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SHARING IS CARING?

Section A: How do mental health professionals write about their lived experience of distress in published journal articles?
A rhetorical and content analysis of first-person accounts

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Section B: Sharing is caring? – how mental health staff and service users perceive the impact of sharing lived experience on recovery

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Summary of the MRP portfolio

Section A: Presents a review of first-person accounts by mental health professionals about their lived experience of mental health published in peer-reviewed journals. The review analyses rhetoric used by authors of the accounts to write about their experiences. Lived experience is defined and explored in the context of mental health care, stigma, power and identity. Common themes across first-person accounts were summarised using content analysis. Clinical recommendations include supporting professionals to reconcile professional and service user aspects of their identity through identification and challenging of implicit role expectations of the "helper" and stigma. Research implications include validating the use of rhetorical analysis tool.

Section B: Presents a study using grounded theory methodology to build a theory of factors influencing the use of self-disclosure of lived experience as a therapeutic intervention, identified by professionals and service users. The study further sought to explore impacts of self-disclosure. The resulting model suggests the process of sharing lived experience is impacted by several individual factors, e.g. beliefs held by professionals and service users about self-disclosure and previous experiences of self-disclosure, as well as NHS context. The model is contextualised within relevant research and clinical and research implications are discussed.

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Abstract:

This review appraises rhetoric and summarises themes across first-person accounts written by mental health (MH) professionals. Studies were eligible for inclusion if: the paper was published in a peer-reviewed journal in English; the account comprised a first-person narrative of lived experience (LE) by a MH professional. Fifteen accounts were evaluated in terms of rhetoric used to write about LE and common themes across them identified using content analysis. Main findings include the use of reason, emotion and shared cultural memories as persuasive strategies. Common themes across accounts included “Lived Experience”, “Recovery” and “LE of MH vs diagnosis”. Implications of findings for clinical practice are discussed, including support for professionals to integrate professional and service user parts of their identity. Methodological limitations, e.g. the need for validation of the appraisal tool and directions for future research, such as a review of service users views on use of LE, are considered.

Keywords: Lived experience, rhetoric, mental health, first-person account, literature review

How do mental health professionals write about their lived experience of distress in published journal articles? A rhetorical and content analysis of first-person accounts

1. Introduction

Mental ill-health and its impacts are more present in public consciousness than ever before (Evans-Lacko, Henderson & Thornicroft, 2013; Schomerus et al., 2012). However, there remains one arena in which mental health (MH) difficulties remain a taboo: that of MH professionals. Despite ongoing stigma, some professionals are starting to open up about their MH experiences. However, little formal research has investigated the effects of MH experiences among MH professionals (henceforth referred to as simply 'professionals') and their disclosures of these on their practice. This paper aims to summarise and appraise how professionals talk about their understanding of their lived experience (LE). The review begins by defining and discussing theoretical concepts of LE, power, stigma and dual identity.

1.1 Defining lived experience of mental distress

Whilst there is no one universally accepted definition of LE, various authors have described the concept. For example, one definition arose from focus groups run by Morgan and Lawson (2015). The groups defined LE broadly as life experience, including achievements, values, skills and interests. However, in the context of MH, they defined LE as experiences of trauma in terms of grief, loss, illness or life changing events, universal to all human beings. Another definition by de Vos, Netten and Noordenbos (2016) described LE as knowledge and understanding gained through direct experience. They proposed that LE includes the actual experience itself as well as the meanings attributed to it by the person going through it. Both definitions consider LE as events in one's life, positive and negative.

Other definitions come from those who define themselves as MH system survivors (e.g. Plumb, 1993). Notably, from survivors' perspectives, the challenge appears to be in surviving the MH system rather than the difficult life situation. Bell (1987; cited in: Plumb, 1993) described the MH system as eroding "confidence and dignity" (p.170) whilst LE is defined as surviving "a difficult life situation which took them into the system" (p.170).

For the purpose of this review, De Vos et al.'s definition of LE is adopted. Their definition crucially includes the importance of how individuals derive meaning from their experiences, which is the subject of this review.

1.2 Context of lived experience of distress in MH professionals

1.2.1 Mental health and power

Since the introduction of asylums in the 19th century and their gradual replacement by modern psychiatric hospitals and increased provision of community care, the role of power and the social processes at play in separating those labelled as "mad" from those who are "sane" have been considered (e.g. Foucault, 2006). Moncrieff & Timimi (2013) described psychiatric medicine as reflecting contemporary moral and political values, "overlaid by the myths of positivism" (Foucault, 1965, p. 267) and disguised as an objective scientific pursuit. This allowed psychiatry to exert power in defining what is regarded valid knowledge (Foucault, 2006). In their systemic examination of the National Institute for Clinical Excellence (NICE) guidance for Attention Deficit Hyperactivity Disorder (ADHD) and depression, for example, Moncrieff & Timimi (2013) argued that NICE guidance is likely shaped by power dynamics and ulterior interests - strengthening dominance of a biomedical understanding of ADHD and depression - as opposed to the presentation of objective data. In other words, psychiatric diagnosis disguises subjective judgements as to the "sanity" or "normality" of an individual's behaviour as medical fact and makes recommendations as to the treatment of the condition (Moncrieff, 2010). Schomerus et al.’s (2012) systematic review and meta-analysis of public attitudes supports this argument. They found public understanding of MH is largely based upon the medical model of MH. However, this understanding has not led to increased acceptance of people with MH struggles (Schomerus et al.,2012). Additionally, Moncrieff (2010) argued that medicalising social problems can be capitalised on by drug companies and prevents consideration of how society should respond to disturbing or dangerous behaviours from a social policy aspect.

More recently, there has been a shift from traditional power structures of asylums to more implicit social control. For example, Wagstaff, Graham, Farrell, Larkin and Nettle's (2018) research interviewing black men with schizophrenia found participants had disengaged from MH services after experiencing them as coercive and controlling. In their study, they found that engagement with MH services was linked to receiving support in accessing accommodation, an issue identified as crucial by the service user group. Study participants perceived interventions offered by the service to be dictated by professionals, often involving the administration of medication. This, in combination with findings that ethnic background is linked to compulsory hospital admission rates (e.g. Lawlor, Johnson, Cole & Howard, 2010) lends credibility to the notion that current psychiatric practices conceal issues which, at least partly, are social.

In summary, it can therefore be argued that the use of psychiatric labels serves the purpose of exerting social control, which leads those who are attributed these labels to be in need of “expert” treatment and disempowered.

1.2.2 Mental health and stigma

As LE emerges within research and clinical practice, professionals have voiced concerns around stigmatisation following disclosure of MH difficulties. A staff survey by Devon Partnership NHS Trust (2009) found that 43% of professionals reported personal experiences of MH difficulties, with 22% accessing services for treatment. However, a third of respondents felt they had to conceal their LE of MH at work, for fear of stigma, misunderstanding and rejection. Edwards and Crisp's (2016) online survey of professionals found over half acknowledged a time when they would have benefitted from seeking help but did not, for fear of potential negative consequences for their fitness to practise. They also named “wanting to solve the problem on their own” as a barrier to accessing help. Such issues may mean incidences of MH difficulties in professionals are under reported.

1.2.3. The impact of LE on identity

Role identity theory (Siebert & Siebert, 2007) provides one explanation for professionals’ reluctance to seek help when experiencing MH struggles. It posits that role identity is an interaction between an individual’s personal and social identity and social role, enforced by societal expectations. Individuals evaluate their role performance against those as well as their own personal expectations. Discrepancies in what one expects of oneself, societal expectations and actual role performance can be perceived as personal failure. For professionals with LE, there is the potential for conflict between their social identity as “helper” and their personal identity as someone with MH difficulties at times in need of help.

Another relevant theory, social idenity theory (Tajfel & Turner, 1986), describes identity as partly shaped by groups one belongs to. Tajfel and Turner (1986) proposed that group membership can impact self-steem and provide a social identity. Tajfel and Turner (1986) delineated three cognitive processes in determining and defining group membership: social categorization – the process of grouping together individuals we perceive as similar; social identification – once an individual identifies as a group member, group identity forms part of the individual’s identity leading to the adoption of a group’s social norms and definitions of appropriate behaviour; social comparison – following adopting membership to a group, individuals favourably compare their group to others creating an “ingroup/outgroup” mentality. The idea of “ingroup/outgroup” mentality has been applied to explain conflict between groups, discrimination and prejudice. A professionals’ “ingroup” mentality may therefore emphasise positive attributes of this group as “helpers” compared to the patient “outgroup” in need of help, enhancing professionals’ self-esteem. Being a member of both the patient and professional group has the potential to cause conflict in one’s sense of self and identity.

A growing body of research examines how professionals with LE reconcile their identities as both “help seekers” and “helpers”. Adame (2011) interviewed five therapists who also identified as ‘psychiatric survivors, “people who have survived human rights violations within the MH system” (p. 901; Adame, 2011) to understand how those therapists integrated survivor and clinical identities. The therapists described an interrelationship between the two parts of their identity. One used the metaphor of a tree, the roots representing the survivor part of his identity and the branches and leaves resembling his professional identity, which is more malleable to change than the roots. Another study by Richards et al. (2016) found participants predominantly constructed separate “professional” and “patient” identities, alternating between these depending on context. Less often, participants drew on their experience as a patient and professional simultaneously, which Richards et al. (2016) labelled an “integrated identity” (p.5).

In line with these findings, the concept of the “wounded healer” first developed by C.G. Jung (1954/1966) proposes that a therapist’s own past or present wounds can strengthen the therapeutic relationship through the therapist’s ability to draw on those wounds (Zerubavel & Wright, 2012). According to this view, the identity of being “wounded” (having LE of MH) and being a “healer” (a professional) sit alongside each other, so that woundedness can be drawn upon to foster the therapeutic process (Jung, 1954/1966).

1.2.4 Scope of this Review

There is evidence for the continued dominance of a biomedical framework shaping public understanding of MH (e.g. Schomerus et al., 2012) and treatment of those experiencing MH struggles (e.g. Moncrieff & Timimi, 2013). It has further been argued that a medical understanding of MH leads to service user disempowerment (Foucault, 2006) and allows MH services to exert social control (Wagstaff et al., 2018) Stigma continues to be attached to MH, which, in addition to the above, may impact help-seeking and disclosure of MH difficulties by professionals (e.g. Edwards & Crisp, 2016; Oates et al., 2017), who face further challenges in reconciling the “patient” and “professional” aspect of their identity (e.g. Richards et al., 2016). Despite this, professionals report positive aspects to LE (e.g. Boyd, Zeiss, Reddy & Skinner, 2016) and some professionals have disclosed their LE in written first-person accounts. These accounts often detail personal difficulties, experiences of help-seeking or being a service user as well as the impact of LE on professional identity and attempts to integrate these experiences. This paper aims to review these accounts with regards to how they address and navigate issues such as stigma, power, and being a service user as well as professional; and how professionals position themselves in regard to their lived experience. The following research questions are used to guide the review:

1. What rhetoric do MH professionals use to write about their experiences in published journal articles?
2. What are common themes in MH professionals’ written accounts?

2. Methods

2.1 Search strategy

An electronic literature search was conducted using Web of Science, Ovid Medline, PsychINFO, Social Policy and Practice, ASSIA and CINAHL (via EBSCO). The search terms used were: (“use of self’ OR "lived experience" OR "expert-by-experience" OR "expert by experience" OR “wounded healer” OR “self disclosure” OR “self-disclosure” OR “Experiential knowledge” OR “experiential wisdom”) AND ("MH professional*" OR "nurse*" OR "psychologist*" OR "psychiatrist*" OR "MH staff" OR " MH practitioner*" OR "doctor*" OR "therapist*" OR "counsel*") AND (“Mental distress” OR “MH”) AND (“personal account” OR “life story” OR “personal story” OR “personal narrative*” OR “autoethnograph*”). Search terms were applied to all literature available electronically up until the 4th of July 2019. Reference lists of identified articles were also searched to screen for additional papers. Table 1 lists inclusion criteria and exclusion criteria.

Table 1 *Inclusion and exclusion criteria*

Inclusion criteria	***Exclusion criteria***
1. The paper is published in a peer-reviewed journal in English 2. The account comprises a first-person narrative of LE by a MH professional	1. Researchers interviewed MH professionals as participants as part of a research project 2. The author did not identify herself as a MH professional with LE 3. The author was a peer support worker

First person accounts by peer support workers or experts by experience were excluded on the basis that arguably they may face different barriers within their role compared to MH professionals as sharing LE is an explicit expectation of their role.

2.1 Development of tool to critically appraise rhetoric

According to Winton (2013), rhetoric analysis seeks to provide knowledge about strategies used in texts “to persuade audiences to accept or support particular constructions of reality, points of view and courses of action” (p. 159). Identifying those strategies enables analysis of how an argument is constructed and its effectiveness depending on the target group (Winton, 2013). Analysing rhetoric consists of consideration of five canons: Invention, Disposition, Style, Memory, Delivery (see table 2).

Based on Corbett (1998; cited in: Winton, 2013) and Leach’s (2011) paper on rhetorical analysis in qualitative researching with text, image and sound, a critical appraisal tool was developed to assess rhetoric for this review (table 2). Definitions for each canon were adopted from Winton (2013).

Table 2

Critical appraisal tool to assess rhetoric.

5 canons of rhetoric	**Assessment criteria**	**Lay language interpretation**
Invention - arguments to support view	Persuasion via: • Reason (citing literature/evidence/research), • Emotions • Confidence in own character (as a professional/ service user etc)	**Invention** There's research – reason - logos Feel with me – emotion - pathos I'm worth listening to - ethos
Disposition - discourse / language for rhetorical effect	What kind of persuasive discourse? • Forensic – nature and cause of past events (e.g. condemning/ defending individual or group) • Epideictic – current issues; defining social norms of acting, speaking or thinking to strengthen audience's commitment to a set of values, or increase agreement • Deliberative – convincing others to do something and/or accept view	**Disposition – rhetorical effect** Look what they did! Right things to do/ think vs wrong things You should think like this/ do this
Style (choice of words, arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language? • Jargon, • Layperson's language (e.g. MH system survivor vs the system as saviour/ helpful vs any other position)?	**Style - language** Jargon Layperson (e.g. heroes and villains)
Memory (use of shared cultural memories as rhetorical strategy)	• Is the account contextualised? If so, how? Where does the author place him/herself within the context (e.g. survivor, professional, other)?	**Memory – shared cultural memories** I'm a… The service user movement… Psychiatry…
Delivery (dissemination vs content)	• Type of journal article was published in • Likely audience which will have access to it	**Delivery** What journal/ magazine? Implications?

2.2 Summarising common themes across accounts

The content of first person accounts reviewed was analysed using content analysis (Erlingsson & Brysiewicz, 2017) with the aim to transform the data into an organised summary. Erlingsson and Brysiewicz (2017) describe content analysis as an inductive process of abstracting data by moving from the manifest literal content, captured in the condensed meaning units, to latent content involving interpretation of the data by the researcher. This is done by developing condensed meaning units, codes, categories and themes, initially staying close to the data until eventually deriving interpretative meaning from its content. The aim of the analysis was to capture key themes across all 15 accounts. For this purpose a code was derived from a condensed meaning unit. Turning condensed meaning units into codes was part of the abstraction process described above. A code was defined as having to occur two or more times across accounts to be included in the final analysis. Codes pertaining to similar issues were then organised into categories. A category was included in the final analysis if it occurred across five or more accounts. The analysis was a process of attempting to strike a balance between exploring common themes across accounts, whilst capturing meaning to give depth to the themes and categories identified.

Abstraction is an inherently subjective process based on the researcher’s interpretation of the data. To provide transparency of the researcher’s own pre-conceptions and understandings of the data, a bracketing interview was conducted. This, in combination with a positioning statement (Appendix A), aided the process of self-reflection and allowed for greater scrutiny of the data analysis process. Table 3 provides a brief summary of each account included in this review.

