reticent compliance.	120	L: Well yeah I did, as well as the medical attention with pills and potions	→ not needing services/support at least played less of a role.
	121	I did some ECBT online um [intake of breath] er I went to occupational	→ medieval.
	122	health, referred by my manager, I did a bit of private counselling as that	→ necessity/compliance
	123	was suggested you know that this might be useful and I thought 'well	→ justifying counselling.
	124	anything's worth a go' [deep intake of breath] [pause] um and I had a	→ complying/passive → because
rather than conviction it would help.	125	protracted period of doing things that I felt I hadn't done for ages sort	others said so → placing
	126	of more creative things so I sort of subjugated my previous interests in	ownership/will on others. Why not
	127	music and I sort of um spent 11 months of doing loads and loads of	recovery own that
	128	creative stuff and music writing and recording um so it was like a flood	meaningful. counselling might be beneficial because of his own knowledge etc.

s own
ition
ing as he
was told.

ionship

casual underplaying R seriousness.
ambivalence
laisez faire

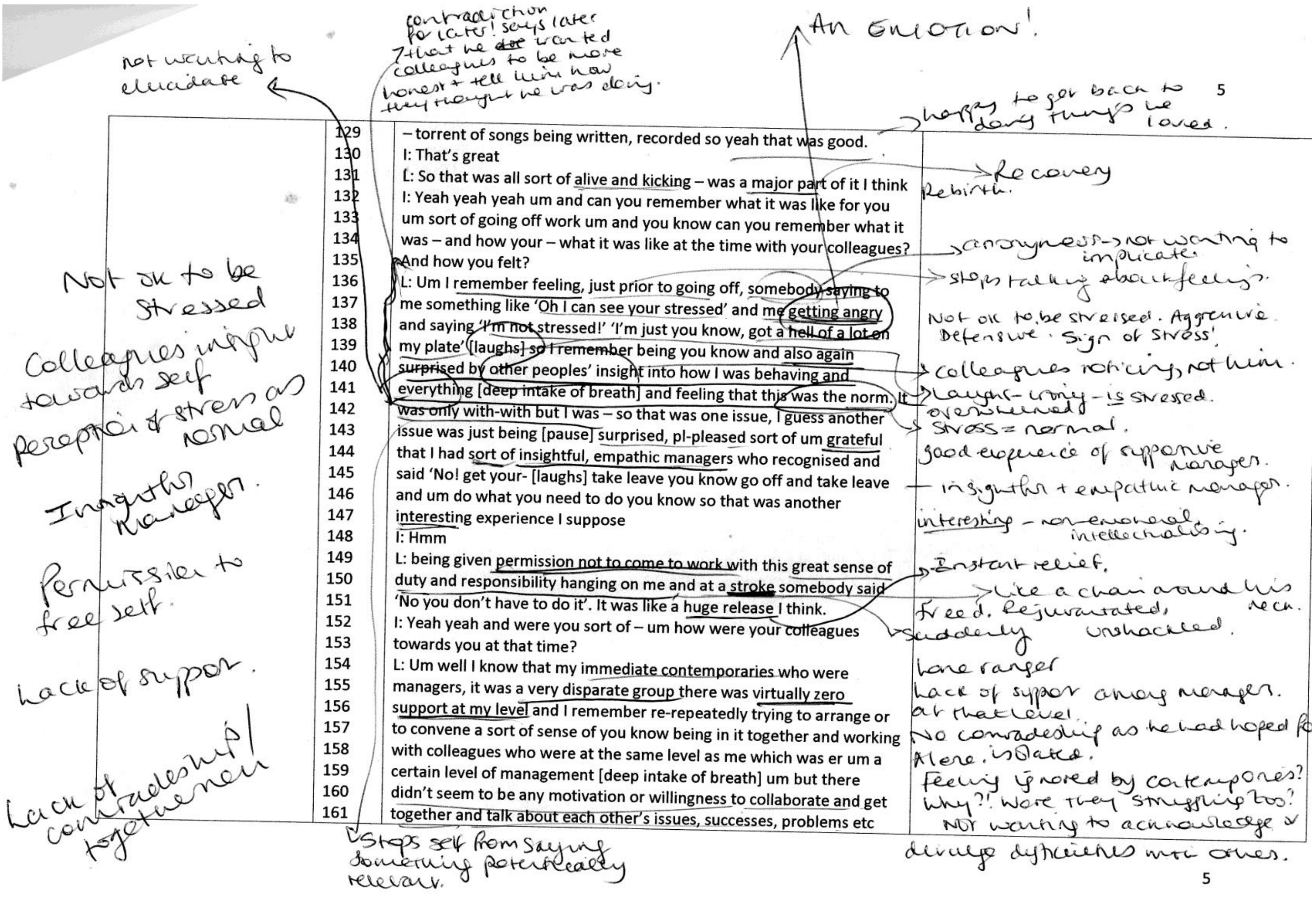
ack of
aith/
lief in
it

did fix himself with help.

Lost his passions, hobbies!
Returned to things he enjoyed doing.

4

Appendix F. Example Extract of Initial Analysis: Coding and Emergent Themes (continued)



contradiction for later! says later that he wanted colleagues to be more honest + tell him how they thought he was doing.

An EMOTION!

not wanting to elucidate

happy to get back to doing things he loved.

5

– torrent of songs being written, recorded so yeah that was good.

I: That's great

L: So that was all sort of alive and kicking – was a major part of it I think

I: Yeah yeah yeah um and can you remember what it was like for you um sort of going off work um and you know can you remember what it was – and how your – what it was like at the time with your colleagues? And how you felt?

L: Um I remember feeling, just prior to going off, somebody saying to me something like 'Oh I can see your stressed' and me getting angry and saying 'I'm not stressed!' 'I'm just you know, got a hell of a lot on my plate' [laughs] so I remember being you know and also again surprised by other peoples' insight into how I was behaving and everything [deep intake of breath] and feeling that this was the norm. It was only with-with but I was – so that was one issue, I guess another issue was just being [pause] surprised, pl-pleased sort of um grateful that I had sort of insightful, empathic managers who recognised and said 'No! get your- [laughs] take leave you know go off and take leave and um do what you need to do you know so that was another interesting experience I suppose

I: Hmm

L: being given permission not to come to work with this great sense of duty and responsibility hanging on me and at a stroke somebody said 'No you don't have to do it'. It was like a huge release I think.

I: Yeah yeah and were you sort of – um how were your colleagues towards you at that time?

L: Um well I know that my immediate contemporaries who were managers, it was a very disparate group there was virtually zero support at my level and I remember re-repeatedly trying to arrange or to convene a sort of sense of you know being in it together and working with colleagues who were at the same level as me which was er um a certain level of management [deep intake of breath] um but there didn't seem to be any motivation or willingness to collaborate and get together and talk about each other's issues, successes, problems etc

Stops self from saying something potentially relevant.

Not ok to be stressed

Colleagues insight towards self

perception of stress as normal

Insightful manager.

Permission to free self.

Lack of support.

Lack of comradeship/togetherness

Recovery

Rebirth.

anonymous → not wanting to implicate.

stops talking about feelings.

Not ok to be stressed. Aggressive. Defensive. Sign of stress!

colleagues noticing, not him.

Laughs – irony – is stressed. overwhelmed

Stress = normal.

good experience of supportive managers.

insightful + empathic manager.

interesting – non-emotional, intellectualising.

Instant relief.

Like a chain around his neck.