Table 3

Summaries of accounts included in this review

Author	**Author's profession**	**Year published**	**Aims of account**	**Main rhetorical devices used**
Fox, J.	Researcher, social worker	2017	- To explore the role of experiential wisdom in developing the mental health professional discourse	-Reason; confidence in character; use of shared cultural memory of being a social worker and a person with psychosis
Frese, F.	Clinical psychologist	2009	-Not stated	-Emotion; confidence in character; layperson's language; use of shared cultural memory of being a person with psychosis
Peterson, A.	Psychiatric nurse	2016	-To invite the reader to come on a journey of discovering meaning and identify of being a nurse with mental illness using autoethnography.	-Reason; confidence in character; use of shared cultural memory of being a psychiatric nurse
Kottsieper, P.	Clinical psychologist	2009	- To describe the impact of the author's experiences in her view of her psychology training and practice; to review progress on recommendations made by SU/professional collaborative for training and practice	-Reason; emotion; use of shared cultural memory of both psychologist and patient
MacCulloch, T. & Shatell, M.	Psychiatric nurse	2009	- A reflection on the 'wounded healer' concept and how it relates to the author's choice of profession.	-Reason; emotion; use of shared cultural memory of 'wounded healer' and psychiatric nurse
Pirrie, M.	Psychiatric nurse	2013	- Not explicitly stated. The author provides a description of how her LE of MH has made her a better MH nurse.	-Reason; emotion; use of shared cultural memory of being a psychiatric nurse
Deacon, M.	Psychiatric nurse	2015	- Not explicitly stated, though the author titles the paper: Personal experience: being	-Reason; emotion; shared cultural memory of experience of depression

			depressed is worse than having advanced cancer – she described the stigma attached to depression as the ‘coughs and colds of psychiatry’ and contrasts this with her experience of depression.	
Burnard, P.	Psychiatric nurse, educator, researcher	2007	- Autoethnographic account of appointment with a psychiatrist to explore experience of being a patient using services and a healthcare professional, author, researcher and educator.	-Reason; objective, detached style of writing; use of shared cultural memory of both ‘patient’ and ‘professional’
SA	Clinical psychologist	2018	- describing the author’s experience of manic psychosis and accessing EIP services; reflecting and linking this with their experience of practising clinically	-Emotion; reason; confidence in character; use of shared cultural memory of person with psychosis and ‘wounded healer’
Sawyer, A.	Psychologist	2011	- For the author’s experience to be a source of hope and inspiration for patients and clinicians (‘a reminder no to give up’)	-Reason; emotion; use of shared cultural memory of being a psychiatric patient in the 1960’s
Coodin Schiff, A.	Social worker	2004	- To explore the author’s recovery from mental illness in the context of the recovery model	-Reason; confidence in character; emotion; use of shared cultural memory of being a ‘survivor of the mental health system’
Lees, R.L.	OT assistant	2014	-a reflection of the author’s personal recovery journey and the difference between her own recovery journey and those she works with. -reflecting on her evolving understanding of recovery as a result of acknowledging	-Reason; emotion; use of shared cultural memory of schizophrenia

			difference in personal journey and the journey of others.	
Olson, T.	Psychiatric nurse	2002	- using own LE to illustrate discrepancies between personal meaning of experiencing mental distress and clinical practice, which the author perceives to be narrowly focused on clinicians' training, personal biases and a lack of awareness and humility in recognising the limits of one's practice.	-Reason; emotion; use of shared cultural memory of being a psychiatric nurse and how this stands in conflict with the 'patient' part of his identity.
Mack, S.	OT	2001	- outlining the story of the author's (OT) journey through mental illness during which she 'discovered' (as opposed to 'recovered') her 'true talents and gifts (strengths)'	-Reason emotion; use of shared cultural memory of lifespan development in form of diary style writing
May, R.	Clinical psychologist	2000	- personal story of recovery from psychosis and how these experiences influence clinical practice as a clinical psychologist	-Reason; use of shared cultural memory of 'psychiatric system survivor'

3. Results

Following the literature search, 15 papers were identified as eligible for review (see figure 1). This section is divided into the five canons of rhetoric, providing summaries of how the accounts made use of them, with illustrative examples. Themes identified through content analysis are also discussed.

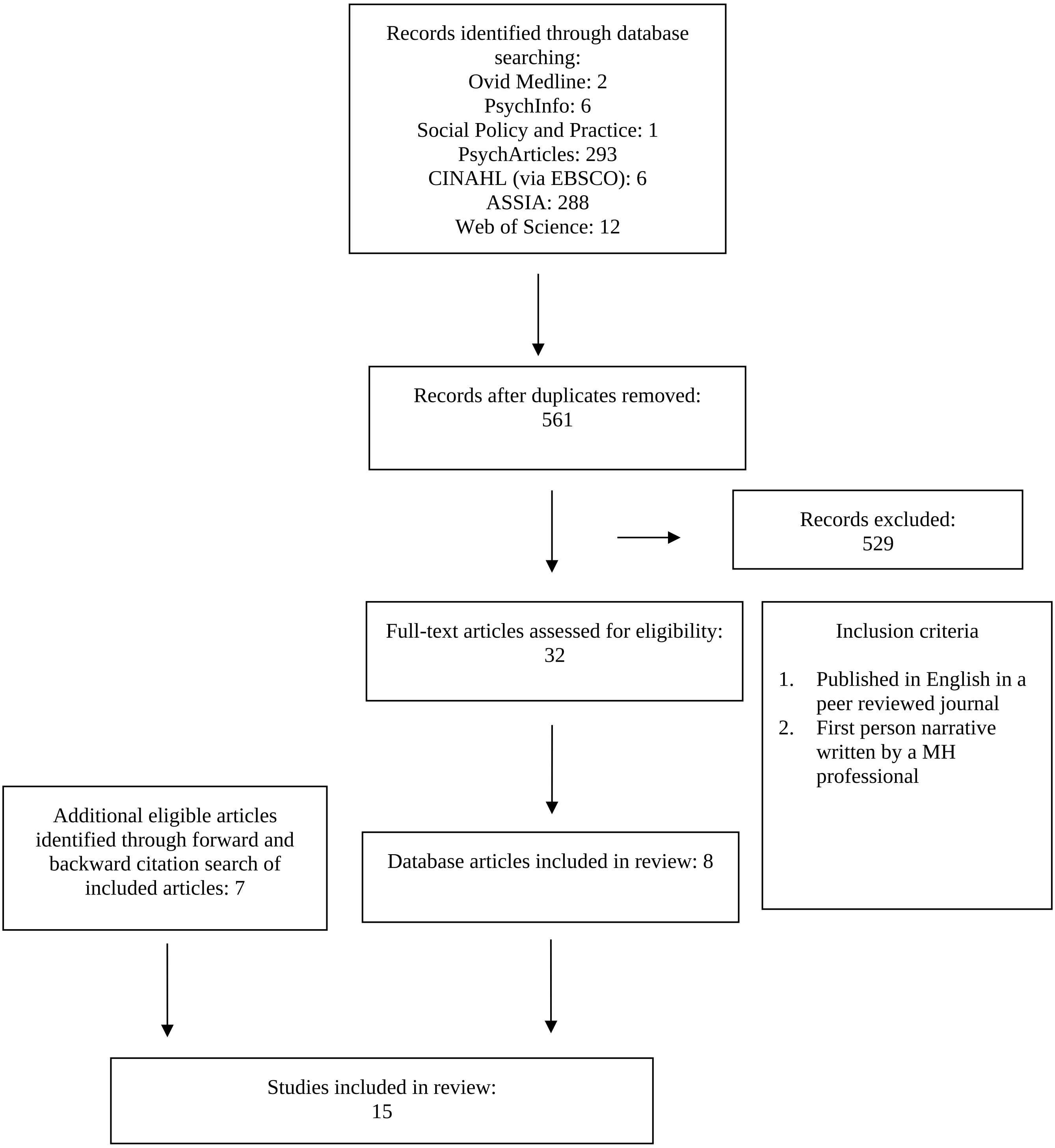

Figure 1 Flowchart illustrating systematic literature search.

3.1 Analysis of rhetoric

This section summarises the results of the rhetorical analysis (Appendix B). Although each canon is presented separately, it is worth noting that there is overlap between them and some of the examples presented below are illustrations for multiple canons.

3.1.1 Invention

This section examines the use of invention as a rhetorical device. Notably, 14 out of 15 papers used reason as a rhetorical device, citing relevant literature and research evidence, and linking this with their experience. This included linking the label of a diagnosis to one's experience of MH (e.g. Deacon, 2015; Kottsieper, 2009; Peterson, 2016), relating one's experience of recovery and treatment to extant literature (e.g. Lees, 2014; Olson, 2002; SA, 2018; Sawyer, 2011; Coodin Schiff, 2004) and contrasting policy and national guidance with current practice or their experience (e.g. Fox, 2017; Kottsieper, 2009).

Eleven out of 15 papers drew on emotion to emphasise their arguments. Emotive words such as "terrified" (Kottsieper, 2009), "horrid agitation" (Deacon, 2015) and "completely terrifying" were used to describe LE of MH (SA, 2018). Elsewhere, the absence of emotion was notable. For example, "I have learned many things from how thirsty lithium can make you", "but in my experience such compliance depends to a greater extent on the medications" (p. 11; Pirrie, 2013) and "I'd been coming up with various excuses for what was wrong with me and why I didn't feel like myself, but eventually I concluded, with careful clinical reflection, that I met the diagnostic criteria for major depressive disorder" (p. 559; Peterson, 2016). These accounts seem to attempt to examine authors' experiences from a position of objectivity

Confidence in character was the least used rhetorical device (five out of 16 papers). SA (2018) draws on this device by naming themselves a "healing healer", derived from the Jungian archetype of the "wounded healer". As a "healing healer", SA sees their experience of seeking help for MH problems as the starting point for their career in clinical psychology, believing their experience gives them insight and greater empathy. Coodin Schiff (2004) adds to this that “prosumers”, professionals with experience of service use, can bridge the gap between the MH system and service users by enabling trust in services, given the value placed on LE by the service user movement. Frese (2009) in his personal account uses confidence in character by calling for professionals who are “far enough along in our careers – and therefore can take the risk of revealing” – to “no longer hide in the shadows” (p. 885), but to “come out” to challenge stigma.

3.1.2 Disposition

Whilst I have attempted to distinguish between the three types of discourses, it is worth acknowledging that they all pertain to presenting ideas about “right” and “wrong” ways of thinking and acting. For this reason, some accounts seemed to feature more than one type of discourse. Of 15 accounts, four appeared to draw on both epideictic and deliberative discourses, seven used an epideictic discourse, two accounts used a deliberative discourse, two drew on a forensic discourse and one account drew on both forensic and deliberative discourses. In accounts using both epideictic and deliberative discourse, the former is drawn upon to set the scene and identify allies who may share the author’s values. Deliberative discourse was used to conclude accounts, seemingly to encourage readers to act on issues identified within the account. Papers using both discourses include Fox (2017), Frese (2009), Kottsieper (2009) and MacCulloch and Shattell (2009). Kottsieper (2009) begins by describing her experience of MH. Referring to relevant literature and research to highlight the value of using LE, she employs epideictic discourse to argue the place of experiential knowledge in clinical practice. She ends the article deliberatively by calling out stigmatising views continually held by MH professionals and calling for greater openness around LE, asking, “How do we expect the public to change their perception if we cannot even choose to safely disclose to one another without fearing adverse consequences?” (p. 187).

The remaining three accounts follow a similar structural pattern. Accounts only utilising epideictic discourse appear to focus on how the authors’ experience links with current societal discourse. An example of this can be found in Peterson’s (2016) account where she situates her understanding of her LE of major depressive disorder within a biomedical context and within her profession as a mental health nurse. She concludes by calling for stories of nurses with LE of MH to be heard. The impact of this is that readers outside the mental health nursing profession may not feel compelled to engage in this kind of activism.

Accounts drawing on deliberative discourse only were the shortest papers and focussed less on linking the authors’ experience to literature or research. Their focus appeared to be on action from the audience, e.g. Deacon (2015) calls for MH professionals to examine their own stigmatising views to avoid minimising the experience of depression, whilst SA (2018) calls for compassion, empathy, refraining from judgment and an integrated MH system to ensure a positive service user experience.

Three accounts drew on a forensic discourse. They presented events chronologically (Burnard, 2007; Mack, 2002; Sawyer, 2011), attempted to remain objective (Burnard, 2007) and were similar to psychiatric case presentations, giving a background to the “patient” (Burnard, 2007; Mack, 2002; Sawyer, 2011).

3.1.3 Style

The canon of style refers to the choice of words, their arrangement, figurative language, and conventions of reading, interpreting and representing. For this review, style was assessed in terms of the language used to write the account, considering use of complex or specialist language (jargon), lay language or language positioning the author in a particular way, e.g. as a MH system survivor or professional.

Fourteen out of 15 accounts used jargon to write about their experiences of MH. Of those, seven also used lay language. Two accounts (Fox, 2017; MacCulloch & Shattell, 2009) used language which neither neatly defined as lay language nor jargon. Fox (2017) draws on the language of the recovery movement, which is idiosyncratic to the movement, but can be understood by an outsider. Some jargon is used in reference to the author's diagnosis, treatment and when referring to policy and guidance. In some cases, jargon seemed to serve the purpose of portraying the author's experience through their professional lens, creating emotional distance between them and their experience. For example, Pirrie (2013) describes taking medication to treat depression. She writes, "when I was first prescribed antipsychotic and antidepressant medications, I was concerned about the associated stigma" (p.11). She then cites literature to support this concern and ends by letting the reader know that "having developed an insight into my illness" (p.11), she concluded that whatever helped manage her symptoms was acceptable. MacCulloch and Shattell's (2009) account employs jargon when referring to treatments and diagnoses, without definitions. The main body of the account is, however, written as a reflective account, looking back on and making sense of personal experiences and professional training using language which would be accessible to laypeople.

Using lay language appears to have the opposite impact of jargon, bringing the reader much closer to the author's experience. Frese (2009) gives the reader a "live" impression of his lived experience of schizophrenia: "Then I began to think, don't we Westerners also have an affinity for the number three?" (p.881). "My mind began to focus on the number three and its possibilities for connecting the values of the East and the West. Clearly, I was on to something of immense consequence. It was a Sunday morning, and I decided I'd go to church at the biggest "temple to the trinity" in the city I was visiting, Mil-wau-kee, Wis-con-sin" (p.882).

3.1.4 Memory

The canon of memory refers to the use of shared cultural memories as a rhetorical strategy. Here, the impact of the author's position is considered, for example as survivors of the MH system or professional within it. Most authors (10 out of 16) wrote their accounts from the position of service users. In these accounts, the experience of MH came before choosing a career within MH.

Coodin Schiff (2004) highlights her identity as a survivor of the MH system and the positive impact of her experiences of MH, hospitalisation and recovery on her clinical work. Coodin Schiff's account focuses on portraying her LE of MH and within the system as a strength adding to her ability to fulfil her professional role.

Four accounts were written from the position of professionals who develop MH difficulties in the course of their career (MacCulloch & Shattell, 2009; Olson, 2002; Peterson, 2016; Pirrie, 2013). All four authors have a background in MH nursing and seemed to draw on this knowledge to understand their MH experiences. Interestingly, all four accounts described a struggle to adjust their sense of self following the emergence of the "service user" part of their identity. Peterson (2016) says: "acknowledging the need for outside help would be an admission of my own professional failure; nurses weren't supposed to be psych patients." (p.559). MacCulloch and Shattell (2009) talk about entering the nursing profession driven by an unconscious desire to understand and cure the self, which became conscious as the authors began to struggle with their own MH. For Olson (2002), "Feeling on the edge of living and dying, I battled the shame that I was now the client, rather than the clinician, and made an urgent call to a psychiatrist." (p.436). As Deacon does, both Peterson (2016) and MacCulloch and Shattell (2006) appear to make refence to the cultural memory of the professional as functioning and experiencing MH struggles challenges this idea.

The authors describe the process of reconciling the “patient” and “nurse” identity in a way that felt less conflicting over time. Peterson (2016) advised that establishing a body of relevant literature about the shifting identities for nurses with mental illness would normalise experiences of MH struggles, helping to combat stigma. The experience of stigma related to MH is also discussed by Pirrie (2013). She argues that MH services could be improved, and stigma reduced, by professionals’ role modelling integrated identities drawing on their LE as well as professional knowledge. Lastly, Olson (2002) and MacCulloch and Shattell (2009) talk about developing self-awareness when reconciling different aspects of their identity. This relates to professionals’ awareness of their own biases, which can conflict with service users’ understanding of their difficulties (Olson, 2002), as well as the ability to reflect on and be attuned to one’s own MH (MacCulloch & Shattell, 2009). Overall, all four accounts conclude that they gained and learned something about themselves through their LE of MH, despite the struggles, making an argument for the use of LE in their practice now.