Freed. Rejuvenated, unshackled.

suddenly

Lone ranger

Lack of support among managers at that level

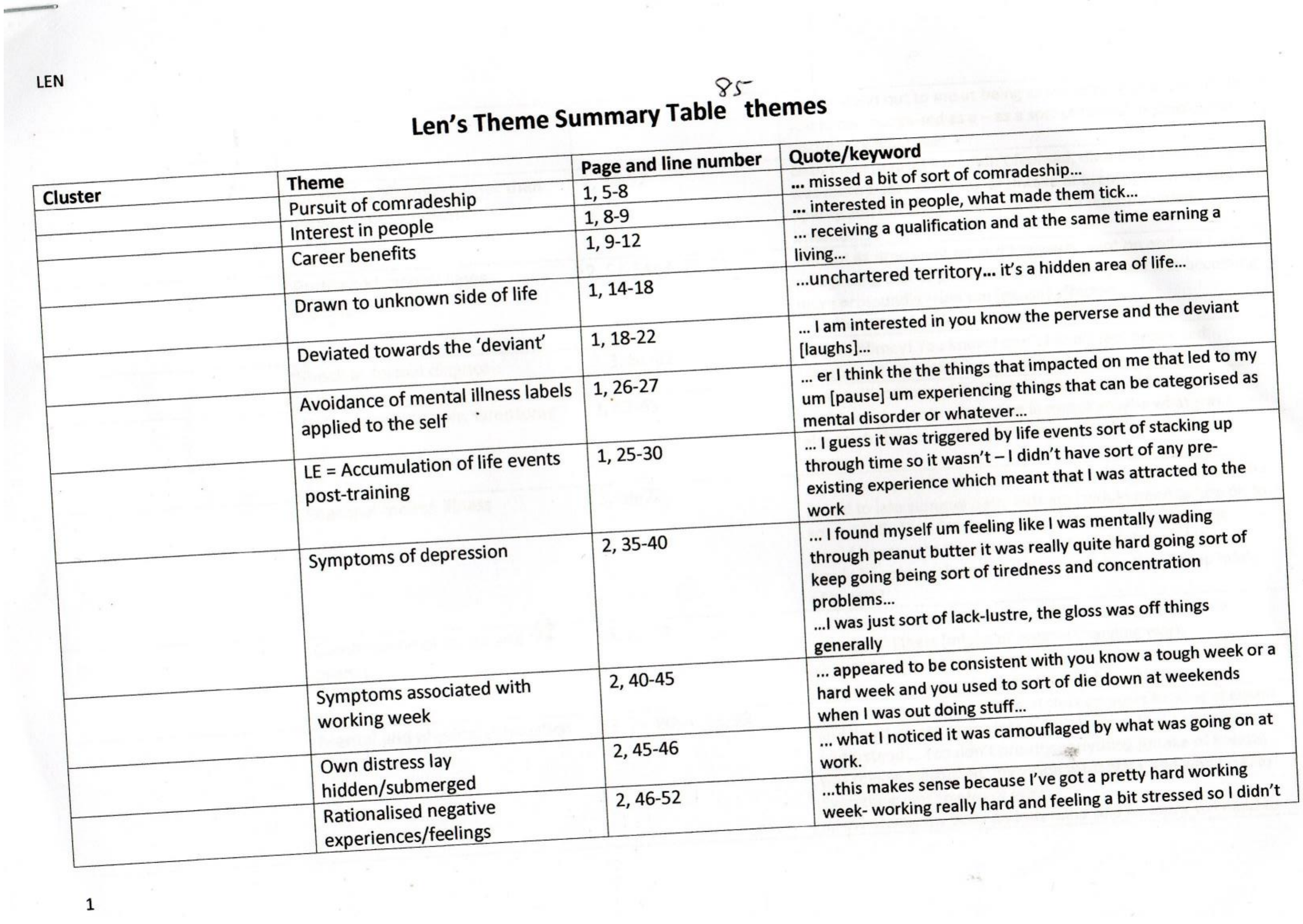
No comradeship as he had hoped for

Alone. isolated.

Feeling ignored by contemporaries? Why?! Were they struggling too? Not wanting to acknowledge & divulge difficulties with others.

5

Appendix G. Example of an Emergent Theme Summary Table



LEN

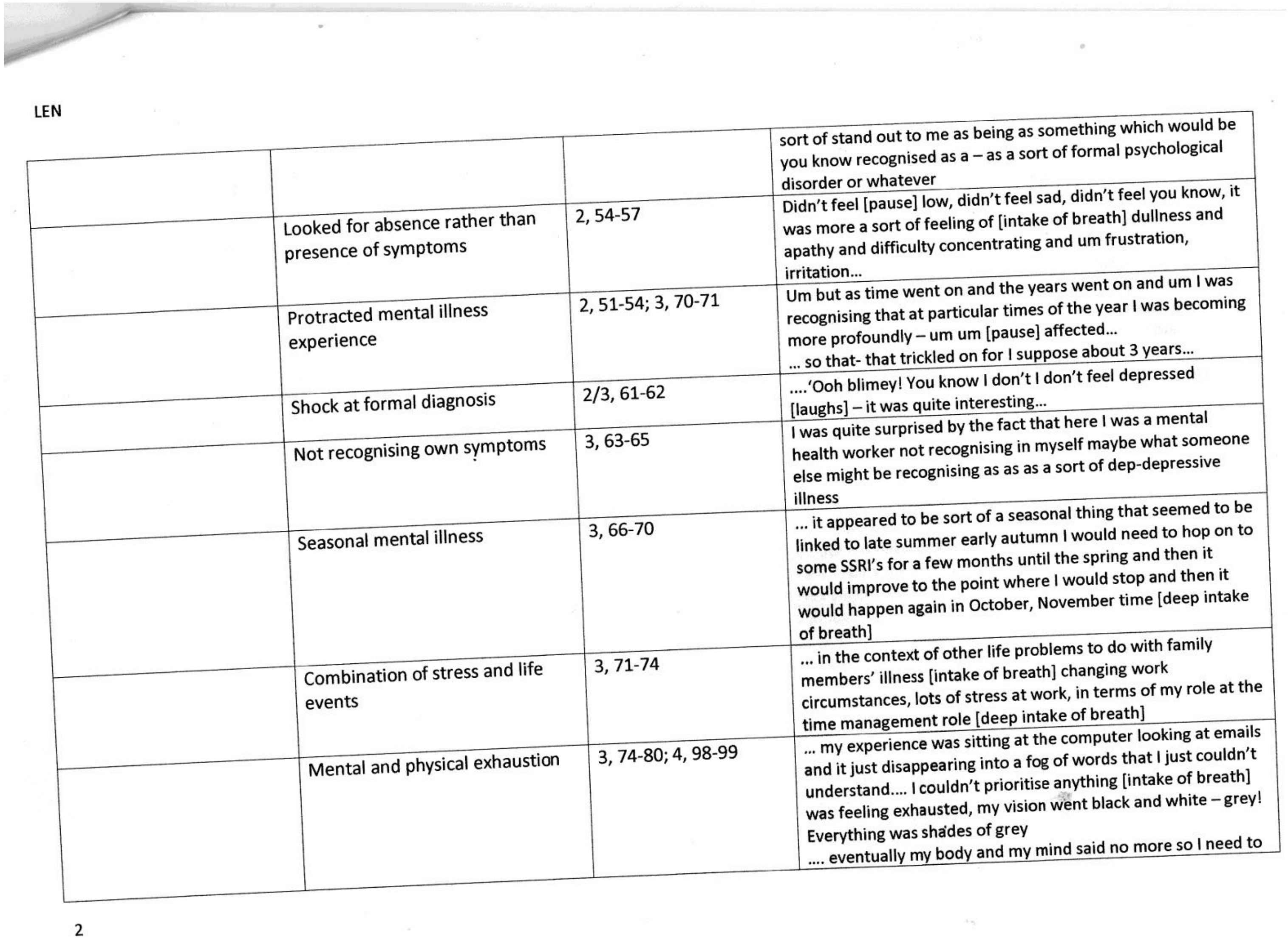
85

Len's Theme Summary Table themes

Cluster	Theme	Page and line number	Quote/keyword
	Pursuit of comradeship	1, 5-8	**...** missed a bit of sort of comradeship...
	Interest in people	1, 8-9	**...** interested in people, what made them tick...
	Career benefits	1, 9-12	... receiving a qualification and at the same time earning a living...
	Drawn to unknown side of life	1, 14-18	...unchartered territory**...** it's a hidden area of life...
	Deviated towards the 'deviant'	1, 18-22	... I am interested in you know the perverse and the deviant [laughs]...
	Avoidance of mental illness labels applied to the self	1, 26-27	... er I think the the things that impacted on me that led to my um [pause] um experiencing things that can be categorised as mental disorder or whatever...
	LE = Accumulation of life events post-training	1, 25-30	... I guess it was triggered by life events sort of stacking up through time so it wasn't – I didn't have sort of any pre-existing experience which meant that I was attracted to the work
	Symptoms of depression	2, 35-40	... I found myself um feeling like I was mentally wading through peanut butter it was really quite hard going sort of keep going being sort of tiredness and concentration problems... ...I was just sort of lack-lustre, the gloss was off things generally
	Symptoms associated with working week	2, 40-45	... appeared to be consistent with you know a tough week or a hard week and you used to sort of die down at weekends when I was out doing stuff...
	Own distress lay hidden/submerged	2, 45-46	... what I noticed it was camouflaged by what was going on at work.
	Rationalised negative experiences/feelings	2, 46-52	...this makes sense because I've got a pretty hard working week- working really hard and feeling a bit stressed so I didn't

1

Appendix G. Example of an Emergent Theme Summary Table (continued)

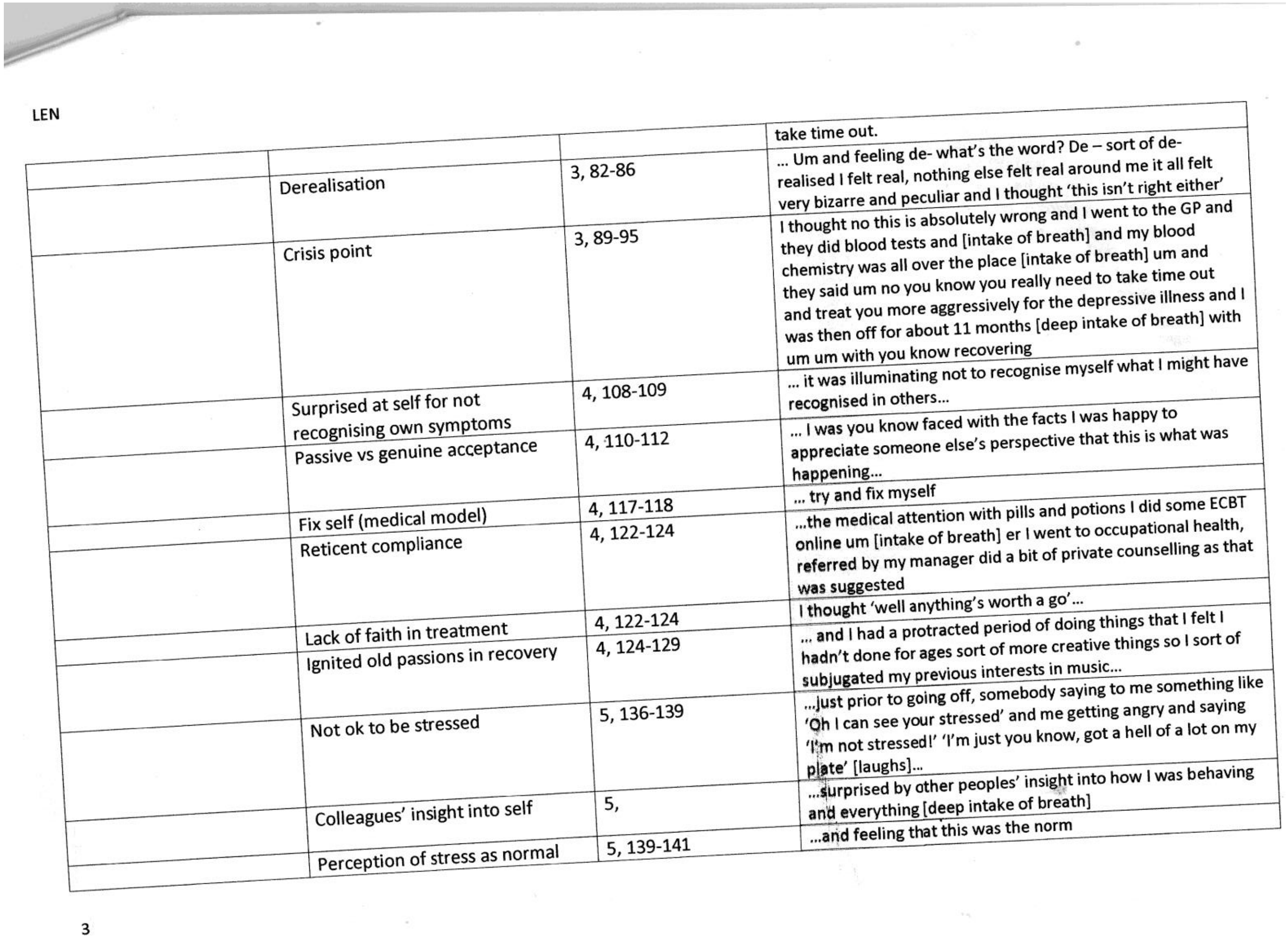


LEN

			sort of stand out to me as being as something which would be you know recognised as a – as a sort of formal psychological disorder or whatever
	Looked for absence rather than presence of symptoms	2, 54-57	Didn't feel [pause] low, didn't feel sad, didn't feel you know, it was more a sort of feeling of [intake of breath] dullness and apathy and difficulty concentrating and um frustration, irritation…
	Protracted mental illness experience	2, 51-54; 3, 70-71	Um but as time went on and the years went on and um I was recognising that at particular times of the year I was becoming more profoundly – um um [pause] affected… … so that- that trickled on for I suppose about 3 years…
	Shock at formal diagnosis	2/3, 61-62	….'Ooh blimey! You know I don't I don't feel depressed [laughs] – it was quite interesting…
	Not recognising own symptoms	3, 63-65	I was quite surprised by the fact that here I was a mental health worker not recognising in myself maybe what someone else might be recognising as as as a sort of dep-depressive illness
	Seasonal mental illness	3, 66-70	… it appeared to be sort of a seasonal thing that seemed to be linked to late summer early autumn I would need to hop on to some SSRI's for a few months until the spring and then it would improve to the point where I would stop and then it would happen again in October, November time [deep intake of breath]
	Combination of stress and life events	3, 71-74	… in the context of other life problems to do with family members' illness [intake of breath] changing work circumstances, lots of stress at work, in terms of my role at the time management role [deep intake of breath]
	Mental and physical exhaustion	3, 74-80; 4, 98-99	… my experience was sitting at the computer looking at emails and it just disappearing into a fog of words that I just couldn't understand…. I couldn't prioritise anything [intake of breath] was feeling exhausted, my vision went black and white – grey! Everything was shades of grey …. eventually my body and my mind said no more so I need to

2

Appendix G. Example of an Emergent Theme Summary Table (continued)