Burnard (2007) illustrates the position of the patient when he outlines his visit to a psychiatrist describing entering and exiting the role of “the patient”. It appears he perceives some loss of power within the patient role, as he writes: “I noted, as the interview drew to a close, a sense of pulling out of the patient role and back into a more equal role – although not entirely.” (p.810).

Lastly, Fox (2017) describes herself as a “service user with a diagnosis of schizophrenia, a qualified and registered social worker, researcher, and senior lecturer” (p.481) and provides an account of her experience of psychosis. She writes as though both parts of her identity are integrated, though it is unclear if and how this happened. In defining the impact of her experience of psychosis on her work, Fox states that her recovery was central to the process of conducting her PhD, where she utilised Participatory Action Research, in line with her own values of partnership working, which she also believes to be the ethos of social work.

3.1.5 Delivery

All accounts reviewed were published in peer-reviewed journals. Despite the format and language across accounts being variable in their use of clinical jargon and lay language, it seems likely these accounts will mostly be accessed by clinicians and healthcare researchers. Fourteen out of 15 articles mention stigma and address its impact on people suffering with MH problems, including the authors. It seems important to acknowledge that, despite efforts from anti-stigma campaigns (see Hanisch et al., 2016 for a review), this continues to be an experience of people with MH struggles.

3.2 Content Analysis

Through content analysis five themes were identified: Recovery; Stigma; Lived experience; LE of MH vs diagnosis; Reconciliation of identity (see table 3 for an overview of themes and categories; see Appendix C for a detailed table containing themes, categories and codes). This section will provide a brief overview of each.

Table 4 *Content analysis themes and categories*

Themes	**Categories**
1. Recovery	1. Factors facilitating recovery 2. Recovery as ongoing
2. Stigma	1. Self-stigma 2. Fear of stigma
3. **Lived experience**	1. Lived experience as an asset 2. Lived experience impacting practice 3. Integrating professional knowledge and lived experience 4. Personal stories as tools
4. **LE of MH vs diagnosis**	1. Individual experience of MH 2. Diagnosis
5. **Reconciliation of identity**	1. Mental health training to understand self 2. Mental health and dual identity

3.2.1 Recovery

“Recovery” was a dominant theme across most accounts, comprising two categories: “Recovery as ongoing” and “Factors facilitating recovery”. Fox (2017) characterised recovery as “cyclical and ongoing” (p.483) and SA (2018) described their healing process as a continual learning process about “the workings of my mind” (p.1). Authors identified a range of factors aiding their recovery. For example, Kottsieper (2009) states antidepressants helped reduce her symptoms. In addition, her “value as a person and place in society were never questioned, even when I felt I had so little to contribute” (p.176). Peterson (2016) highlights the importance of support “should I lose ‘well’ me’”. (p.559). Lastly, Olson (2009) talks about the importance of hope for recovery being held by both the client and clinician.

3.2.2 Stigma

The theme “Stigma” consists of two categories: “self-stigma” and “fear of stigma”. The definition for self-stigma was derived from accounts within the review, for example Deacon (2015) wrote about seeing one’s MH “as a character flaw” (p. 458), whilst Olson (2009) describes battling with the shame of being a service user. Within the category “self-stigma” I distinguished between the codes “internalising stigma” and “holding self-stigmatising views”. The code “internalising stigma” attempts to capture a dynamic, conscious process between oneself and the environment, where beliefs held by others about mental health interact with beliefs held by the self about the self. On the other hand, the code “holding self-stigmatising views” captures a static state, in which stigmatising perceptions about the self, have become part of a more unconscious and fixed world view. This means that it might be harder to identify those beliefs. Holding self-stigmatising views within the accounts was often related to feeling shame or blame for one’s own condition or failure to fulfil a role. For example, Olson (2009) describes holding a belief that as a nurse he should be able to take care of himself, failure to do so makes him a “bad nurse”. Implicit in this belief is the idea of mental illness as a weakness. By comparison, Peterson (2016) describes blaming herself for letting disclosing her diagnosis get in the way of supporting a friend needing mental health care. The interaction here is between stigma held by Peterson about her own mental health and assumed beliefs others may hold about her if they were to find out about her diagnosis.

The category "fear of stigma" is defined by authors' fears related to others finding out about their mental health condition. In addition to the above example, Kottsieper (2009) and Sawyer (2011) described hiding their difficulties from colleagues for fear of being stigmatised. Burnard (2007) and Sawyer (2011) felt they confronted this fear by publishing their first-person account.

3.2.3 Lived experience

This theme comprises four categories: Lived experience as an asset; lived experience impacting practice; integrating professional knowledge and lived experience; and personal stories as tools. The two categories with the highest frequency and spread of codes were "lived experience as an asset" and "personal stories as tools". Although most accounts identified LE as an asset without providing detail (e.g. SA, 2018), LE was most frequently cited as giving insight and the capacity to empathise. The ability to empathise was identified as impacting practice by making it easier to connect with someone else's experience of MH struggles. Pirrie (2013) stated that experiencing stigma associated with taking psychotropic medication made her aware of the potential impact of this on adhering to advice regarding taking medication, allowing her to respond to ambivalence about taking medication more empathically.

In the category "lived experience impacting practice" authors described how their experience of MH shaped their practice. May (2000) states that the LE of psychosis imparted upon him the importance of "being real, being myself" (p.9) to avoid alienating service users and of believing in others' ability to recovery, which he takes into his practice. SA (2018) relates their own positive experience of help-seeking as a resource they draw on in their clinical work, whilst Sawyer (2011) describes the challenge of remaining open to service users’ experience of schizophrenia without becoming defensive based on her own experiences.

The category “integrating professional knowledge and lived experience” consists of two codes. “Combining professional and experiential knowledge” describes the various ways in which authors have successfully used both their LE and professional training. For example, Burnard (2007) is able to observe his psychiatric appointment both from the point of view of a service user (feeling listened to and heard) and professional (having an opinion as to what treatment might help). “Difficulty integrating professional and experiential knowledge” comes about when authors have rubbed up against traditional practice frameworks based on academic knowledge only (Fox, 2017) and when attempting to consolidate LE with therapeutic models and traditionally prescribed boundaries of the therapeutic relationship (Kottsieper, 2009).

The “personal stories as tools” category pertains to how authors have made use of first-person accounts themselves, and the aims they had in publishing their stories. Kottsieper (2009) states that first-person accounts can “give voice” (p.180) to the service user experience as well as challenge stigma. Similarly, Frese (2009) and May (2000) had the aim of challenging predominant societal discourse about schizophrenia. Personal stories were also identified as having a place in informing training and practice. Sawyer (2011) published her account as a “cautionary tale, a warning against diagnostic fads and careless practice” (p. 776) whilst Deacon (2015) attempted to take her learning from reading others’ accounts of depression into her clinical work. Lastly, authors identified personal stories as means of giving hope and insight to those reading them. For example, Mack (2001) concludes her account by stating that she hopes her story provides courage to those experiencing mental distress and insight to those reading it.

3.2.4 LE of MH vs diagnosis

The theme 'LE of MH vs diagnosis' comprises the categories "individual experience of MH" and "diagnosis". Within the category "individual experiences of mental health" authors most frequently used words relating to the fear or terror they experienced. In their account SA (2018) stated that listing the symptoms did not do the terror they felt justice and likened their experience to a "horrific nightmare" (p.1). Lees (2014) describes her experience as "hard to process" (p.125) and "scary" (p.125) and Mack (2001) says she was "very afraid of her symptoms" (p.47), which she doesn't understand. Feeling out of control was another recurrent description of authors' experience of MH struggles. Mack (2001) described being ravaged by unpredictability and the viciousness of her inner turmoil whilst Frese (2009) stated feeling out of control as part of his experience of schizophrenia. Of note is that all codes relating to the "experience of mental health" category communicated negative aspects of authors' experiences of MH.

The "diagnosis" category describes authors' experiences of receiving a diagnosis. The experience of being diagnosed seemed to stand in contrast to the authors' lived experiences of mental health described above. SA (2018) writes "Yet diagnostic checklists cannot fully explain the experience of developing, living and recovering from psychosis" (p.1). No account described receiving a diagnosis as a positive experience. Mack (2001) felt her "label" attracted "treatment of derogatory cynicism" (p.47) and Sawyer (2001) stated that she was "misdiagnosed, which led to mistreatment and brought with it social and professional stigmatization and self-stigmatization" (p.786). May (2000) in his account states that having a family history of schizophrenia, "clinicians quickly made a diagnosis" (p.6). He was told he needed to be on medication for the rest of this life and described battling social exclusion as a result of the stigma attached to the diagnosis.

3.2.5 Reconciliation of identity

The last theme “reconciliation of identity” consists of two categories: “Professional training to understand self” and “mental health and professional role defining identity”. This theme captures authors’ understanding of how their experiences of mental distress fit with their professional role and training. The category “professional training to understand self” summarises how authors either drew on their professional training to understand subsequent experiences of mental distress or pursued training in a mental health profession in order to understand their experiences. For example, Sawyer (2011) states that she drew on the “clinician part” (p.784) of herself to make sense of a trauma response she experienced, while Mack (2001) described training as an occupational therapist “as a journey of self-discovery” (p.49).

The category “mental health and professional role defining identity” describes how authors reconciled two parts of their identity – the professional and service user – which at times can stand in conflict with one another. Frese (2009) reported holding a lot of knowledge “about mental illness – personally and professionally- and the two parts of my life are closely intertwined” (p.880). He describes how predominant discourses about the chronicity of schizophrenia may continue to dominate as a result of those recovering from the condition not talking about it. In standing up and identifying himself he challenges this discourse and presents both parts of his identity: the person with schizophrenia and the psychologist. Burnard (2007) describes himself as “an insider in that I am a healthcare professional, researcher and educator, and an outsider in that I belong to a group of people (those who have mental health problems) whom are still stigmatized” (p. 809). Unlike Frese (2009), Burnard (2007) describes a process of stepping in and out of the patient role. He leaves the reader unclear whether this means that he sees his “patient” and “professional” role as entirely separate and independent from one another.

4. Discussion

This review set out to answer the question of how professionals write about their LE in published journal articles as well as to identify common themes across accounts. This section will discuss these findings in relation to empirical evidence and extant theory. It will also discuss limitations of the analysis of rhetoric and implications for the use of LE in clinical practice. Recommendations for future research will be set out.

4.1 What rhetoric do MH professionals use to write about their experiences in published journal articles?

The rhetoric professionals drew on to describe their experiences of MH was analysed with the aim of identifying strategies used to bring to life those experiences. In this section, the impact of the most pertinent strategies will be discussed.

Accounts drew on a combination of reason, emotion and confidence in character to make their arguments. The impact of backing individual experience with empirical research appeared to lend credibility to their argument. The use of reason seems in keeping with all accounts being published in peer-reviewed scientific journals whose audience is likely to value reason as a persuasive strategy.

The use of emotion had the impact of bringing the reader close to the author’s experience. The absence of emotion in some accounts was also noticeable (e.g. Pirrie, 2013; Sawyer, 2011). Sawyer (2011) divided her account into subheadings such as “My case” (p.776), “Initial treatment” (p. 777) and “Transfer unimproved” (p. 779). This gives an impression of emotional distance between events and their impact on the author. When Sawyer (2011) then used emotion to describe a therapeutic encounter with a valued clinician, the contrast impresses upon the reader how hopeless aspects of her journey may have felt, intersected with few, seemingly cherished positive experiences.

It appears that the use of emotion as a rhetorical tool is much dependent on the stance of the author as to whether emotion would increase or in fact decrease an account's rhetorical power. Burnard (2007) grapples with the tension of this in his autoethnographic account (the process of documenting and reflecting on one's own experience) of a visit to a psychiatrist. He concludes autoethnography allows for a "fairly impersonal and reasonably objective account of the events" (p. 812) whilst critiquing the impossibility of verification of his subjective observations. This highlights the conflict between traditional values of objectivity within science and one's personal views and emotions which undoubtedly impact the research process. The use of personal reflection to provide transparency within the research process is already recommended and commonly used in qualitative research methodology (Elliott, Fischer & Rennie, 1999). However, those reflections are still rarely featured in published articles. The accounts reviewed here may make an argument for the place of reflections on personal views and emotional reactions in published work, to allow for an understanding of the researcher's position and scrutiny of it.

Also, of note is the use of shared cultural memories within the accounts, particularly implicit assumptions and role expectations of professionals as "functioning" (Deacon, 2015) and differences in how LE of MH is understood and integrated into one's identity and sense of self (e.g. Coodin Schiff, 2004; Peterson, 2016). Authors with LE of MH prior to starting their career in MH appeared to view their LE as an asset and themselves as resilient (e.g. Coodin Schiff, 2004; Kottsieper, 2009) whilst authors who encountered MH struggles in the course of their career appeared to face a conflict of identity and eventual reconciliation, i.e. finding peace with, their sense of self (e.g. Peterson, 2016, Olson, 2002). Role identity theory (Siebert & Siebert, 2007) provides one possible explanation for this. Discrepancies between individual and societal role expectations and role performance may be more likely to occur for those, who have first taken on the role of "professional" and "helper" and are then later faced with the role of "patient" or "help-seeker". It is possible that authors with LE of MH prior to entering a MH profession have already gone through a reconstruction of their sense of self, drawing on more positive narratives about their service user identity (e.g. Richards et al., 2016). More research on the construction of identity and sense of self is needed to elucidate this difference identified within the review.

4.2 What are common themes in MH professionals' written accounts?

I have used content analysis to identify common themes across accounts reviewed. In this section I will discuss the three themes consisting of the highest frequency of codes: "Lived experience", "recovery" and "LE of MH vs diagnosis".

Within the theme of "lived experience", authors reported their "lived experience as an asset". The idea of LE as an asset is in line with Jung's (1954/1966) "wounded healer" archetype as well as findings by Boyd et al. (2016) that professionals feel that sharing LE can instil hope. The impact of using LE within the therapeutic relationship remains up for debate due to discrepancies in definition of self-disclosure and methodological issues in researching this area (see Henretty & Levitt, 2010).

Reflected in the "integrating professional knowledge and lived experience" category are Richards et al.'s (2016) findings of attempting to consolidate LE and professional aspects of the self. The category "first-person stories as tools" could be seen as an extension of the "LE as an asset". "First-person stories as tools" describes how written first-person accounts may be used to challenge stigma, inform training and practice and provide insight into LE of MH to professionals as well as to provide hope to service users. As stigma continues to be a barrier in talking about MH (e.g. Devon Partnership NHS Trust, 2009; Edwards & Crisp, 2016) exploring the effectiveness of first-person accounts to challenge stigmatising views may present a potential avenue for future research. The involvement of service users in commissioning, planning, delivering and researching MH care in the UK has been stipulated in a number of best practice guidelines (e.g. Sheldon & Harding, 2010) and examples of how institutions have implemented these have been published (e.g. Holttum, Lea, Morris, Riley & Byrne, 2011). However, there is limited evidence of the impact of service user involvement on MH care practice (e.g. Crawford et al., 2002) and the question remains whether exposure to people with LE of MH reduces stigma. Research has identified a lack of shared definition of involvement (McCusker, MacIntyre, Stewart & Jackson, 2012) and poor implementation of participation (Storm & Edwards, 2013) as reasons for sparsity of published work. Future research may want to focus on filling this gap.

The “recovery” theme captures ideas reflected in the recovery model of a continual process of learning about the self and one’s strengths (Storm & Edwards, 2013) and identified factors facilitating this process. The factors identified here have been identified in previous reviews, for example Leamy, Bird, Le Boutillier, Williams and Slade (2011) who identified thirteen characteristics of recovery (see table 4).

Table 5 *Characteristics of recovery journey (Leamy et al., 2011)*

1. Recovery is an active process
2. Individual and unique process
3. Non-linear process
4. Recovery as a journey
5. Recovery as stages or phases
6. Recovery as a struggle
7. Multidimensional process
8. Recovery is a gradual process
9. Recovery as a life-changing experience
10. Recovery without cure
11. Recovery is aided by supportive and healing environment
12. Recovery can occur without professional intervention
13. Trial and error process

The category “recovery as ongoing” identified within accounts is reflected in the characteristic of recovery as a journey. “Factors facilitating recovery” included the code “having a support network”, mirrored in the characteristic “recovery aided by supportive and healing environment.