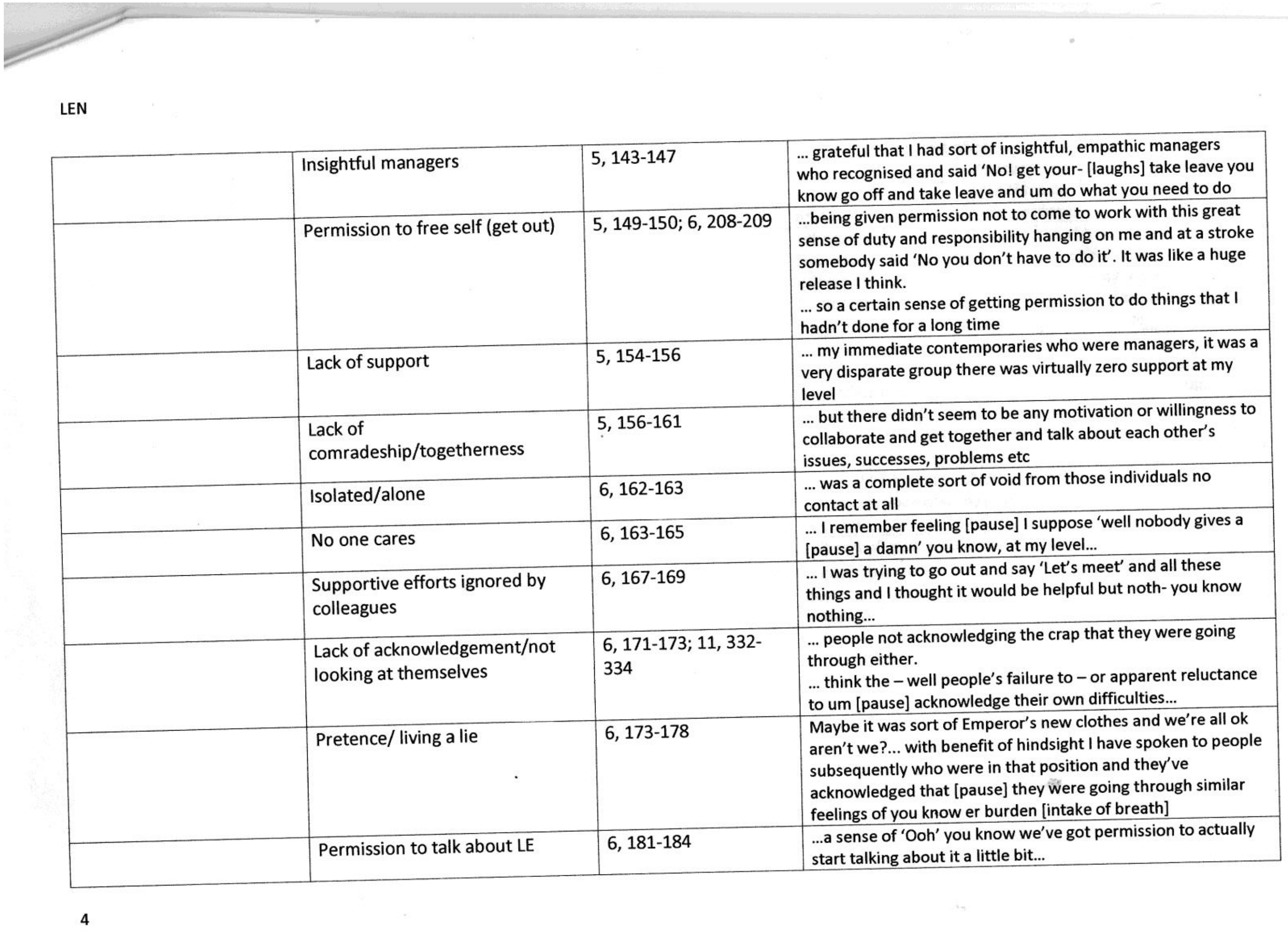


LEN

			take time out.
	Derealisation	3, 82-86	... Um and feeling de- what's the word? De – sort of de-realised I felt real, nothing else felt real around me it all felt very bizarre and peculiar and I thought 'this isn't right either'
	Crisis point	3, 89-95	I thought no this is absolutely wrong and I went to the GP and they did blood tests and [intake of breath] and my blood chemistry was all over the place [intake of breath] um and they said um no you know you really need to take time out and treat you more aggressively for the depressive illness and I was then off for about 11 months [deep intake of breath] with um um with you know recovering
	Surprised at self for not recognising own symptoms	4, 108-109	... it was illuminating not to recognise myself what I might have recognised in others...
	Passive vs genuine acceptance	4, 110-112	... I was you know faced with the facts I was happy to appreciate someone else's perspective that this is what was happening...
	Fix self (medical model)	4, 117-118	... try and fix myself
	Reticent compliance	4, 122-124	...the medical attention with pills and potions I did some ECBT online um [intake of breath] er I went to occupational health, referred by my manager did a bit of private counselling as that was suggested
	Lack of faith in treatment	4, 122-124	I thought 'well anything's worth a go'...
	Ignited old passions in recovery	4, 124-129	... and I had a protracted period of doing things that I felt I hadn't done for ages sort of more creative things so I sort of subjugated my previous interests in music...
	Not ok to be stressed	5, 136-139	...just prior to going off, somebody saying to me something like 'Oh I can see your stressed' and me getting angry and saying 'I'm not stressed!' 'I'm just you know, got a hell of a lot on my plate' [laughs]...
	Colleagues' insight into self	5,	...surprised by other peoples' insight into how I was behaving and everything [deep intake of breath]
	Perception of stress as normal	5, 139-141	...and feeling that this was the norm

3

Appendix G. Example of an Emergent Theme Summary Table (continued)

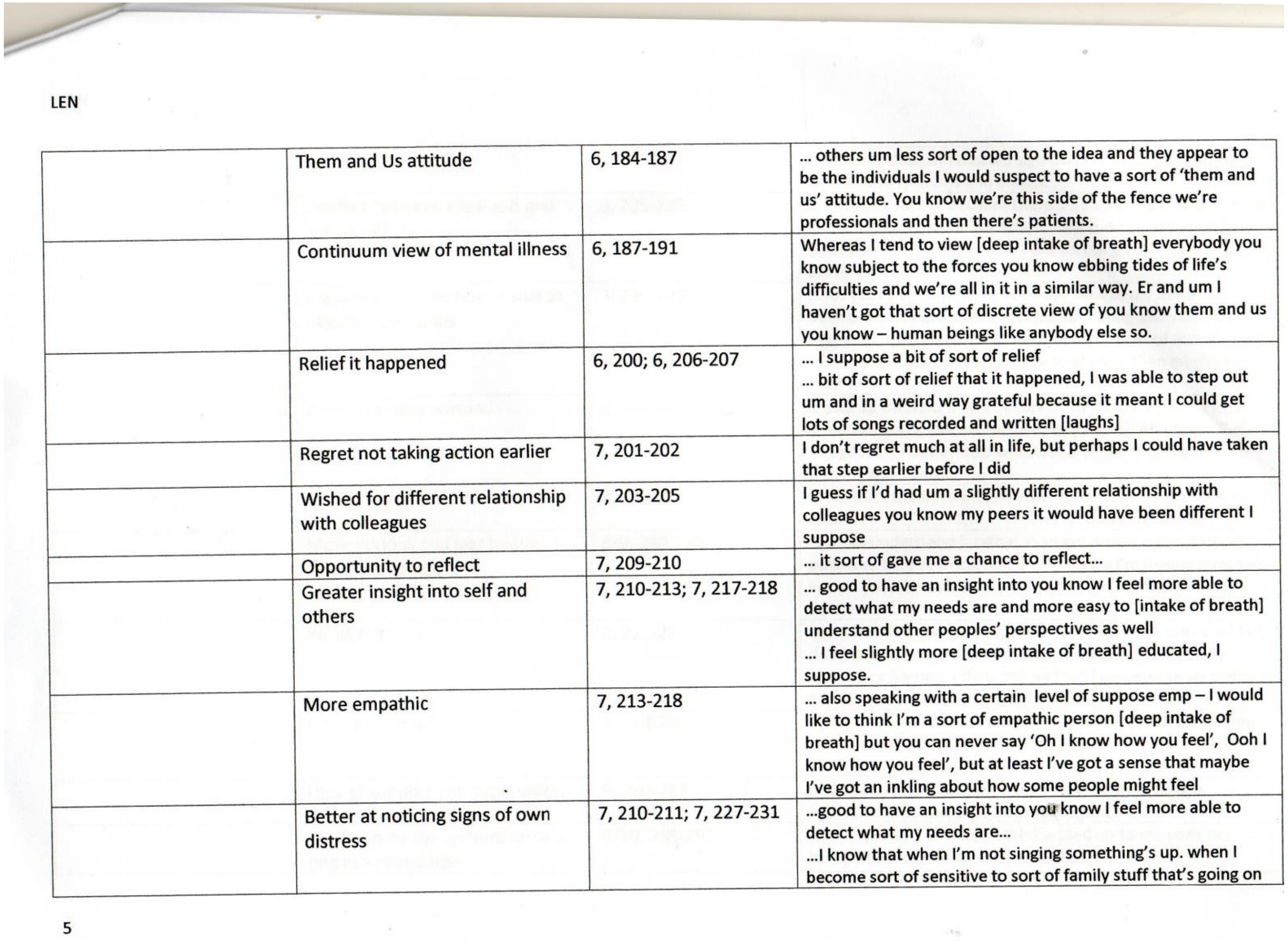


LEN

	Insightful managers	5, 143-147	... grateful that I had sort of insightful, empathic managers who recognised and said 'No! get your- [laughs] take leave you know go off and take leave and um do what you need to do
	Permission to free self (get out)	5, 149-150; 6, 208-209	...being given permission not to come to work with this great sense of duty and responsibility hanging on me and at a stroke somebody said 'No you don't have to do it'. It was like a huge release I think. ... so a certain sense of getting permission to do things that I hadn't done for a long time
	Lack of support	5, 154-156	... my immediate contemporaries who were managers, it was a very disparate group there was virtually zero support at my level
	Lack of comradeship/togetherness	5, 156-161	... but there didn't seem to be any motivation or willingness to collaborate and get together and talk about each other's issues, successes, problems etc
	Isolated/alone	6, 162-163	... was a complete sort of void from those individuals no contact at all
	No one cares	6, 163-165	... I remember feeling [pause] I suppose 'well nobody gives a [pause] a damn' you know, at my level...
	Supportive efforts ignored by colleagues	6, 167-169	... I was trying to go out and say 'Let's meet' and all these things and I thought it would be helpful but noth- you know nothing...
	Lack of acknowledgement/not looking at themselves	6, 171-173; 11, 332-334	... people not acknowledging the crap that they were going through either. ... think the – well people's failure to – or apparent reluctance to um [pause] acknowledge their own difficulties...
	Pretence/ living a lie	6, 173-178	Maybe it was sort of Emperor's new clothes and we're all ok aren't we?... with benefit of hindsight I have spoken to people subsequently who were in that position and they've acknowledged that [pause] they were going through similar feelings of you know er burden [intake of breath]
	Permission to talk about LE	6, 181-184	...a sense of 'Ooh' you know we've got permission to actually start talking about it a little bit...