The theme “LE of MH vs diagnosis” captures the individual authors’ experiences which contrasts the process of being given a diagnosis. Authors used descriptions such as “terror”, “fear” and “feeling out of control” to describe their experiences. Paying attention to the individual’s experience of MH rather than clinical descriptors may help in acknowledging the hardship people with MH struggles face. It may also bring into focus barriers to successful engagement with treatment.

4.3 Limitations

For this review I developed a tool to critically appraise rhetoric in first-person accounts of professionals with LE of MH based on ideas from Corbett (1998; cited in: Winton, 2013), Leach (2011) and Winton (2013). Whilst this kind of analysis has been used to appraise language used in policy papers, political speeches (Winton, 2013) and literature (Leach, 2011) I am not aware of previous published attempts of analysing first-person accounts of professionals' LE of MH using rhetorical analysis. As such, I have no standard to compare this analysis to. It should also be acknowledged that the analysis reflects the impact of first-person accounts' rhetoric on me, which makes it inherently subjective and it should be noted that I embarked on this review holding the opinion that LE of MH enrichens clinical work. It is possible that someone else analysing the accounts would have reached a different conclusion. The issue of subjectivity could have been redressed by asking another researcher to apply the tool to the same accounts and compare the rhetorical strategies prominent to them.

Another limitation is the exclusion of grey literature which may have added rigor to the analysis with the possibility of identifying differences, if any, between language used in peer-reviewed journal articles and grey literature. It should also be noted the difficulties I experienced in identifying accounts eligible for inclusion in this review. This was largely due to the discrepancies in keywords and terminologies used to write about the topic of LE. As the flow diagram demonstrates, half of the accounts were identified by scanning referencing lists and becoming familiar with authors who have publicly spoken about their LE of MH. This review explored rhetoric of first-person accounts of LE of MH and therefore excluded studies, which interviewed professionals about their LE. Including studies which interviewed professionals may have yielded different results.

4.4 Implications for research

Future research may seek to apply the critical appraisal tool in different research contexts to ascertain its usefulness within qualitative research and allow for its development. A repeat of the analysis of the accounts above by a different researcher may also improve reliability of the analysis conducted by me. It would also be interesting to carry out a review of the rhetoric employed by professionals, in the grey literature, to compare findings. Lastly, this review focused on how professionals understand the impact of LE on themselves and by extension on their clinical work. What is absent within this review is the voice of the service user and their views about practitioners bringing their LE into clinical work.

4.5 Implications for clinical work

This review highlighted that people who are professionals with LE of MH can struggle to reconcile the professional and service user part of their identity. Whilst professionals consider their LE an asset, stigma both internalised and experienced from others may add to clinicians' difficulty in developing a more integrated sense of self. Several authors of the accounts reviewed here (e.g. Kottsieper, 2009; Pirrie, 2013) call for efforts to be made to support integration of LE and professional identity. This may require rethinking the assumptions we make and attributes we ascribe to MH professionals. For this, a willingness to explicitly reflect on barriers, both individual and institutional, to allowing LE into MH care practices may need to take place. It may also require relinquishing some of the power inherent in the "expert' position and for this to be shared with those, whom we aim to support. This, in combination with continuing the development of community-based approaches to mental health care may aid the move away from focusing on individual psychopathology towards a model of care which is participatory, inclusive and strengths-based (see Rhodes & Langtiw, 2018 for an exploration of the contribution of community psychology to clinical psychology).

4.6 Conclusion

This review used analysis of rhetoric to assess how professionals write about their LE and identified common themes across those accounts using content analysis. Within the rhetorical analysis, I highlighted and explored authors' use of reason as a persuasive strategy in keeping with the tradition of academic writing. I also highlighted the potential value of explicit reflection on one's emotions and views within empirical research and the need to share those reflections within publications. Themes identified within the content analysis were explored in relation to extant literature and research, in particular the apparent struggle faced by clinicians in reconciling professional and service user parts of their identity. This struggle may be exacerbated by implicit role expectations of professionals as functioning as well as stigmatising views regarding MH. Efforts to support the development of a more integrated sense of self may want to focus on identifying personal and institutional barriers to allowing consideration of how LE can be incorporated within MH care as well as "letting go of" the "expert" position of professionals moving towards models of care, which focus less on individual responsibility and more on strengths-based, participatory practices.

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Section B: Empirical Paper

Sharing is caring? – how mental health staff and service users perceive the impact of sharing lived experience on recovery

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Abstract

Research shows that both mental health (MH) professionals and service users perceive benefits from professional self-disclosure (SD) of lived experience (LE). These benefits include an improved therapeutic alliance, normalising experiences of MH and service users feeling more hopeful. This study used grounded theory methodology to develop a theory of the factors impacting the likelihood of professionals' use of SD of LE and identify possible outcomes. 15 service users and professionals took part in this study. The emergent theory describes the core category of "The process of sharing LE – mediating factors and outcomes", and its dynamic relationship to three related categories: "NHS culture", "Context of therapeutic relationship" and "The emergence of EbEs and PSWs". Findings contribute to the evidence base that SD of LE has the potential to be a valuable therapeutic intervention and considers possible barriers to its implementation within the NHS.

Keywords: Lived experience, grounded theory, self-disclosure, mental health

Sharing is caring? – how mental health staff and service users perceive the impact of sharing LE on recovery

1. Introduction

1.1 The road to recovery

The mental health (MH) recovery movement, taking inspiration from other rights campaigns, such as the black, gay and women's liberation movement, aimed to advocate for the rights of those suffering with MH struggles (Chamberlin, 1990).

Recent years have observed a shift in MH care from viewing recovery as reduction in symptoms towards recognising recovery as the reclaiming of valued social roles and building a life worth living to the individual concerned (Tew et al., 2012). Recovery-oriented practice therefore promotes MH service users to become active participants in their lives, empowered to be self-determinate and manage their difficulties with an emphasis on strengths and positive attributes (Roberts & Boardman 2014).

Leamy, Bird, Le Boutillier, Williams and Slade (2011) conducted a systematic review and narrative synthesis of the literature to develop a framework for personal recovery. Out of their review they identified characteristics of the recovery journey as well as the conceptual 'CHIME' framework, which specifies five recovery processes: connection, hope and optimism about the future, identity, meaning in life and empowerment.

1.2 Recovery and self-disclosure of lived experience

To support individually meaningful recovery, the concept of sharing lived experience (LE) has emerged as an idea that individuals who have 'lived through' and 'survived' difficulties are uniquely equipped to support those experiencing MH difficulties (Roberts & Boardman, 2014). This has given rise to hypotheses of possible mechanisms of and factors influencing the use of such self-disclosures (SD). Of particular interest has been their impact on the relationship between professionals and service users and on recovery. SD has been defined in several ways, leading to difficulties in conducting systematic literature reviews to explore the impact of SD within therapy work. Fuertes, Moore and Ganley (2019) distinguish between two types of SD: the disclosure of personal, factual information, such as interests and attitudes; and the disclosure of self-involving information, such as reactions and impressions, to the service user in-session as they occur. The disclosure of self-involving information is considered of therapeutic value by a range of therapy models, for example psychoanalysis and humanistic psychotherapy (Ziv-Beiman, 2013) whilst the benefit of SD of ‘nonimmediate’, factual information about the therapist continues to be disputed (Ziv-Beiman, 2013).

In addition to multiple definitions, other barriers to researching SD include how SD is measured (i.e. frequency or level of intimacy of disclosure; Henretty & Levitt, 2010) and research designs (e.g. single-session mock therapy interactions unlikely to represent real-life therapeutic relationships; Henretty & Levitt, 2010). Despite these, research suggests SD is overall positively related to service users’ experience of the therapeutic relationship, although SD of factual personal information can impact the working alliance negatively (Pinto-Coelho, Hill & Kivlighan, 2016). Therapist attunement to the service user also regulates successful SD (Pinto-Coelho et al., 2018), reflected in service user reports that SD can lead to both hope and worry (Lewis-Holmes, 2016). Henretty and Levitt (2010) concluded SD appears to be a helpful therapeutic intervention, with evidence to support this view. However, they cautioned its success depends on multiple individual and contextual factors. They offer guiding prompts (who, what, when, why, how) to support professionals in using SD ethically and effectively. This project adopts Ziv-Beiman’s (2013) definition of ‘nonimmediate’ SD; “the sharing of personal distress or difficulties", to elucidate the impact of this contested therapeutic intervention.

1.3 The role of peer support and experts-by-experience

There have been efforts to incorporate LE as part of MH service provision in the form of peer support (Department of Health; DoH, 2008). Peer support has a long-standing tradition outside of statutory MH services (Lawton-Smith, 2013).There is now growing recognition that people with LE of MH can fill a gap in MH care provision, in the form of peer support to facilitate recovery (Gillard & Holley, 2014) and as 'experts-by-experience' providing experiential knowledge to consult on service provision and improvement (Oates, Drey & Jones, 2017). Although research has identified benefits for services and peer workers (e.g. Lawton-Smith, 2013 for a review), issues have also been raised (e.g. Gillard & Holley, 2014). Sinclair (2018) shares her experience of microaggression as a peer worker and a review by Vandewalle et al. (2016) found peer workers reported many barriers to successful implementation of peer support, including professionals' negative attitudes and poor role implementation. Additionally, Oates et al. (2017) argue the introduction of peer workers and experts-by-experience does not address the continued taboo of disclosure of LE within MH professionals and leaves experiential knowledge amongst professionals unacknowledged.

1.4 Lived experience of mental health in professionals

As with SD, there is no universally accepted definition of LE. Morgan and Lawson (2015) ran focus groups, which defined LE broadly as life experience, including achievements, values, skills and interests. In the context of MH, the groups defined LE as experiences of trauma in terms of grief, loss, illness or life changing events, universal to all human beings. By comparison de Vos, Netten and Noordenbos (2016) described LE as knowledge and understanding gained through direct experience. They proposed that LE includes the experience itself and meanings attributed to it by the person going through these.

Recent data on NHS staff sickness revealed mental ill-health was the main reason for staff absence in April 2019 (Copeland, 2019). Anxiety, stress, depression and other psychiatric illnesses accounted for 25% of full-time equivalent (FTE) staff absence days, by far exceeding other reasons. Psychiatric illness was also named as the reason for absences amongst senior managers and managers in almost a third of cases (Collins, 2019). Devon Partnership NHS Trust (2009) found a third of survey respondents reported concealing their LE of MH at work, for fear of stigma, misunderstanding and rejection. Similarly, in Edwards and Crisp's (2016) online survey of professionals, over half acknowledged a time they would have benefitted from seeking help but did not, for fear of potential negative consequences for their fitness to practise. Wanting to solve the problem on their own, fear of worsened future job prospects as well as stigma have also been identified as barriers to accessing help (Roberts, Good, Wooldridge & Baker, 2011; Edwards & Crisp, 2016; Boyd, Zeiss, Reddy & Skinner, 2016), which may mean incidences of MH difficulties in professionals are under-reported.

At the same time, research shows professionals draw on LE to support their work with service users. Professionals felt their LE enabled them to instil hope and feel empathy (Boyd, Zeiss, Reddy & Skinner, 2016; Devon Partnership Trust, 2009) although they did not share their LE explicitly (Boyd et al., 2016). Roberts et al. (2011) suggested personal experiences of MH might uniquely equip staff to be empathetic, insightful and motivated to work within MH. This, combined with research suggesting 9%-10% of variance in perceived therapist genuineness is accounted for by therapist SD (Gelso, 2014), suggests LE may play an important role in how professionals build meaningful, supportive relationships with service users.

In some areas of psychological treatment, e.g. addictions (Culbreth, 2000) and eating disorders (de Vos, Netten & Noordenbos, 2016) the use of LE as a positive influence on recovery is well established. Though it appears that LE of MH is common within mental health professionals, it is still seldom spoken about or recognised within services (Richards, Holttum & Springham, 2016).

1.5 Aims and research questions

Currently, there is limited research to integrate professionals' and service users' ideas about the effects of SD of LE on aspects of service user recovery (Henretty and Levitt, 2010; Lewis-Holmes, 2016). The service user voice within research and the development of guidelines appear mostly absent (Lewis-Holmes, 2016). This project therefore aimed to develop a preliminary theory of factors influencing the likelihood of using SD of LE within the therapeutic relationship, as identified by professionals and service users. The study further aimed to identify impacts following SD of LE, experienced by both professionals and service users. Grounded theory (GT) methodology, a qualitative approach particularly suited to the exploration of intricate social dynamics (Uqruhart, 2013), was used. Specifically, the research questions were:

1. What factors impact the use of self-disclosure of lived experience within a therapeutic relationship?
2. What impacts, if any, do staff and service users perceive following staff self-disclosures of lived experience?

2. Method

2.1 Design

Initially, I joined several participation groups across the host trust to recruit a group of service user and staff volunteers, with the aim of using participatory action research (PAR) to conduct the project. Due to the requirements of doctorate level training of leading, and therefore holding, ultimate decision-making power for the research, it was not possible to conduct this project as PAR. Instead, I collaborated with the group of volunteers to develop the idea and design of the project.

I used grounded theory (GT) as described by Charmaz (2006) and Urquhart (2013) as a framework for gathering and analysing data.

2.2 Methodology

Grounded theory methodology (GTM) produces a theory grounded in the data (Urquhart, 2013). The resulting theory attempts to elucidate and explain relationships between concepts identified within the data. Because my research attempted to capture the temporal dynamic between staff self-disclosure and its perceived mechanisms and impacts on service users, GT seemed the most appropriate method. I adopted a constructivist epistemological stance as described by Charmaz (2006). This is consistent with my own view that reality is constructed within a social context and highly dependent on individuals' interpretations of experiences, and encourages the researcher, me, to reflect on their own views, biases and perceptions. Charmaz describes constructivist GT as an interpretative approach in which the data are actively constructed by both researcher and participants. Constructivist GT seeks to study how and why meanings and actions in specific circumstances arise. Given the research questions relate to individuals' unique experiences of the impact of staff SD, and their impressions of the process around this, an interpretative approach appeared to align with this aim. Lastly, constructivist GT does not seek to portray an objective view of the phenomenon, rather the data analysis and subsequent theory are subject to the researcher's understanding of the data and present *one* possible explanation of the question under study. Charmaz (2016) advocates for "developing methodological self-consciousness to turn a deeply reflexive gaze back on ourselves and the research process as well as on the empirical world" (p.35).

2.3 Ethical considerations

Ethical approval to conduct this research was granted by the NHS London – Surrey Research Ethics Committee (Appendix D). To allow potential participants to consider participation without feeling pressured by my presence, information sheets and an advert were distributed through mailing lists, the trust's monthly newsletter and service user and staff meetings and participation groups. Those interested contacted me either via email or phone. None of the participants who agreed to partake dropped out or asked to withdraw their interview. Once informed consent was obtained (Appendix E), interviews were audio-recorded and stored on an encrypted memory stick and password-protected laptop using Axcrypt encryption software. Participant anonymity was maintained by allocating each participant a number and removing identifying information from the transcripts. Given the nature of the research, the study had the potential to bring up difficult memories of LEs of MH for both staff and service users. Therefore, before beginning the interview, all participants were verbally reminded of their right to withdraw at any point and ask me to pause the interview, should this feel necessary. All participants were also informed of the researcher's responsibility to communicate risk with relevant parties. Staff who were members of a regulated profession were reminded of their duty to adhere to their own professional code of conduct and obligation to report breaches of the code. A space for discussion of these issues was provided at the beginning of each interview. All participants were provided with relevant information regarding services or organisations that could offer support should they feel they needed it. These included contact details for MIND and Samaritans, as well as trust internal support structures for employees.

2.4 Participants

Sixteen participants were interviewed. Twice, for participants 2 and 7, the audio recording software failed. For participant 2, the researcher produced notes from memory of the conversation which were sent to the participant for editing and verification. Unfortunately, for participant 7, this process was not possible, as several interviews had taken place on the same day and information obtained from this specific interview could not reliably be documented. Therefore 15 participants were included in the final analysis. Demographic information gathered was limited to participants' gender, role within the NHS at the point of the interview, and other roles held within or outside of the NHS during or prior to interview (see table 1).

Table 1 *Participant demographics and roles within the NHS prior or outside to and/or during interview.*

Participant number	**Gender**	**Role within the trust at point of interview (clinical, managerial non-clinical staff, service user, expert by experience, peer support worker, peer trainer)**	**Other roles held as identified by participants at point of interview or prior**
1	Male	Clinical	Service user/carer
2	Female	Clinical	Service user
3	Male	Managerial non-clinical	Service user
4	Male	Peer trainer	Service user
5	Female	Expert by experience	Service user
6	Female	Expert by experience	Service user
7 *	Male	Peer trainer	Service user
8	Female	Expert by experience	Service user
9	Female	Managerial non-clinical	Carer
10	Female	Expert by experience	Service user
11	Female	Service user	Peer mentor (outside NHS)
12	Male	Expert by experience	Peer support worker, service user
13	Male	Expert by experience	Service user
14	Female	Peer trainer, expert by experience	Service user, NHS staff
15	Female	Clinical	Service user
16	Female	Expert by experience	Service user and carer

Note: Expert by experience is the term used by the host trust for staff employed to draw on their expertise of mental health service use.

*Participant 7 was excluded from the analysis due to malfunctioning recording equipment.

As table 1 illustrates, every participant identified as holding a dual identity, so it proved difficult to divide participants into the service user and staff group as initially intended. I therefore decided it would be most useful to provide information on their primary role within the NHS at the point of the interview taking place, as well as other secondary roles they may hold currently or have held previously.

2.5 Procedure

As a result of a two-hour consultation meeting with the group of volunteers, I developed two information sheets (Appendix F) and two interview schedules for service users and staff (Appendix G). Feedback on the draft and final versions for both was sought from the group. Examples of the impact of members' input include: changing the language of the information sheet for service users to layperson's language, for which they provided suggestions; enlarging the font of the service user information sheet to ensure it was accessible to as many service users as possible.

2.5.1 Recruitment

Following ethical approval, information sheets were distributed across the host trust, initially by the second thesis supervisor, who had access to mailing lists as well as support from the communication team, who published a brief advert of the study (Appendix H) in the trust's monthly newsletter. Information sheets were also distributed at staff and service user meetings and participation groups. Those interested to partake contacted me via email and a date for either a face-to-face, telephone or Skype/Zoom interview was arranged. Of the 16 interviews, nine were face-to-face, and seven via technology. Initially, it was hoped to recruit equal numbers of staff and service user participants. However, once it became clear that participants all seemed to have had experience of service use as well as holding or having held a paid role within the trust, I decided to focus on participants' journey into working for the trust and the role their LE played within their work.

2.5.2 Data collection

Face-to-face interviews took place across several trust bases depending where participants were located. Travel costs could be reimbursed for up to £10. Interviews lasted 50- 70 minutes. In collaboration with a group of service user and staff volunteers, I developed two interview schedules, one for staff and one for service user participants. Questions for staff focused on what and how they decided to share about themselves, as well as impacts and outcomes of sharing. Questions for experts-by-experience focused on their experience of service use, of relationships with staff and the impact of hearing about their LE. If a participant had not had experience of sharing or hearing about staff's LE, they were asked to imagine what the impacts would have been. Throughout data collection it became clear that all participants identified in some way as both trust staff members (clinical, non-clinical staff and experts-by-experience, all paid for some aspects of their work) and service users. Consequently, I adapted the interview schedule to include a question about their role within the trust. It also became clear that a big part of participants' recovery was taking on roles such as peer support workers, peer trainers or experts-by-experience, so I included a question about participants' perception of their recovery journey and the impact of sharing this as part of their work. For participants primarily working in clinical or managerial non-clinical roles who had not shared their LE with service users, I included a question about whether they had told a colleague about it and explored reasons around this. A question on whether stigma was an issue was also added for all participants to provide an opportunity to explore experiences of service use in relation to this and barriers to sharing LE.

By being adaptable and reflexive in interviews, I hoped to sufficiently cover all aspects of the process of professional to service user disclosure and its impacts on individual recovery and how this process fits within NHS culture. Urquhart (2013) advises that a balance needs to be struck between gathering enough data to build an understanding of the area under investigation whilst keeping in mind the scope and aims of the project. I realised as I began to transcribe and analyse the interviews that the impact of the process of self-disclosure reached beyond the relationship between professional and service user. I attempted to capture and hypothesise the further reaching effects of self-disclosure; it is important to note these are hypotheses somewhat outside the original research question. Nonetheless, I present these in the hope that future investigations can explore this further.

2.5.3 Data analysis

To analyse the data I followed guidance provided by Charmaz (2006, 2016) and Urquhart (2013). They emphasise that GT is not a linear process, rather it can require the researcher to repeat or return to earlier stages of data collection or analysis. The first four interview transcripts were analysed line-by-line to facilitate open-minded coding (Charmaz, 2006). Throughout the analytic process, I wrote memos (Appendix I) to capture observations and comparisons across transcripts, to explore connections and ideas about potential future categories (Charmaz, 2006). The categories resulting from the initial analysis were grouped together and organised into the first draft of a diagrammatic representation of the theory (Appendix J). To analyse the next five interviews, I used focused coding, identifying codes which frequently occurred in the first four interviews. This served to identify patterns and relationships between categories (Charmaz, 2006). Lastly, theoretical coding was employed to conceptualise how substantive categories relate to each other and hypothesise how they can be integrated into a theory. Once all transcripts were coded, there were 786 codes altogether. Because of the large amount of codes, I moved back and forth throughout the coding process between codes identified in earlier transcripts and focused codes to rethink labels and categories. NVivo 12 Pro software was used to aid organisation and analysis of transcripts.

2.6 Quality assurance

Elliott, Fischer & Rennie's (1999) guidelines for qualitative research informed the quality assurance process. They recommend transparency around one’s own views and perspectives, providing credibility checks by an experienced researcher and a record allowing the reader to understand the analytic process. In line with these recommendations, several strategies to encourage reflection and reflexivity throughout the research process were employed (Tufford & Newman, 2012). A reflective diary was kept throughout the research process. This, in combination with a bracketing interview conducted by a colleague during the data analysis stage, informed the writing of a positioning statement (see Appendix A) to aid the process of self-reflection described by Charmaz (2016).

When analysing the data, I followed Charmaz's (2006) and Tufford and Newman's (2012) guidance on keeping memos to track and capture how ideas developed. Charmaz (2006) further advises to focus codes on actions and processes to identify relationships between participants' experiences, aiding the development of theory. In line with Elliott et al.'s (1999) suggestion to provide credibility checks, two coded transcripts were discussed with the lead supervisor who had significant experience in conducting grounded theory research. I also shared draft theories throughout the analysis with this supervisor for discussion. The use of diagramming and documentation of evolving codes and categories also aimed to ensure transparency throughout the analytic process (Appendix J).

3. Results

3.1 Overview of the model

Figure 1 presents a model capturing the core category of *'The process of sharing LE - mediating factors and outcomes'* and its relationships with other categories identified within the data. The model attempts to encapsulate the process of sharing professional LE within the therapeutic relationship, which is impacted upon by a variety of contextual factors, such as service users' and professionals' beliefs about LE; practice, ethics and values held by professionals; service users' previous experiences of therapeutic relationships; and the culture of the NHS.

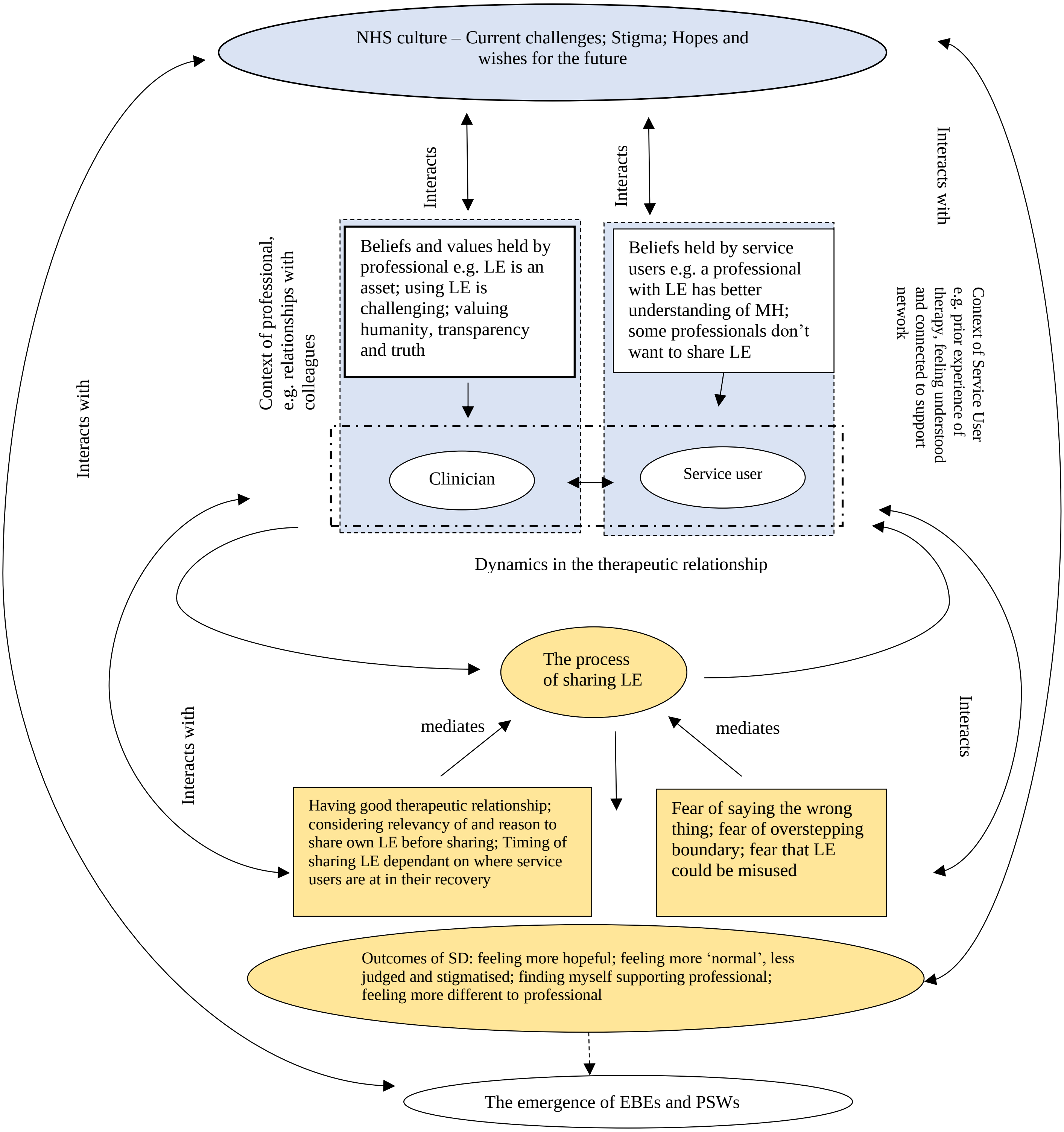

Figure 1. The process of sharing LE – beliefs, mediating factors and outcomes.

Table 2 *Categories and subcategories of "The process of sharing LE – beliefs, mediating factors and outcomes.*

Categories	Category description	Subcategories
NHS culture	This category describes the NHS culture within which both professional and service users operate. The subcategory "*current challenges*" consists of codes relating to: delivering services with minimal resources; and power imbalances. The subcategory "*stigma*" contains codes pertaining to the experience and challenge of stigma. The subcategory "*hopes and wishes for the futur*e" summarises codes relating to: changing views about LE; a desire for the culture to change; and to learn from past mistakes around participation and service user involvement.	1. Current challenges 2. Stigma 3. Hopes and wishes for the future
Context of therapeutic relationship	This category operates within the NHS culture and comprises factors brought to the relationship by both the professional and service user. "*Context of professional*" includes: beliefs held about the use of LE and SD; personal values such as supporting service user involvement; the task of integrating personal and professional identity; and drawing on both LE and professional knowledge to inform practice. "*Context of service user*" includes: feeling understood by and connected to a support network, previous experiences of therapeutic relationships; and how they conceptualise recovery. The "*dynamics in the therapeutic relationship*" represent an interplay between those factors, for example: relating to each other on a human level; acknowledging difference and being open to understanding each other's perspective; being aware of the professional's desire to be liked, which is seen to be different to being helpful.	4. Context of professional 5. Context of service user 6. Dynamics in therapeutic relationship
The process of sharing LE – mediating factors and outcomes	This was identified as the core category most pertinent to the research question and at the centre of and feeding into by the remaining categories. It contains participants struggle with "*Defining LE is difficult*" and identifies "*factors mediating use of SD of LE*" within the therapeutic relationship. It also summarises "*outcomes of SD*" identified by participants and hypothesises as to how these outcomes impact on individuals as well as the wider context.	7. Defining LE is difficult 8. Factors mediating SD of LE 9. Outcomes of SD
The emergence of EBEs and PSWs	This category relates to "The process of sharing LE-mediating factors and outcomes" as becoming an EBE or PSW was identified as a potential outcome of self-disclosure. It "*describes and defines the role of EBEs and PSWs*" as well as "*motivations to enter EBE or PSW role*" and the challenges faced within them. Although it is related to the *"outcomes of SD"* subcategory, I decided to create a new category as 10 out of 15 participants spoke about aspects of these roles, which made it feel significant as a standalone category. I viewed taking on the role of an EBE or PSW as a delayed outcome of service use. Participants talked about wanting to contribute to MH care and restoring power imbalances within the role. This category is linked with and impacts on 'NHS culture' and the *"challenges in EBE and PSW work"* mirror some of the *"factors mediating SD of LE"*. For example, the codes "being mindful of boundaries and nature of therapeutic relationship" and "needing and wanting guidance around how to use LE" in "*factors mediating SD of LE*" seem to be mirrored in the code "experiencing difficulties in maintaining boundaries within PSW and EBE work" in "*challenges in EBE or PSW work*". It seems	10. Defining and describing the role of EBE and PSW 11. Motivations to enter EBE or PSW role 12. Challenges in EBE or PSW work

	that in drawing on LE professionals, EBEs and PSWs can face similar difficulties.

3.2 Core category

The core category identified was "**The process of sharing LE – mediating factors and outcomes"**. This section describes this process and how it relates to the other categories identified. The first task for participants seemed to be to define 'LE'. The subcategory *"defining LE is difficult"* captures participants' struggle in circumscribing what LE is. Instead of a definition, participants emphasised the importance of recognising the universality of experiences of psychological distress, which is not unique to people accessing mental health services but common to everyone. As participant 15 stated:

"I describe things as 'we', so I tend to gravitate and I always have to quite sort of universal, like idiosyncratic formulations and problems rather than things based on a particular diagnosis … there's something for me about suffering is about being human and it could happen to any of us".

Participant 1 was the exception in thinking more specifically about what constitutes LE:

"*In clinic the experiences I would draw on that I would share are about my experiences of parenting…the challenges of being a parent……but I'm, that might be a slightly different meaning of the word than the new official meaning, which ….captures some discrete episode of mental health distress, which I think in itself is slightly problematic cos it is in itself slightly institutionalised."*

Also contained within the core category are *"factors mediating SD of LE"* identified by professionals and service users. Considering relevancy of and reason to share own LE before sharing was a pertinent mediating factor within this subcategory. Participant 2 stated:

"I wouldn't share personal things about myself with all service users. I think it needs to be relevant to them, but I am also careful that they might use what I tell them against me, although this has never happened."

Participant 5 demonstrated the importance of professionals reflecting on their motivations to self-disclose by saying:

"When it's been actually negative it's because it sort of felt like it was subverting the relationship that we had. You know I wanted to be the service user, I wanted them to be the staff."

The mediating factors within this category highlight the complexity of the process of deciding when to share LE. Participant 16 emphasised this point:

"I don't know how you can best advise people as to when it's right or wrong …cos sometimes hearing the words I know what you're going through sometimes that is a lift and sometimes that gets your hackles up."

Other mediating factors included: having a good therapeutic relationship; being mindful of boundaries and nature of therapeutic relationship; and a lack of time and resources hindering sharing of LE (see Appendix K for additional codes).