4

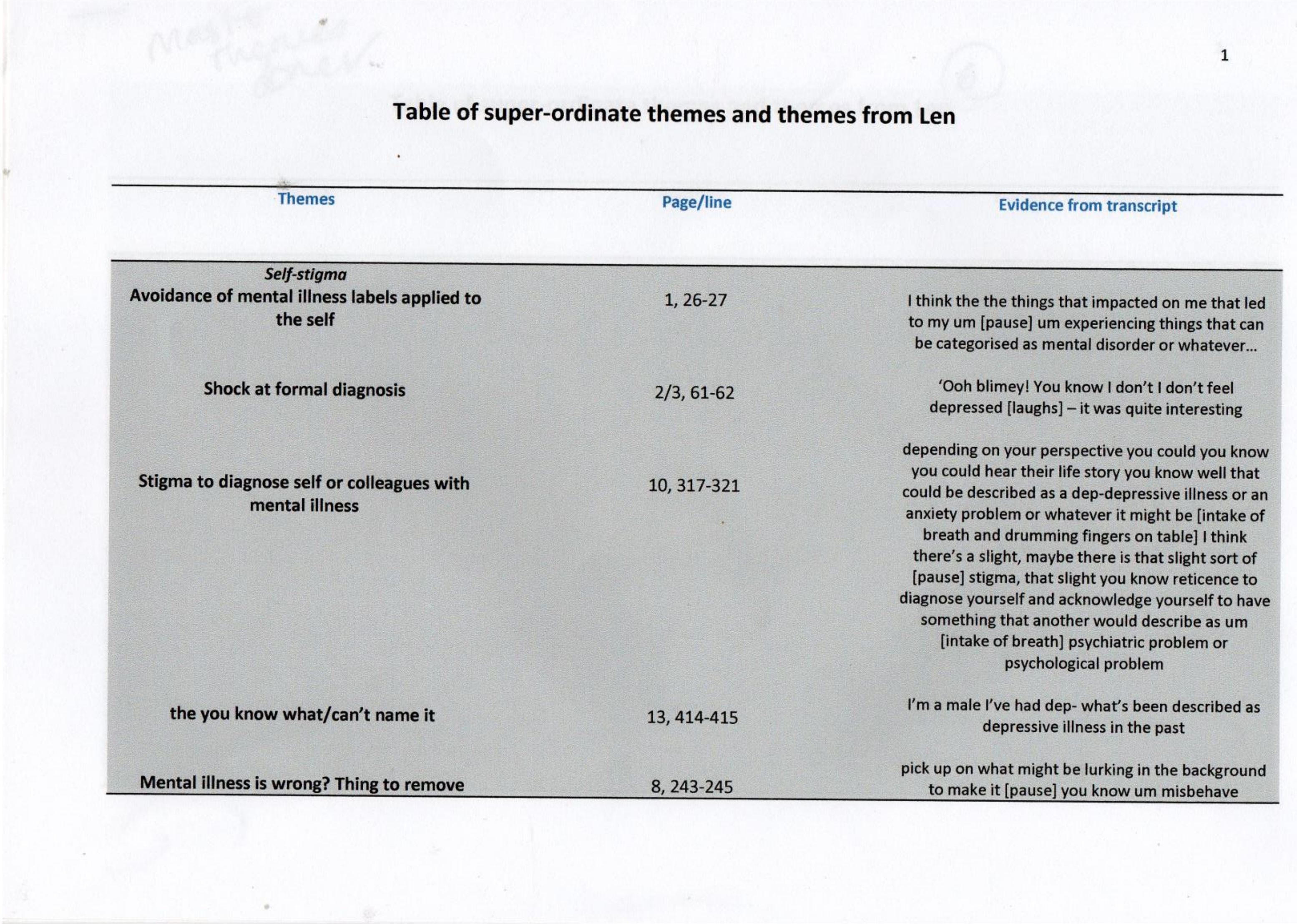
Appendix G. Example of an Emergent Theme Summary Table (continued)



LEN

	Them and Us attitude	6, 184-187	… others um less sort of open to the idea and they appear to be the individuals I would suspect to have a sort of 'them and us' attitude. You know we're this side of the fence we're professionals and then there's patients.
	Continuum view of mental illness	6, 187-191	Whereas I tend to view [deep intake of breath] everybody you know subject to the forces you know ebbing tides of life's difficulties and we're all in it in a similar way. Er and um I haven't got that sort of discrete view of you know them and us you know – human beings like anybody else so.
	Relief it happened	6, 200; 6, 206-207	… I suppose a bit of sort of relief … bit of sort of relief that it happened, I was able to step out um and in a weird way grateful because it meant I could get lots of songs recorded and written [laughs]
	Regret not taking action earlier	7, 201-202	I don't regret much at all in life, but perhaps I could have taken that step earlier before I did
	Wished for different relationship with colleagues	7, 203-205	I guess if I'd had um a slightly different relationship with colleagues you know my peers it would have been different I suppose
	Opportunity to reflect	7, 209-210	… it sort of gave me a chance to reflect…
	Greater insight into self and others	7, 210-213; 7, 217-218	… good to have an insight into you know I feel more able to detect what my needs are and more easy to [intake of breath] understand other peoples' perspectives as well … I feel slightly more [deep intake of breath] educated, I suppose.
	More empathic	7, 213-218	… also speaking with a certain level of suppose emp – I would like to think I'm a sort of empathic person [deep intake of breath] but you can never say 'Oh I know how you feel', Ooh I know how you feel', but at least I've got a sense that maybe I've got an inkling about how some people might feel
	Better at noticing signs of own distress	7, 210-211; 7, 227-231	…good to have an insight into you know I feel more able to detect what my needs are… …I know that when I'm not singing something's up. when I become sort of sensitive to sort of family stuff that's going on