In terms of the outcomes of sharing LE participants identified positive outcomes, such as feeling more ‘normal’, less judged and stigmatised, feeling understood and heard, feeling more hopeful, improving therapeutic alliance. Negative outcomes included feeling more different to the professional and hearing about others’ LE whilst in distress yourself not always helpful. Participant 5 illustrates the feeling of being understood and heard:

“The good experience I am thinking of, really made me feel that they’ve had a better understanding of my mental health condition. I got bipolar affective disorder and she shared with me that she also has bipolar. So, I immediately felt that she would have a better understanding…it removed the stigma, but there is always a feeling of stigma even with mental health staff who understand. And that really helped to remove that stigma, so I thought okay, so they are not judging me, which made me feel better.”

3.3 NHS culture

This category consists of the subcategories *“current challenges”*, *“stigma”* and “*hopes and wishes for the future”*. Both staff and service users identified power imbalances, underfunding and lack of resources as *“current challenges”* faced by professionals and service users.

“I think a lot of the doctors don’t have the time to sit and listen. They are overworked, there’s not enough doctors out there, enough psychiatrists for everyone that needs them.” (P11)

“I do think some of these nurses don’t think that we’re really fellow human beings.”(P10)

Participant 1 added to the notion of power imbalances by recognising that care priorities and needs tend to be organised by a professional agenda and participant 14 illustrated the struggle in calling out those power imbalances in an example of talking about the work she does through the ‘experts by experience’ scheme:

“I’ve forgotten to claim for it but the team that organise it, they’ve got no record of what work they’ve given me. Now, I want to know why they think that’s acceptable to operate like that when none of the department in the trust would dare to say ‘Yes, we employed someone in the team on a substantive role, but we’ve got no records of it’. That would never happen.”

The *“stigma”* subcategory comprised codes relating to experiences of stigma and how to challenge it. It appeared that participants felt some mental health diagnoses attract more stigmatisation than others. Participant 12 illustrated this:

“Well there is not just stigma, there is also, I hate to say it, but there is an actual, a certain trend in certain mental health illnesses. So, OCD and bipolar are quite trendy sort of mental………Paranoid schizophrenia is connected to someone who is in Broadmoor.”

Both professional and service user participants described experiencing stigma within the NHS, for example participant 3:

“I used to work in clinical services in the communities, and I was stuck in a… a lower banded job for a long time because of my mental health problems”

In addition to experiencing stigma, participants identified holding self-stigmatising views as damaging and getting in the way of asking for help:

"Yeah, I think self-stigma is the most crippling. It's the walls that you put around yourself" (P10).

Although both staff and service user participants identified instances of having experienced or observed stigma, participant 1 appeared to hold the view that it would no longer be legitimate to express stigmatising views outwardly:

"I don't know at a preconscious or conscious but silent level what people might make of that. Whether they might go 'Oh yes, outwardly I have to kind of sign up to this involvement agenda and be seen to be doing the right thing and therefore…"

On the other hand, participant 12 describes his experience of the trust as follows:

"There's always stigma, there's stigma within [trust]. There is still stigma now.... even though mental health is talked about greatly…. because I had a history with forensic when I came into PICU this time I had stigma written all over me."

This may indicate, as demonstrated in previous examples, that some experiences of MH carry more stigma than others, which service users may be more acutely aware of than staff. In terms of challenging stigma, normalising experiences was identified as helpful:

"…the social worker encouraged me to talk to a friend about one thing that ….I felt bad about and I got up the courage to actually talk to her and she said 'Oh, I had the same thing with my brother' and that made me feel like more part of normal society, you know, that it's not just me being a nutter" (P10).

Some causes for the existence of stigma were also identified. Participant 6 wondered whether mental health services provide an opportunity for staff to project difficulties into service users rather than owning these themselves:

"Human beings have a tendency if they are experiencing their own problems in whatever context to sometimes project their own problems onto others and criticize others in any way they can think."

In the subcategory "Hopes and wishes for the future" participant 5 spoke about wanting learning to take place from past mistakes around participation and to change the way it is implemented:

[In the context of being an interviewer on a panel:]

"A lot of staff haven't got a clue so they 'oh I always ask the service users if they'd been happy with the service…and I always hand them a feedback form'. And that's not participation at all, so none of ladder of participation and the levels. So, I think look I am asking this question… I am a service user on an interview panel you could use that as an example. But they don't even…. It's somehow…. still not part of the culture." (P5)

Participants also articulated a desire for a change in culture within the NHS wanting to pose questions such as:

"How can you treat someone, who doesn't want to take medication?" (P10).

When asked about what she hoped to gain from asking this question, participant 10 replied:

"Well a considered answer…. Maybe some indication that they have thought about it before."

There was also some acknowledgment that views around the value of LE are slowly changing as evidenced by the fact that some participants had noticed personal experiences of MH listed as a desirable criterion when applying for jobs:

"You never quite know exactly how that's kind of heard but what I experienced was a willingness to hear about that, not least by putting it in the erm desirable column." (P1).

3.4 The context of the therapeutic relationship

This category consists of three subcategories: *"The context of the professional"*; *"The context of the service user"*; *"Dynamics in the therapeutic relationship*".

The *"context of the professional"* subcategory comprises contextual factors, beliefs and values held by the professional which can impact on their interaction with service users. Examples codes for these are 'having close, supportive relationships with teams and colleagues', 'seeing LE as an asset'; 'looking at commonalities rather than differences with service users'. Participant 1 said:

"I mean I draw on my [lived] experiences as much as some of the other essential criteria, certainly a lot more than my undergraduate psychology degree."

Participant 6 emphasised the idea of common experiences rather than difference:

"Lots of us, and it's not just people who suffer from mental disorder, lots of us can experience in any context of life distress."

The "context of service user" subcategory covers codes such as "previous experiences of therapeutic relationships"; "feeling understood by and connected to a support network"; "beliefs held by service users about LE".

"Having my husband understand what I'm going through is absolutely invaluable" (P16)

Participant 5, 10, 12 and 13 all discussed the impact of having received diagnoses of psychoses and bipolar, having been hospitalised and receiving psychotropic medication as a treatment for their MH. None of them have been offered talking therapies. Participant 5 describes the impact of this:

"I've never had…well not for 30 years I never had any sort of therapy in terms of maybe CBT or counselling. Or any means of getting to the bottom of why it all happened….it feels

like a trauma having been in hospital, even though it wasn't a horrible experience, it was a trauma and I feel like I've never had a chance to talk to anybody about that stuff."

Both the *"context of professional"* and *"context of service user"* are hypothesised to contribute to the third subcategory *"Dynamics in the therapeutic relationship*". This subcategory summarises the interplay of the contextual factors identified above, such as 'relating to each other on a human level'; 'distinguishing between understanding service users' experiences and having a superficial understanding'; 'needing to be liked and being a helpful therapist are different things'.

"I think just in terms of assumptions of similarity, you know this idea that people might want to be liked by their patients. That doesn't necessarily mean they're gonna be that helpful to them." (P1)

Participant 12 also reflected on professionals' motivation for sharing:

"But I felt sometimes with certain people that have told me about their lived experience of mental health, I just think sometimes I think are they just telling me because they want me to like them."

Being liked appears to meet a need within staff:

"how we are trying to get our attachment needs met that were never met in our childhood, I don't know if anyone has ever done a study on the level of insecure attachment for health professionals" (P1)

Being helpful at times may mean challenging service users to think about change, e.g. participant 10:

"Well, because the CPNs always nursed me, you know, they asked me how are you, how have you been and all that, whereas this social worker said to me how could your life be better, what can you do to improve your life. She made me work…"

It seems that sharing LE is not inherently of therapeutic value to service users but that, at times, they were able to tell that SD may have been primarily driven by the motivations and needs of the professional.

Within the process of SD model, the contextual factors and beliefs held both by professionals and service users are considered more static stable factors which interact with mediating factors identified in the core category and impact on the professional's decision to use self-disclosure of LE.

3.5 The emergence of EBEs and PSWs

*"***The emergence of EBEs and PSWs***"* was identified as a category separate from the core category and the "*outcomes of self-disclosure*" subcategory. Although not directly related to either of the research questions, when analysing the interviews and subsequently grouping and exploring the resulting codes, I noticed that all participants interviewed under the 'service user' label had chosen to train as either EBEs or PSWs following their involvement with mental health services and brought their experience of this work to the interviews. I therefore began to explore the reasons why participants chose to remain involved with the trust within these roles. Three subcategories were identified: "*Defining and*

describing the role of EBE and PSW";" *Motivations to enter EBE or PSW role"*; "*Challenges in EBE or PSW work"*. It appeared that engaging in either of these roles was a delayed result of involvement with services in contrast to some of the more immediate outcomes of the use of self-disclosure, e.g. 'improving therapeutic alliance' and feeling more 'normal', less judged and stigmatised'. The subcategory "*Defining and describing the role of EBE and PSW*" summarises the purpose of these roles within the NHS, which was identified as bridging the gap between staff and service users, e.g.:

"But it was just so nice that they could see me as a bridge between them and the staff because there is this gulf and a lot of the time they are hiding stuff." (P5)

and 'wanting to give hope for recovery and shaping what the trust offers', e.g.:

*"Because I wanted new staff to see what the trust was about and how they were going to help people like me." (*P4).

Participant 3 also raised the issue of putting support and supervision in place for EBEs and PSWs and being clear about the remit and purpose of their role. Within the subcategory "*Motivations to enter EBE or PSW role*" participants talked about 'wanting to be meaningfully involved in service delivery, evaluation and development', 'wanting an equal say and restoring the power balance' and 'enjoying the EBE role':

"So, the interview panels, then there is focus groups, steering group meetings for various services. yes, and I went to board meeting for a care service board meeting and it's brilliant

*because you really feel you've been listened to and I think most of my recovery has come from that… from being taken seriously and being called an expert…" (*P5)

In the last subcategory "*challenges in EBE or PSW work*" talked about the difficulty of neither belonging to the staff nor service user group, feeling less valued than other professions and finding it difficult to ask for help and admit to struggles. Interestingly, EBEs and PSWs appeared to struggle with similar issues identified by professionals, for example staff identifying experiences of stigmatisation for having LE and the impact of this on how capable others perceive them to be. Participants also raised the issue of maintaining boundaries within their EBE or PSW role. Participant 14 said about her role as a peer trainer:

"I think there's very little support for us as a team about making appropriate disclosures and striking the balance of professional boundaries, so it's no wonder people get it wrong."

Participant 3 also acknowledged lack of training, governance and structure for PSWs and EbEs as an issue in supporting them managing therapeutic boundaries. The struggle to maintain boundaries was also reflected in the core category when participants grappled with defining when LE was appropriate to disclose. The issue of how to maintain boundaries to ascertain safety for both service user and professional whilst letting these be flexible enough to be adjusted is a complex one. Participant 14 illustrates the feeling of boundaries being too rigid by saying:

"I guess I do expect a relating on a human level and if that's not apparent, I can't trust them with my care. Like mechanical and cold and I'm left thinking 'But do you really get me?"

Participant 15 illustrated the need for safety within the relationship:

"It is important for people when I'm in my professional role, for them to feel safe with you and boundaries can help people to feel safe. And I don't want those boundaries to be unravelled in a way which becomes unhelpful for them and for me".

4. Discussion

This study, using GT methodology, attempted to build a theory of the factors impacting the likelihood of use of SD of LE in therapeutic relationships. It also aimed to identify effects of such disclosures. The results offer a model capturing the process of sharing LE in the context of the therapeutic relationship, identifying contextual and individual factors impacting on this process, as well as the impacts of outcomes of sharing LE on the professional, service user and wider NHS context.

4.1 What factors impact the use of self-disclosure of lived experience within a therapeutic relationship?

The analysis identified that considering relevancy of and reason to share LE was a pertinent factor impacting a decision to disclose LE or not. The consideration of relevancy and reasons to share involves reflecting on assumptions about similarity of experiences and professionals' motivations of sharing these. Participants described sharing to further therapy work or building on the therapeutic alliance as helpful compared to disclosures driven by professionals' emotional needs, which were considered unhelpful. These findings reflect previous research (Hanson, 2005; Lewis-Holmes, 2016; Pinto-Coelho et al., 2018).

Another factor in deciding to use SD was timing of disclosures. This related to how long professional and service user had known each other and where service users were at in their recovery. Having had time to build trust and being mindful of the level of distress of service users in relation to their MH were linked to deciding to use SD. It was considered that service users who had only recently begun to experience MH struggles might be less able to make use of SD than service users who had some time to make sense of their own experiences. Although timing has been identified as a crucial factor in considering the use of SD (Pinto-Coelho et al., 2018, 2016), this factor has not yet been the explicit subject of research (Henretty & Levitt, 2010).

Having a good therapeutic relationship was a factor mediating the use of SD. Included in this were having respect for one another and trust, previously highlighted by Lewis-Holmes (2016).

Fear of saying the wrong thing or giving the wrong advice was identified as a factor impeding use of SD. Professionals identified a fear of private things becoming public and both professionals and service users spoke about a fear of saying the wrong thing, worrying that this might lead to the service user feeling worse or the professional ‘getting into trouble’. Interestingly, only one participant could identify an instance where their fears came true in the context of their role as a PSW. Pinto-Coelho et al. (2018) mention fear in the context of professionals’ imposing their difficulties onto service users, which may relate to the above worry of making service users feel worse, whilst Byrne, Happell and Reid-Searl (2017) linked fear to information about professionals’ mental health being publicly known, a finding replicated in the current study.

4.2 What impacts, if any, do staff and service users perceive following staff self-disclosures of lived experience?

Participants identified several outcomes of SD of LE. Amongst them were feeling trust, understood and heard, feeling more ‘normal’ (Pinto-Coelho et al., 2018) and an improved therapeutic alliance (Simonds & Spokes, 2017), findings previously reported elsewhere. Interestingly, previous research (e.g. Lewis-Holmes, 2016) has talked about the impact of stigma as a barrier to the disclosing LE of MH, whilst interviewees in this study identified SD of LE as a means of decreasing stigma and feeling less judged. Disclosing LE of MH has been hypothesised to decrease MH-related stigma by a number of professionals (Frese, 2009; Kottsieper, 2009; Mack, 2002). Participants also identified feeling more hopeful as a result of professionals’ SD of LE, a finding which has been replicated in the literature numerous times (e.g. Boyd et al., 2016; de Vos et al., 2016; Roberts & Boardman, 2014).

Participants also discussed instances when hearing about professionals’ LE may not be helpful. These instances included: When the sharing of LE was experienced as silencing, for example the service user felt not able to disagree with the professional’s perspective or felt that their space was taken up by the professional; when service users felt caught up in the ‘living in distress now’; when it was felt that professionals wanted sympathy from service users; and when sharing LE blurred the boundaries of the relationship. Audet (2011) obtained similar findings, namely that SD can create confusion about roles and boundaries in the therapeutic relationship and that using SD too liberally can lead service users to feeling silenced. Being too caught up in one’s own MH experiences appears to be related to timing use of SD as discussed above. Experiencing high levels of distress in relation to MH may also limit service users’ ability to make use of professionals’ SD of LE. This might in part be due to feeling that professionals assumed a similarity in experiences which service users cannot (Pinto-Coelho et al., 2018). As identified by participants in this study, this assumption of similarity may lead service users to feel their experiences are invalidated or that the professional is requiring a sympathetic response. Either can cause a rupture in the therapeutic relationship or lead to the blurring of boundaries.

4.3 Clinical implications

The current study sought to elucidate the impact of professionals' sharing LE on service user experience of treatment. Participants in this project stated that SD of LE gives them hope for recovery, normalises their experiences and makes them feel less judged and stigmatised. This has potential implications for improving service user engagement with services, especially for those who experience MH struggles and are least likely to access services, such as people with a diagnosis of schizophrenia (Wagstaff, Graham, Farrell, Larkin, & Nettle, 2018).

This project further highlights that stigma continues to be a deterrent in talking about MH struggles for both staff and professionals. One possibility for this to be addressed could be through reflective practice, which has an emerging evidence base in being effective in supporting professionals to process emotions and experiences with service users (Fenton & Kidd, 2019).

The findings of this study highlight that both professionals and EbEs/PSWs struggle with the issue of maintaining flexible, safe boundaries, which emphasises the need for continued monitoring of shifts in roles and boundaries within the therapeutic relationship. Explicit exploration of issues such as differences in power and the context the relationship between professional and service user exists within, may also help in negotiating roles and boundaries.

4.4 Limitations

This study attempted to develop the evidence base on the use of SD of LE in MH. However, it is worth commenting on a number of limitations. Firstly, the sample consisted of participants who all identified as having LE of MH and all largely in favour of its use within MH services. Conducting interviews with professionals who do not identify as having LE of MH may have yielded different results. In addition to that participants who were primarily interviewed as service users all chose to return to the trust as EbEs or PSWs. The views of service users who chose not to seek employment with the trust in one of those roles following treatment are not represented here but may enrichen the analysis.

It is also worth highlighting some methodological limitations. Although some of the coding of the interviews was checked by the thesis supervisor, reliability of the analysis would have been improved by another researcher coding the transcripts and comparing codes. Lastly, feedback on the model developed from the analysis could have been gathered from study participants. Respondent validation would have lent further credibility to the results.

4.5 Directions for future research

Although this study did not specifically ask participants to differentiate between self-involving and nonimmediate personal, factual information, the definition for SD of LE specified in the interview schedule sought to elicit participants’ views of the latter. The results here do not support the notion that SD of nonimmediate information is problematic, however future research may seek to replicate these findings.

The study identified stigma as a barrier to sharing LE, whilst sharing LE was also thought to have the power to reduce stigma. Evidence shows that anti-stigma interventions vary in success of reducing stigmatising views in professionals. Research may seek to further elucidate the role of SD of LE in reducing stigma. This may include clarifying the role of reflective practice in freeing professionals to begin to share experiences more openly and to examine their views and biases within a safe environment.

The project initially intended to utilise PAR. Future projects may consider the potential value PAR could add to this area, both in terms of accessing a wider range of knowledge and experience to shape the research, but also in terms of acting on good intentions of empowering those who MH care is designed to serve.

4.6 Conclusions

This study used GT methodology to explore factors impacting use of SD of LE in the context of the therapeutic relationship. Findings revealed the process of SD is mediated by several factors, such as relevancy and motivation of sharing, timing, having a good therapeutic relationship and fear of saying the wrong thing. The resulting model highlights the process of SD is linked to several individual and contextual factors, such as the context of the professional and service user, the context of the therapeutic relationship as well as the culture within the NHS. Shorter term outcomes of SD include feeling more hopeful, feeling more normal, less judged and stigmatised. Participants also identified entering roles as EbE and PSWs as a result of their experience of service use in order to shape services and restore the power imbalance. Challenges within the roles were identified as feeling less valued than professionals and struggling to ask for help when experiencing both professional and MH difficulties. The problematic impact of culture on professionals' experience of the NHS as a workplace should be noted and steps taken to address this.

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Appendix A. Positioning statement

Reflexivity

I reflected on my own views and biases on the research topic during a bracketing interview. At the time of conducting this research project I was a 30-year old white European female in my final year of training. My interest in how mental health professionals can bring their own experiences into their work, however, started before training. I was working as a healthcare assistant in a child and adolescent Tier 4 inpatient ward when I first became acutely aware of my frustration of working clinically with young people, most of them having their very first and acute experience of distress. This frustration was born out of a sense that as a staff team we had to maintain an emotional distance to the people we looked after. I was left feeling that I was watching young people feeling lonely and isolated in their experience from afar. I have now come to understand that their experiences touched some of my own deeply painful and personal experiences. I had a sense that sharing my experiences might in some way alleviate their feelings of loneliness and isolation, at the same time I was unsure how to go about this and worried about what would happen if I did share my personal experiences. As my career within mental health progressed, I became increasingly interested in what draws people to work in mental health. On a personal level, I believed that my own experiences meant that I was able to relate to people accessing services and often found myself in a position of being an ally to them.

With this in mind, I embarked on this project. The following are reflections on how I believe my own experiences and stance have impacted the research process.

In my mind, the distinction between those who are ‘sane’ and those who are ‘mad’ has always been an arbitrary one as I believe that all of us have ‘mad’ parts. Reading some of Foucault’s work on the function of asylums in separating the ‘mad’ from the ‘sane’ to exert social control and the psychoanalytic idea of projection, in which professionals disown themselves of their madness and project it into their ‘patients’ made a lot of sense to me based on own experiences but also observations of staff service user relationships and service setups. When I first developed the idea for this research, I had the intention of shaking up beliefs about people who are mental health professionals and people who use services with the aim of encouraging more self-awareness and a willingness to reflect within the professional group. I hoped that I could challenge the othering of those with a mental health condition by pointing out the obvious: that all of us have likely had experiences which posed a challenge to our mental well-being.

The above means that I entered the research process wanting to make an argument for the possibility of integrating the personal and professional parts of our identity. I was curious about what my fellow mental health colleagues and people who use services would think of this idea. With my curiosity and aims for this project, I also began to think about my role as a researcher, traditionally defined as an objective observer vs the idea of being an active ingredient in shaping the process. To me, it made sense that I would in some way influence and shape the process with my own beliefs and ideas. I began this project with the desire to make an argument for the liberation of people with lived experience, professional or not, and although this desire hasn’t changed altogether, I also began to develop an interest in the subtleties of interactions and sharing experiences. The learning I take away from this project is that we can use language powerfully to free a person up to talk about their experiences.

Appendix B

Critical appraisal tool to assess rhetorical power in first person written accounts of MH professionals with LE (based on Corbett, 1998; in Winton, 2013)

Paper	5 canons of rhetoric	Assessment criteria	How the paper met them	Additional considerations
Fox, J. (2017)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-Reason: cites relevant theory, research evidence and policies and situates her perspective in these -Confidence in character: p.481 "social worker is a protected title that can only be used by those suitably qualified and registered with the Health and Care Professionals Council" -Emotions: used to describe experiences of MH	What are the aims of the account? -To explore the role of experiential wisdom in developing the mental health professional discourse Is the author's perspective described and taken into accounted/ reflected on? -Author describes professional background and her experience of psychosis, though does not talk about how both relate/connect or reflects on how her personal experience may have impacted on her career choice. Implicitly, the author values partnership working and recovery approaches, which she deems to align with social work ethos. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? - Not explicitly in this account. Is the author writing on behalf of a certain group (e.g. MH professionals with depression)
	Disposition (organisation of discourse – written language- for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-Epideictic: author seems clear proponent of recovery approach and seems to encourage particularly social workers and nurses to act in accordance with the approach's values which according to her aligns with both professions' values -Deliberative: convincing readers of utility of recovery approach and need to include experiential knowledge in trying to understand MH, alongside professional wisdom and knowledge acquired through research.	
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the system as	-Language of 'recovery movement' – neither jargon, nor layperson's language, but requires familiarity with recovery approach	

		saviour/helpful vs any other position)		or about their own personal experience? What is the impact of this? -She seems to particularly address the article to nurses and social workers. Unclear why. This has the impact that it the article feels exclusively relevant to these two groups of professionals, which feels ‘othering’. Relevance to practice? -She explores broadly how experiential wisdom can inform practice and research, as well as policy guidance, though does not appear to link how professionals may manage their experiential wisdom alongside professional work. Does the account fit/ not fit with what we already know? Are these links made explicitly? -Yes. The account situates itself within the recovery model, emphasising collaboration and partnership with links to current policy and research.
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-Context of being a social worker and service user with diagnosis of psychosis, however, both parts of the author’s identity seem separated (also in the text) and not integrated (how does personal impact her practice and vice versa?)	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-Schizophrenia Bulletin – peer-reviewed, scientific journal publishing a variety of written work related to psychosis/schizophrenia.	

Paper	5 canons of rhetoric	Assessment criteria	How the paper met them	Additional considerations
	Invention (finding arguments to support one’s point of view)	Did the author use: reason (defined as citing literature/evidence/research),	-Mostly emotion, no references to empirical research included.	What are the aims of the account?

Frese (2009)		emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	Some reference made to policy though this is vague. -Confidence in character – call to MH professionals like himself with LE to lead way to talk about experiences of serious MH -Paper mostly written from position of service user	-Not stated. Is the author’s perspective described and taken into accounted/ reflected on? -Author’s experience described, unclear how he made sense of this; did not present reflections. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -No explicit exploration of own position, the impact of status or power (being a white male etc?) Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -He writes from the perspective of a person with schizophrenia and severe mental health difficulties, who is also a psychologist. The article gives the impression that it wants to challenge, particularly senior professionals, to begin to talk about their LE. Relevance to practice?
	Disposition (organisation of discourse – written language- for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-Epideictic – call to senior MH professionals in particular to talk about their experiences to pave the way for others ultimately to improve equality -Deliberative – highlighting and challenging stigma by highlighting occurrence of MH across population and therefore need to talk about it.	
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-Mostly layperson’s language used. -Seems to talk from SU perspective. Neutral positioning to MH system portrayed despite involuntary hospital stays – no opinion or judgement provided on this	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	‘I’m a person with schizophrenia’ Some biographical information provided	

	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-Peer reviewed journal of health policy thought and research – aimed at government, health industry readers, health care advocates, scholars of health.	-No links to practice. As above the article appears to be a call to 'speak out' and challenge stigma around MH. Does the account fit/ not fit with what we already know? Are these links made explicitly? -Difficult to say as little is said about the context in which his difficulties occurred. The experiences the author describes fit with other accounts of schizophrenia. -Links his account with need to challenge stigma and speak out about MH challenges, though does not seem to have direct experiences of being stigmatised against (only advised not to talk about his MH difficulties by supervisors.
Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a	- reason: author links own experience of major depressive disorder to literature and evidence base	What are the aims of the account? -To invite the reader to come on a journey of discovering

Peterson (2016)		professional/service user or other) as a tool of persuasion?	-confidence in character: identity as trained professional nurse drawn upon throughout the account.	meaning and identify of being a nurse with mental illness using autoethnography. Is the author's perspective described and taken into accounted/ reflected on? -The author describes how her understanding of MDD is related to her training as a nurse. She draws on a biomedical perspective of MH, including in terms of treatment but acknowledges other understandings, too. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -Yes, the author speaks from the perspective of a nurse with MDD and makes sense of the experience within a medical model. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -Though written from perspective of a nurse with MDD, it does not seem that the author assumes her experiences are like others'. Using her
	Disposition (organisation of discourse – written language- for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-epideictic: author describes how her experiences fit within current biomedical discourse of major depressive disorder and how this understanding fits with nursing training and profession	
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-author draws both on layperson's language and jargon. She describes experiences of MDD in lay terms and links these with what she knows of mental health.	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-nurse identity when patient identity 'emerged' – professional identity existed before patient. -No background information provided on how MDD came about, this may be irrelevant to the author who uses biomedical model to make sense of her experiences.	

				professional knowledge to make sense of her experiences creates a distance to the emotional impact of what the experience must have been like in the moment. It appears somewhat detached. Relevance to practice? -The author raises the important issue of how MH professionals can consolidate professional aspects of their identity with also being a patient. Does the account fit/ not fit with what we already know? Are these links made explicitly? -The author states her experience of MDD fits with what she observed as a practising nurse. However, no specific links to theory or evidence are made. -The author mentions pertinent issues, e.g. stigma, the importance of making sense of one's experiences and the need for support from others.
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-published in a peer-reviewed journal relevant to MH nurses.	

Paper	5 canons of rhetoric	Assessment criteria	How the paper met them	Additional considerations
Kottsieper (2009)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-relevant research literature cited throughout and linked with the author's personal experience of 'dysthymia' (reason) -emotion: used in the context of describing her experience of dysthymia ('terrified'; 'helpless to control my pain')	What are the aims of the account? -To describe the impact of the author's experiences in her view of her psychology training and practice; to review progress on recommendations made by SU/professional collaborative for training and practice Is the author's perspective described and taken into accounted/ reflected on? -The author goes some way to describe her own experiences of MH and the impact of these on her 'functioning'. She places her MH into the context of her training and work as a psychologist and describes the impact both her experience of MH and professional training have on one another (using LE to instil hope in others, sharing of her experiences with colleagues, stigma, wanting to draw on experiential knowledge more specifically). Some reflections provided, e.g. having a supportive network of friends, family and colleagues which allowed her to recover, as well as professional help, though not much detail provided. Unclear what the
	Disposition (organisation of discourse – written language- for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-epideictic: author describes her experience of MH and argues for a place of experiential knowledge in clinical practice citing relevant empirical research and literature. -deliberative: at the end of the article the author writes about stigma in professionals and asks a series of questions ('How do we expect the public to change their perception if we cannot even choose to safely disclose to one another without fearing adverse consequences?' etc) with the intention to convince the reader of the value of experiential knowledge. She ends the section with 'I definitely feel that my personal experiential knowledge of a mental disorder has added a valuable dimension to my competence as a provider'.	
	Style (choice of words, their arrangement, figurative language, conventions of	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the system as	-jargon: e.g. dysthymia, reference is made to concepts and ideas without defining these, e.g. 'cognitive restructuring',	

	reading, interpreting and representing)	saviour/helpful vs any other position)	‘schizophrenia’, ‘logical positivism’ etc.	drivers were to become a psychologist. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -This is briefly mentioned though again without detail. Some acknowledgment that the author has access to support others may not have, no experiences of being discriminated against or stigmatised – no reflections detailed on this. No background information on author’s other experiences provided and reflections on this are absent in the article. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -It seems that the author attempts to straddle both her experience as a service user and as a psychologist, detailing how she draws on both in her therapeutic work. She does not seem to particularly identify with an SU identity and seems to view her experiences through the lens of a psychologist in wanting to
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-Context provided in brief description of author’s ‘nervous breakdown’ – detail of experience provided without context as to what led to the breakdown or any other early experiences. -author appears to identify as a psychologist with LE and the paper appears to be directed at other professionals with LE. -Notably she does not see herself as someone with serious mental disorder	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-peer-reviewed journal publishing contributions from a range of disciplines addressing controversies and diverse statements pertaining to humanistic psychology. Likely to be accessed and read by MH professionals.	

				draw on those experiences in her practice. Using professional knowledge to understand personal experience in the way the account is written creates a distance to the author's experiences of dysthymia, in an attempt to view them objectively (?). Relevance to practice? -Relevance to practice described and research literature to back this up cited. The author discusses the importance of hope in enabling recovery, this is based on her own experience of needing others to be hopeful on her behalf when she was unwell. The self-disclosure literature is discussed as well as the impact of stigma both within professionals and the public. Does the account fit/ not fit with what we already know? Are these links made explicitly? -Yes, links made explicitly throughout the account

Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research),	-reason: research evidence cited to lend credibility to 'wounded healer' concept	What are the aims of the account?