Appendix H. Example Extract of a Superordinate Theme Summary Table



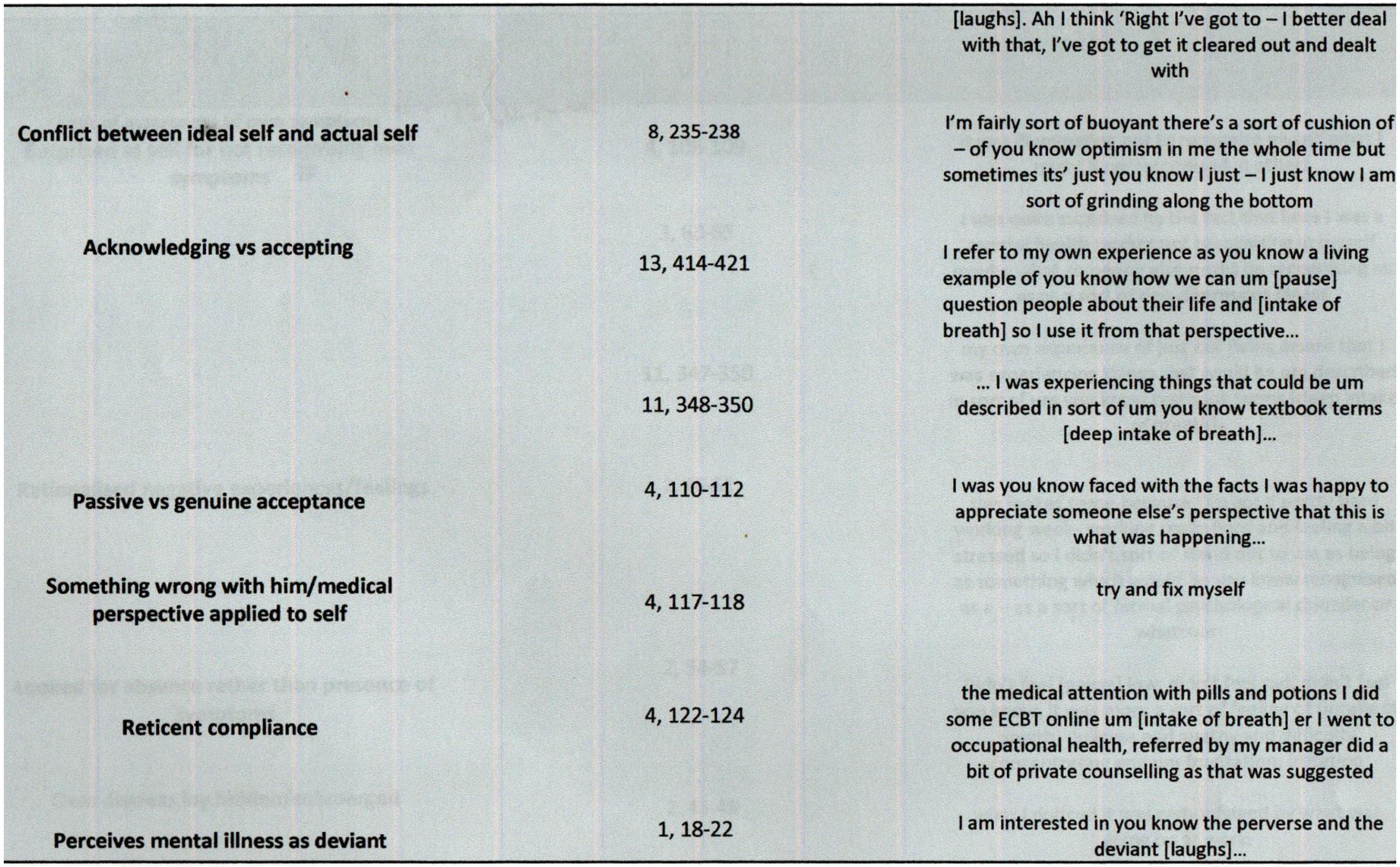
Master Themes done

1

Table of super-ordinate themes and themes from Len

Themes	Page/line	Evidence from transcript
Self-stigma **Avoidance of mental illness labels applied to the self**	1, 26-27	I think the the things that impacted on me that led to my um [pause] um experiencing things that can be categorised as mental disorder or whatever…
Shock at formal diagnosis	2/3, 61-62	‘Ooh blimey! You know I don’t I don’t feel depressed [laughs] – it was quite interesting
Stigma to diagnose self or colleagues with mental illness	10, 317-321	depending on your perspective you could you know you could hear their life story you know well that could be described as a dep-depressive illness or an anxiety problem or whatever it might be [intake of breath and drumming fingers on table] I think there’s a slight, maybe there is that slight sort of [pause] stigma, that slight you know reticence to diagnose yourself and acknowledge yourself to have something that another would describe as um [intake of breath] psychiatric problem or psychological problem
the you know what/can’t name it	13, 414-415	I’m a male I’ve had dep- what’s been described as depressive illness in the past
Mental illness is wrong? Thing to remove	8, 243-245	pick up on what might be lurking in the background to make it [pause] you know um misbehave

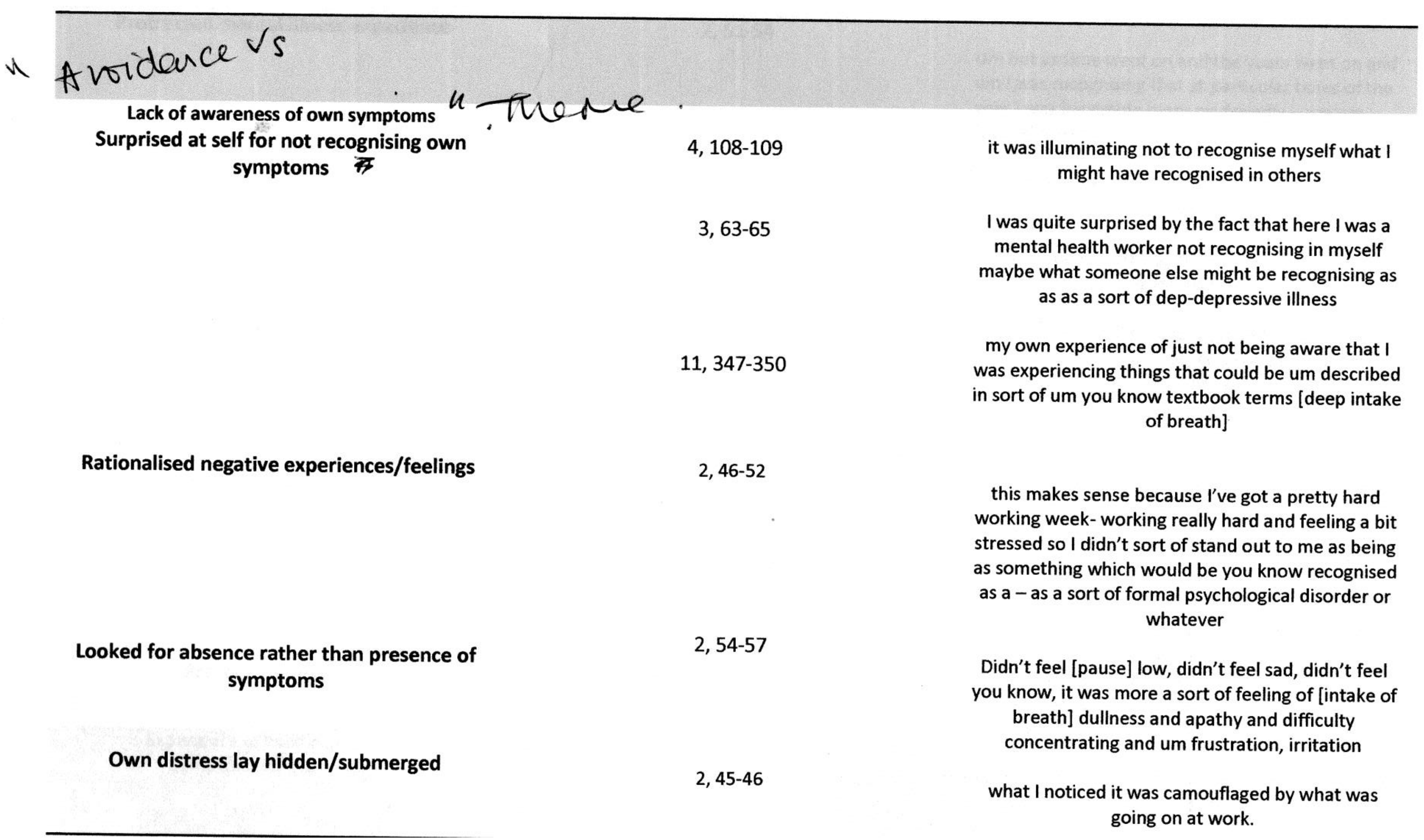
Appendix H. Example Extract of a Superordinate Theme Summary Table (continued)



		[laughs]. Ah I think 'Right I've got to – I better deal with that, I've got to get it cleared out and dealt with
Conflict between ideal self and actual self	8, 235-238	I'm fairly sort of buoyant there's a sort of cushion of – of you know optimism in me the whole time but sometimes its' just you know I just – I just know I am sort of grinding along the bottom
Acknowledging vs accepting	13, 414-421	I refer to my own experience as you know a living example of you know how we can um [pause] question people about their life and [intake of breath] so I use it from that perspective…
	11, 348-350	… I was experiencing things that could be um described in sort of um you know textbook terms [deep intake of breath]…
Passive vs genuine acceptance	4, 110-112	I was you know faced with the facts I was happy to appreciate someone else's perspective that this is what was happening…
Something wrong with him/medical perspective applied to self	4, 117-118	try and fix myself
Reticent compliance	4, 122-124	the medical attention with pills and potions I did some ECBT online um [intake of breath] er I went to occupational health, referred by my manager did a bit of private counselling as that was suggested
Perceives mental illness as deviant	1, 18-22	I am interested in you know the perverse and the deviant [laughs]…

2

Appendix H. Example Extract of a Superordinate Theme Summary Table (continued)



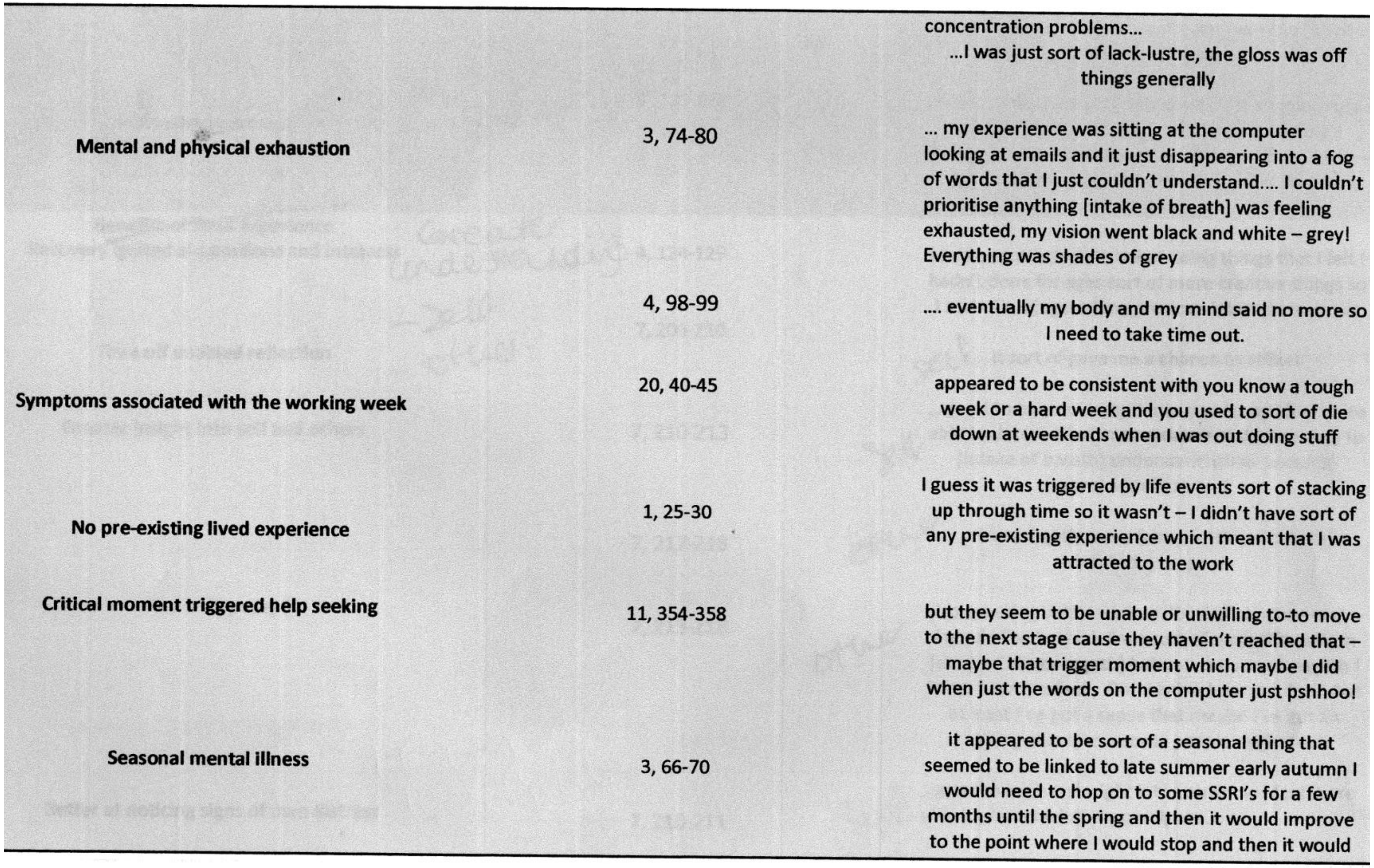
" Avoidance vs " Theme.

Lack of awareness of own symptoms **Surprised at self for not recognising own symptoms**	4, 108-109	it was illuminating not to recognise myself what I might have recognised in others
	3, 63-65	I was quite surprised by the fact that here I was a mental health worker not recognising in myself maybe what someone else might be recognising as as as a sort of dep-depressive illness
	11, 347-350	my own experience of just not being aware that I was experiencing things that could be um described in sort of um you know textbook terms [deep intake of breath]
Rationalised negative experiences/feelings	2, 46-52	this makes sense because I've got a pretty hard working week- working really hard and feeling a bit stressed so I didn't sort of stand out to me as being as something which would be you know recognised as a – as a sort of formal psychological disorder or whatever
Looked for absence rather than presence of symptoms	2, 54-57	Didn't feel [pause] low, didn't feel sad, didn't feel you know, it was more a sort of feeling of [intake of breath] dullness and apathy and difficulty concentrating and um frustration, irritation
Own distress lay hidden/submerged	2, 45-46	what I noticed it was camouflaged by what was going on at work.

Appendix H. Example Extract of a Superordinate Theme Summary Table (continued)

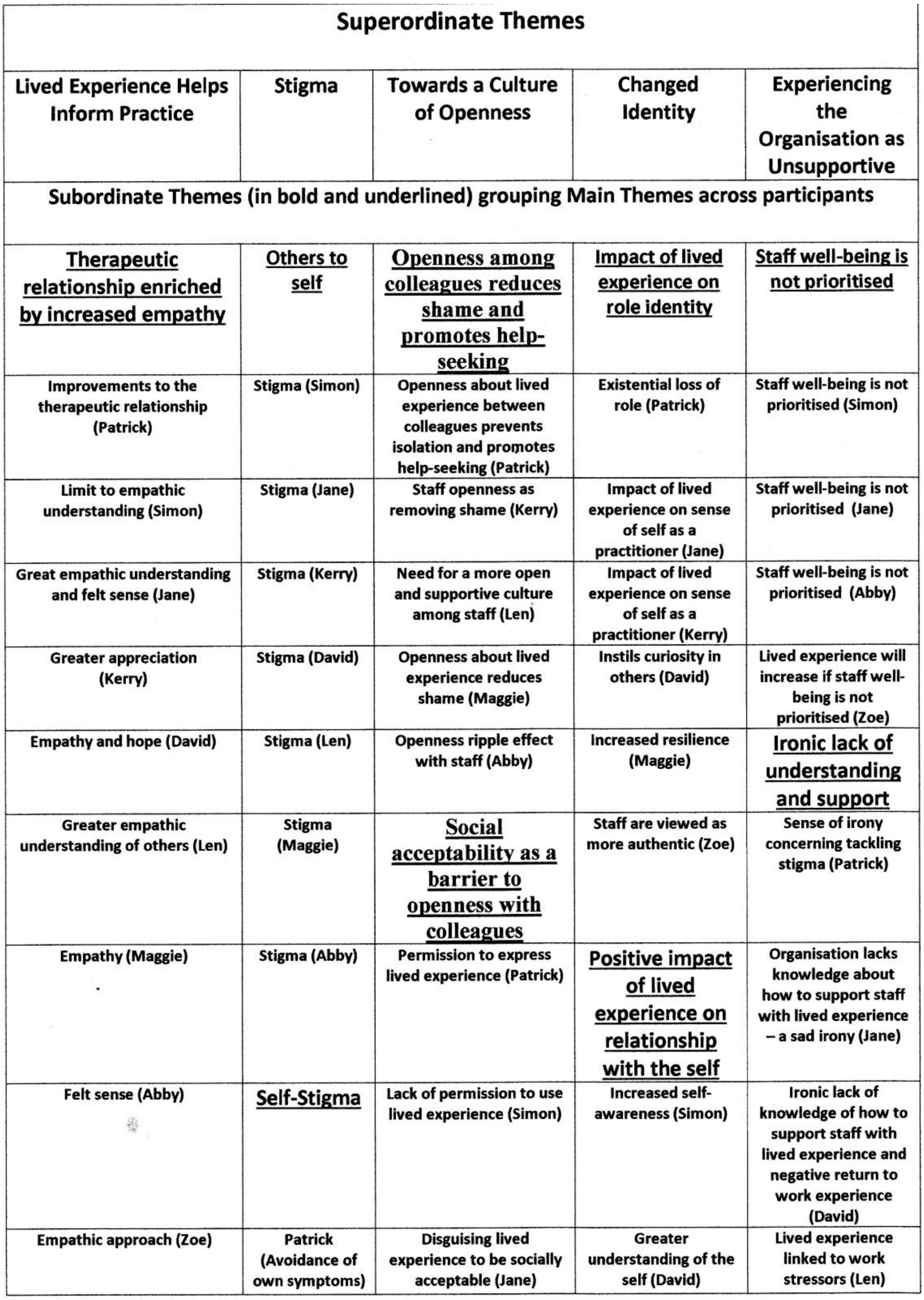
Protracted mental illness experience	2, 51-54	Um but as time went on and the years went on and um I was recognising that at particular times of the year I was becoming more profoundly – um um [pause] affected…
	3, 70-71	… so that- that trickled on for I suppose about 3 years…
	6, 171-173	people not acknowledging the crap that they were going through either.
	11, 332-334	… think the – well people's failure to – or apparent reluctance to um [pause] acknowledge their own difficulties
Denial/maladaptive coping	10, 305-309	I think there's an approach to that which is a mixture of um [pause] shutting down er out of work and putting behind you and you know holding it back and then gritting your teeth and going into the working week and getting through [intake of breath] um [pause] which is incredibly unhealthy
Pretence/living a lie	6, 173-178	Maybe it was sort of Emperor's new clothes and we're all ok aren't we?… with benefit of hindsight I have spoken to people subsequently who were in that position and they've acknowledged that [pause] they were going through similar feelings of you know er burden [intake of breath]
Experience ~~of lived~~ experience **Symptoms of depression** LE linked to work stressors.	2, 35-40	I found myself um feeling like I was mentally wading through peanut butter it was really quite hard going sort of keep going being sort of tiredness and

Appendix H. Example Extract of a Superordinate Theme Summary Table (continued)



		concentration problems… …I was just sort of lack-lustre, the gloss was off things generally
Mental and physical exhaustion	3, 74-80	… my experience was sitting at the computer looking at emails and it just disappearing into a fog of words that I just couldn't understand…. I couldn't prioritise anything [intake of breath] was feeling exhausted, my vision went black and white – grey! Everything was shades of grey
	4, 98-99	…. eventually my body and my mind said no more so I need to take time out.
Symptoms associated with the working week	20, 40-45	appeared to be consistent with you know a tough week or a hard week and you used to sort of die down at weekends when I was out doing stuff
No pre-existing lived experience	1, 25-30	I guess it was triggered by life events sort of stacking up through time so it wasn't – I didn't have sort of any pre-existing experience which meant that I was attracted to the work
Critical moment triggered help seeking	11, 354-358	but they seem to be unable or unwilling to-to move to the next stage cause they haven't reached that – maybe that trigger moment which maybe I did when just the words on the computer just pshhoo!
Seasonal mental illness	3, 66-70	it appeared to be sort of a seasonal thing that seemed to be linked to late summer early autumn I would need to hop on to some SSRI's for a few months until the spring and then it would improve to the point where I would stop and then it would

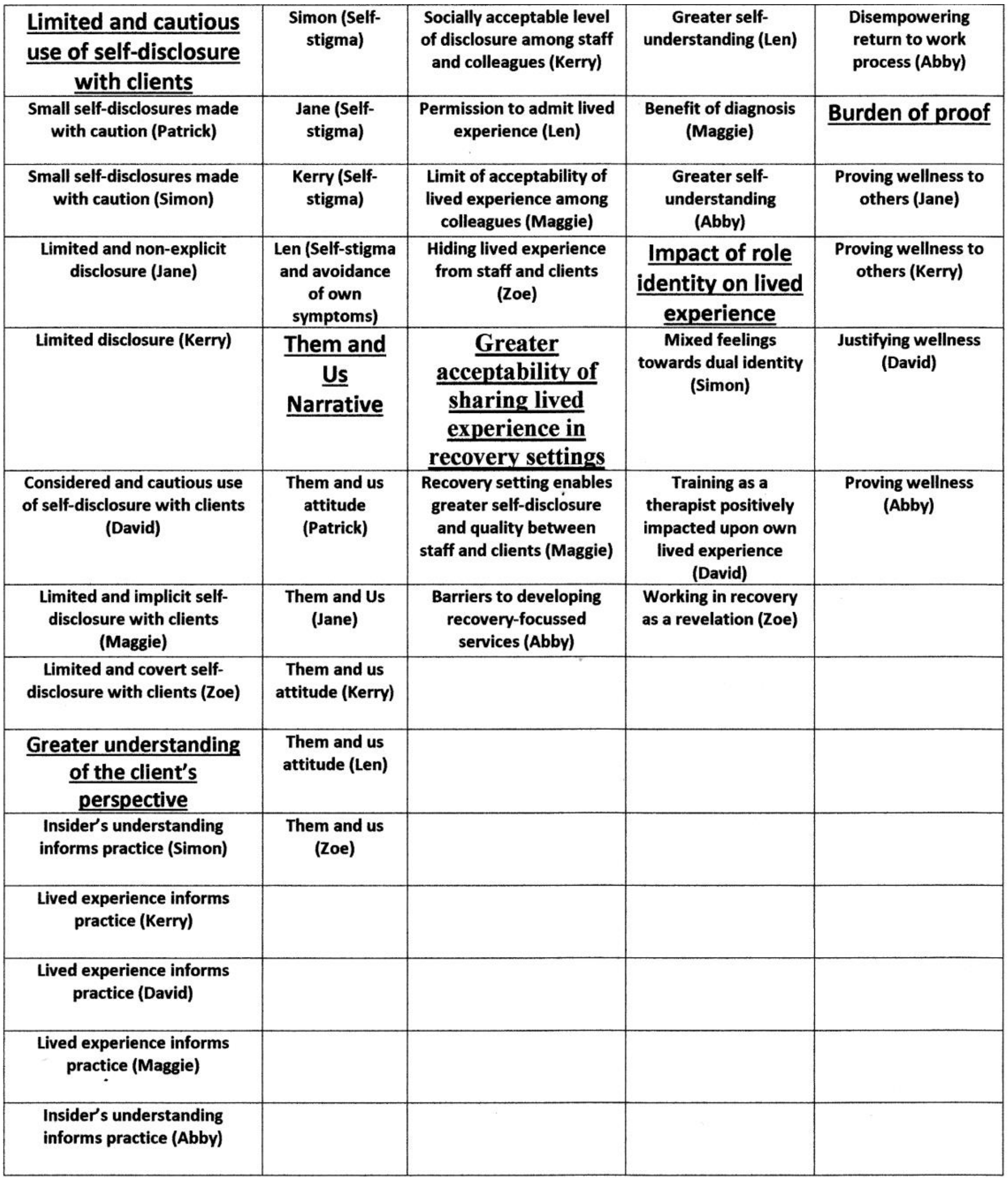
Appendix I. Table of Individual Participant's Superordinate Themes within Sample's Subordinate and Superordinate Themes



Superordinate Themes

Lived Experience Helps Inform Practice	**Stigma**	**Towards a Culture of Openness**	**Changed Identity**	**Experiencing the Organisation as Unsupportive**
Subordinate Themes (in bold and underlined) grouping Main Themes across participants				
Therapeutic relationship enriched by increased empathy	**Others to self**	**Openness among colleagues reduces shame and promotes help-seeking**	**Impact of lived experience on role identity**	**Staff well-being is not prioritised**
Improvements to the therapeutic relationship (Patrick)	Stigma (Simon)	Openness about lived experience between colleagues prevents isolation and promotes help-seeking (Patrick)	Existential loss of role (Patrick)	Staff well-being is not prioritised (Simon)
Limit to empathic understanding (Simon)	Stigma (Jane)	Staff openness as removing shame (Kerry)	Impact of lived experience on sense of self as a practitioner (Jane)	Staff well-being is not prioritised (Jane)
Great empathic understanding and felt sense (Jane)	Stigma (Kerry)	Need for a more open and supportive culture among staff (Len)	Impact of lived experience on sense of self as a practitioner (Kerry)	Staff well-being is not prioritised (Abby)
Greater appreciation (Kerry)	Stigma (David)	Openness about lived experience reduces shame (Maggie)	Instils curiosity in others (David)	Lived experience will increase if staff well-being is not prioritised (Zoe)
Empathy and hope (David)	Stigma (Len)	Openness ripple effect with staff (Abby)	Increased resilience (Maggie)	**Ironic lack of understanding and support**
Greater empathic understanding of others (Len)	Stigma (Maggie)	**Social acceptability as a barrier to openness with colleagues**	Staff are viewed as more authentic (Zoe)	Sense of irony concerning tackling stigma (Patrick)
Empathy (Maggie)	Stigma (Abby)	Permission to express lived experience (Patrick)	**Positive impact of lived experience on relationship with the self**	Organisation lacks knowledge about how to support staff with lived experience – a sad irony (Jane)
Felt sense (Abby)	**Self-Stigma**	Lack of permission to use lived experience (Simon)	Increased self-awareness (Simon)	Ironic lack of knowledge of how to support staff with lived experience and negative return to work experience (David)
Empathic approach (Zoe)	Patrick (Avoidance of own symptoms)	Disguising lived experience to be socially acceptable (Jane)	Greater understanding of the self (David)	Lived experience linked to work stressors (Len)

Appendix I. Table of Individual Participant's Superordinate Themes within the Sample's Subordinate and Superordinate Themes (continued)



Limited and cautious use of self-disclosure with clients	Simon (Self-stigma)	Socially acceptable level of disclosure among staff and colleagues (Kerry)	Greater self-understanding (Len)	Disempowering return to work process (Abby)
Small self-disclosures made with caution (Patrick)	Jane (Self-stigma)	Permission to admit lived experience (Len)	Benefit of diagnosis (Maggie)	**Burden of proof**
Small self-disclosures made with caution (Simon)	Kerry (Self-stigma)	Limit of acceptability of lived experience among colleagues (Maggie)	Greater self-understanding (Abby)	Proving wellness to others (Jane)
Limited and non-explicit disclosure (Jane)	Len (Self-stigma and avoidance of own symptoms)	Hiding lived experience from staff and clients (Zoe)	**Impact of role identity on lived experience**	Proving wellness to others (Kerry)
Limited disclosure (Kerry)	**Them and Us Narrative**	**Greater acceptability of sharing lived experience in recovery settings**	Mixed feelings towards dual identity (Simon)	Justifying wellness (David)
Considered and cautious use of self-disclosure with clients (David)	Them and us attitude (Patrick)	Recovery setting enables greater self-disclosure and quality between staff and clients (Maggie)	Training as a therapist positively impacted upon own lived experience (David)	Proving wellness (Abby)
Limited and implicit self-disclosure with clients (Maggie)	Them and Us (Jane)	Barriers to developing recovery-focussed services (Abby)	Working in recovery as a revelation (Zoe)	
Limited and covert self-disclosure with clients (Zoe)	Them and us attitude (Kerry)			
Greater understanding of the client's perspective	Them and us attitude (Len)			
Insider's understanding informs practice (Simon)	Them and us (Zoe)			
Lived experience informs practice (Kerry)				
Lived experience informs practice (David)				
Lived experience informs practice (Maggie)				
Insider's understanding informs practice (Abby)				