MacCulloch & Shattell (2009)		emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-emotion: idea of admitting to one's woundedness described as 'brave'; idea that LE enables empathy	-A reflection on the 'wounded healer' concept and how it relates to the author's choice of profession. Is the author's perspective described and taken into accounted/ reflected on? -The author draws on the concept of 'wounded healer' to make sense of his own experiences. In this context, research evidence is cited to back up his arguments. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -Some detail is provided about the author beyond identifying as a 'wounded healer' and psychiatric nurse. Some reference is made to the impact of past and current experiences on the author's MH and his practice as a nurse. No details described as to the author's socioeconomic background and why he chose nursing as a career. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-deliberative: 'Heron (2001) would claim that we are all, in some way, wounded, but that many of us have been so conditioned by our upbringing, education and socialisation that we are truly unaware of our deeply buried hurt.' -epideictic: continued existence of stigma, LE exists and it's an asset (empathy and altruism)	
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	- written as reflective account, looking back on and making sense of personal experiences and professional training -use of some jargon (ECT, anxiety, depression, 'voluntary patient) -identity of 'wounded healer' ('confession')	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-author identifies himself as 'wounded healer' and psychiatric nurse – which the author described as helping him to begin to understand his own psychopathology and	

			impact of early childhood experiences -context of own ‘breakdown’ briefly mentioned	experience? What is the impact of this? -Position of wounded healer and psychiatric nurse speaking from his own experience. The focus seems to be on the woundedness as a source of understanding and empathy as a starting point for his clinical practice, the professional knowledge and experience provides the channel for the personal. The impact is that the account feels genuine, open and emotive. Relevance to practice? -The author states ‘woundedness’ gives rise to greater empathy and understanding of those he works with Does the account fit/ not fit with what we already know? Are these links made explicitly? -Links made throughout to ‘wounded healer’ idea and arguments cited as to why the author believes LE to be common amongst practitioners and the potential benefits and pitfalls of this on therapeutic work.
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-peer-reviewed journal reporting on issues related to psychiatric and mental health nursing -journal publishes both data-based and theoretical papers	
Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**

Pirrie (2013)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason: citing literature (not research evidence) relating to the role of LE (or not) in MH professionals – e.g. unfair to be elevated to expert status in working with MH without having any experience of it. -emotion not explicitly referred to but invoked through author's description of her own experiences ('I have learned many things from how thirsty lithium can make you….'; '…but in my experience such compliance depends to a greater extent on the medications' side effects, which can range from involuntary muscle movement and joint stiffness to weight gain, sedation to effects on unborn foetuses.'	What are the aims of the account? -Not explicitly stated. The author provides a description of how her LE of MH has made her a better MH nurse. Is the author's perspective described and taken into accounted/ reflected on? -Perspective of MH nurse, no information re choice of profession; author's understanding of her own MH not clarified or contextualised, though appears to be impacted on by professional training as a nurse (medication as treatment only thing mentioned to provide information of author's recovery journey) Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -This cannot be clearly established from the account; however, it seems that the author draws on nursing training to make sense of her experiences. For lack of other information, the account seems to lack depth and appears cold (?). The author also makes reference to the helpfulness of 'measured self-disclosure'
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or	-epideictic: LE of MH helps in understanding MH clients and in improving service provision	

		accepting a particular point of view		though admits that she has not done this – no reflections on this or reasons provided. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -Author appears to write from her own perspective as a nurse with LE. Little other information is provided beyond that she has taken medication to get better and this makes it hard to get a sense of her recovery. The impact of this is that it feels hard to connect with the emotion of the experience the author describes. The reader is kept at a distance. Relevance to practice? -Broadly, the author states that LE helps her understand her clients, no further detail provided. Does the account fit/ not fit with what we already know? Are these links made explicitly? -As above, links between LE and increased understanding of MH made. 'Wounded healer' concept referred to as well as
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-jargon: 'major depression with psychotic features' -author appears to write about experiences through the lens of her nursing training rather than something more personal	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-idealistic mental health nurse -then receiving a diagnosis -account contextualised within nursing profession	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-peer-reviewed journal publishing research, literature reviews, case studies, opinion pieces and description of practice articles. The journal's website states that it focuses on areas such as communication, education, service users, therapeutic practice and workforce.	

				other theories. No research cited to support ideas.
Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
Deacon (2015)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason: the author cites research evidence and other literature to both make links with and contrast her own experience of depression -emotion: subjective experience of depression described, this is particularly powerful where contrasted against objective knowledge of depression	What are the aims of the account? -Not explicitly stated, though the author titles the paper: Personal experience: being depressed is worse than having advanced cancer – she described the stigma attached to depression as the 'coughs and colds of psychiatry' and contrasts this with her experience of depression. Is the author's perspective described and taken into accounted/ reflected on? -The author describes personal impact of depression in contrast with and linked to her professional nursing training and the impact of this on how stigma can be experienced (disapproving of stigma objectively/professionally, but subjectively internalizing stigmatising views and thoughts about oneself) Is the author able to acknowledge the position from which they speak and the
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-Deliberative: cancer is worse than depression (title); stigma related to depression means that practitioners with depression find it even harder to talk about their experiences -the author argues that each individual's experience of depression should not be minimised and that practitioners must examine their own stigmatising thoughts and feelings	
	Style (choice of words, their arrangement, figurative language, conventions of	What kind of language does the author use: jargon, layperson's language? (Mental	-both jargon and layperson's language used – jargon when describing objective aspects of	

	reading, interpreting and representing)	health system survivor vs the system as saviour/helpful vs any other position)	depression, layperson’s language for description of author’s experience of depression	impact this has on what they bring? -reflection in regard to stigma and the author’s own stigma discussed and the impact of this on view of herself. Unclear how other aspects of the author’s background/experience have shaped the views communicated in the article. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -She seems to write from her own experience but about the debilitating impact depression can have to one’s life which shouldn’t be minimised. She writes as someone with cancer and someone with depression (depression is worse than cancer). The comparison of depression being worse than cancer alerts the reader to remain sensitive to others’ individual experiences and to take these seriously. Relevance to practice? -Yes, self-reflection of own stigmatising views and thoughts and how these made it harder to speak out about
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-Some context provided as depression being a life-long struggle -author describes herself as a nurse with depression -description of how she experienced depression (‘mood disorder as a flaw’, ‘utterly drained and physically agitated simultaneously’, ‘horrid agitation’, ‘self-loathing’ etc.) contrasted with objective description of depression (NICE: moderate depression) – sets the scene for difference between clinical language and personal experience	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	- peer-reviewed journal in the area of psychiatric and mental health nursing.	

				own difficulties; the author also writes about how others' LE of MH has impacted her learning and hopes that her LE can impact others' learning. Does the account fit/ not fit with what we already know? Are these links made explicitly? -Topic of stigma and minimising depression in context of author's own experience discussed and links to practice and her own experience of being a nurse clearly made. The impact of the author's experience on therapeutic work is not clear.
Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
Burnard (2007)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-mostly reason citing research literature and evidence to give context to the approach he is utilising. He seems to attempt to examine his own experience in an objective and reflective way more so than trying to make a case or argument about his profession or MH diagnosis.	What are the aims of the account? -Autoethnographic account of appointment with a psychiatrist to explore experience of being a patient using services and a healthcare professional, author, researcher and educator. Is the author's perspective described and taken into accounted/ reflected on? -The author attempts the use of an autoethnographic approach to describe and reflect on his experience of a psychiatric interview in the context of
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of	-Closest: forensic? Describing the nature and impact of events using objective language without seemingly attempting to make a particular argument.	

		acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view		being a patient and healthcare professional. Detailed reactions and reflections on his interview are examined and described. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -The author reflects on his status as mental health professional and the impact this may have had on the course of the interview in affording him ‘special treatment’. The author further reflects on his position as a researcher using an approach which does not allow for objective examination of events and expresses his frustration with the lack of detachment with the process. He further questions the value of reflecting and in how far looking at the past can help inform what happens presently as in his view memories are highly biased and inaccurate. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-Author seems to attempt to use objective language to describe his experience. This isn’t entirely free of psychiatric jargon but could be understood by a layperson.	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	- Author feels himself assuming patient role during the interview. Context of bipolar disorder also being a way of living in the world as opposed to ‘illness’ or ‘problem in living’. -does the patient role mean having less of a sense of empowerment?	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	- peer-reviewed international journal publishing articles on policy development, practice, research and education. The journal’s website further states that it seeks out critical debate and to promote practitioner as well as consumer perspectives.	

				experience? What is the impact of this? -‘The writer was diagnosed with bipolar spectrum condition 40 years ago…’; ‘I am an insider in that I am a healthcare professional, researcher and educator and an outsider in that I belong to a group of people (those who have mental health problems) whom are still stigmatised.’ Describing himself as a ‘healthcare professional’ has the impact that the account feels relevant to the entire group of professionals (inclusive). Describing himself as an insider and outsider adds to this impression and makes the account feel accessible. Relevance to practice? -The author emphasises power imbalance in the psychiatrist-patient relationship – which he understands as necessary in order that the patient be helped. Question whether MH professionals with lived experience are treated differently by services than other service users. Question also around his appearance (‘well turned out, pleasant and cooperative’), what if he hadn’t been? Question regarding the use of

				autoethnographic accounts written by service users to inform MH care. Does the account fit/ not fit with what we already know? Are these links made explicitly? -Presence of stigma within professionals (including author) but in this context assuming what he might know and understand regarding his mental health given his professional background. Own experience of being stigmatised and the impact of this briefly mentioned too in making him ‘loathe to discuss your condition’. The author seemed to think that this afforded him more power and more of an equal say in his treatment, though he emphasised that he can’t know this. Less insight provided into the impact of diagnosis on author’s view of himself as a nurse or his practice as a nurse.

Paper	5 canons of rhetoric	Assessment criteria	How the paper met them	Additional considerations
	Invention (finding arguments to support one’s point of view)	Did the author use: reason (defined as citing literature/evidence/research),	-emotions: emotive language used to describe psychotic experiences (‘completely	What are the aims of the account?

SA (2018) - anonymous		emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	terrifying'; 'propelled straight back into horror'; '…EIP service was a beacon of hope during incredibly dark months') -some literature cited (Jung – wounded healer), other references relate to relevant policy and guidance; no research cited -confidence in character: positive EIP experience as service user as starting point for clinical career (labelled by author as 'healing healer' vis a vie 'wounded healer')	-describing the author's experience of manic psychosis and accessing EIP services; reflecting and linking this with their experience of practising clinically Is the author's perspective described and taken into accounted/ reflected on? -Author describes vividly their experience of manic psychosis and briefly mentions a family history of MH (depression) difficulties. Main focus of the article is a 'richer and necessarily unsanitised account of accessing and working in' EIP services'. Reflection of 'wounded healer' idea as rather being a 'healing healer'; reflection of having caring, compassionate experience of accessing EIP on author's practice now in trying to draw on her LE of manic psychosis and her LE of being given a service. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -Within the context of EIP services, the author positions themselves as someone being treated for manic depression as
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-deliberative (?) – compassion, empathy and lack of judgement are successful ingredients in making EIP services a positive experience	
	Style (choice of words, their arrangement, figurative language, conventions of	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the	-layperson's language – emotive, impactful language used to describe experience of MH	

	reading, interpreting and representing)	system as saviour/helpful vs any other position)	- some jargon: Bipolar Affective Disorder Type 1 without definition; Early Intervention in Psychosis service – no definition - wounded healer concept only briefly mentioned, not described or elaborated on.	well as working clinically within that context. The account focuses on how their LE of manic depression and being a service user in EIP impact on the author's clinical work in EIP. No broader context provided. No detail of treatment provided or recovery journey beyond seeing a psychiatrist and clinical psychologist. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -The article focuses on the author's experience of manic psychosis and EIP services. On the basis of that, they extrapolate from their experience to inform their own practice as well as making recommendations for service development. The author's focus on EIP services makes it feel relevant to that particular service context although the author raises issues relevant to all services. The article is published anonymously and to some extent the impression of anonymity is maintained throughout the article as the focus is mainly on the experience of the distress
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	- author seems to position themselves as dual identity practitioner -'healing healer' - Using own positive experience of EIP service to inform clinical practice	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-peer-reviewed journal publishing recent developments and evidence-based hypotheses re the aetiology and treatment of schizophrenia. This includes first person accounts and	
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or	-epideictic: personal narrative of child sexual abuse contrasted with prevalent cultural discourse to encourage change in cultural narrative.	

		accepting a particular point of view		without background and of receiving a service. Relevance to practice? -Author emphasises importance of non-judgmental, compassionate approach to MH (specifically to manic psychosis) and integrated service provision to avoid repeated assessments. Although the author specifically writes about EIP and psychosis, this seems relevant across services. Capacity to empathise; taking time to build up trust with a clinician. Does the account fit/ not fit with what we already know? Are these links made explicitly? -As above. Recommendations made in the context of EIP services , but also services more generally (‘I feel strongly that fragmented services requiring repeat assessments, and waiting lists for support are actively unhelpful for the treatment process.’). Also importance of trust, compassion, empathy and non-judgmental approach emphasised.
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-both layperson’s language and jargon. Therapeutic narrative, poetry and prose – layperson’s language; main text contains some jargon.	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-Victim and survivor or male sexual abuse -‘wounded healer’	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-Peer-reviewed journal addressing issues around losses relating to family, health and ageing from both a psychological and medical perspective. It publishes a range of articles including empirical research, case studies, book reviews and point-counterpoint discussions.	

Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
Sawyer (2011)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason: account written in a way that appears to recount events in an objective and detached ways (e.g. no feelings expressed in the text regarding labels given to the author by professionals) ; the paper is divided into different sections and reads like a clinical case presentation ('My case', 'Initial treatment', 'Transfer unimproved' etc.). In the latter part of the account the author links her experience of the therapeutic alliance with relevant research literature. -emotion apparent in the account when the author writes about helpful encounters with clinicians ('My isolation and shame could be displaced, if only briefly, by gratitude for his kindness and intelligence'), however generally it appears that the account is trying to be more objective.	What are the aims of the account? -For the author's experience to be a source of hope and inspiration for patients and clinicians ('a reminder no to give up') Is the author's perspective described and taken into accounted/ reflected on? -The author provides a description of her experience of MH and the treatment she received. She also talks about the impact of how she was treated by professionals had on her and reflects on how this was coloured by her experiences of being sexually abused by men within her family as a child. The author further provides a reflection of the impact of her experiences on her therapeutic work, namely to remain humble and curious but also to be aware of her own defensiveness about schizophrenia so that she is able to spot 'psychotic thinking in others.'
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group)	-somewhat forensic in providing a chronological account of her hospitalisation and recovery. This is put into historical context of the state of psychiatric treatment at the	

		Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience's commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	time. Though this seems to be done indirectly, the author does condemn careless diagnostic practices ('Nevertheless much of the treatment I received made me worse. In part, this was because I was misdiagnosed, which led to mistreatment and brought with it social and professional stigmatization and self-stigmatization'; 'Meticulous differential diagnosis requires information gleaned from history and context, as well as clear evidence of characteristic symptoms.') -deliberative: encouraging seasoned therapists to be outspoken about personal struggles to dispel and challenge stigma; encouraging reflection on own self-stigma which may get in the way of speaking up.	Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -The author's background (e.g SES, where she grew up, family situation) is not detailed. The author speaks from the position of a patient who was misdiagnosed and received unhelpful treatment which worsened her condition. This has influenced the author's clinical work in making an effort to maintain an open stance. Having received psychotherapy, the author cautions against prejudice of clinicians denying their need for therapy as this denial can impact on their patients. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -The author writes about her own personal experience of MH, some causes of her distress and how she survived. The account has an intimate and personal touch to it, which makes it a compelling read.
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson's language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	Jargon – psychotherapeutic language used throughout (transference, counter-transference, objects etc.)	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-Contextualised within psychiatric practice from the 1960's through to the time the article was published. The author describes herself as a	

			‘patient’ who was hospitalised on several occasions and provides a detailed account of her journey towards recovery. In the latter part of the paper she describes herself as a ‘psychologist’ who draws on their LE in their work as a source of humility and openness.	Relevance to practice? -As the author points out, this personal account links existing empirical research to her personal experience of the healing impact of a good, trusting therapeutic relationship. It also reminds clinicians of the importance to remain open to patients in their care and to pay attention to each unique individual. She further points out the importance of assuming reasonability in the symptoms and experiences of people who express psychological distress. Does the account fit/ not fit with what we already know? Are these links made explicitly? -As above. Links are explicitly made between personal experience of therapeutic alliance and empirical research around this.
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-peer-reviewed journal which focuses on clinical challenges faced by psychotherapists in clinical situations or therapeutic dilemmas.	

Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
Coodin Schiff (2004)	Invention (finding arguments to support one’s point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason: background of SU movement described, recovery model and underlying ideology introduced. -confidence in character: as a prosumer, the author of the article states that she is in a unique position to express ‘profound empathy’ for other	What are the aims of the account? -To explore the author’s recovery from mental illness in the context of the recovery model

			‘consumers; she also states: ‘Prosumers might also be the only professional a consumer will trust, as the consumer movement values lived experience.’ -emotion: implicitly present when author talks about ‘a state of constant ache and torment’. Not much else is described in terms of how she experienced her distress.	-To examine the question “what is recovery?” -Author’s own recovery is explored from a model of recovery Is the author’s perspective described and taken into accounted/ reflected on? -The author provides a historical perspective of the ‘survivor movement’ and the beginnings of the recovery model. She puts the recovery model in the context of ‘prosumers’ being a valuable asset to services. The author describes her experiences from the perspective of being a ‘consumer’ of MH services but doesn’t detail anything about the career in healthcare she chose or the impact of her LE on her as a professional. Some reflections provided in the author’s own recovery process , e.g. the importance of music in grounding and connecting to feel human when feeling dehumanised; the importance of knowledge of medical lingo in taking control/participating in her care. Is the author able to acknowledge the position from which they speak and the
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-epideictic – describing current state of MH system ‘survivors’ and the on-going development and adaptation of the recovery model in current context of MH treatment. The author highlights and describes her role within this as a ‘prosumer’ advocating for a recovery model of MH and for prosumers to ‘educate professionals about the lived experience of consumers, and can be taken seriously by professionals because of their credentials.’	
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-jargon: language specific to the recovery model and humanistic ideology (‘self-determination’, ‘existential philosophy’)	

				impact this has on what they bring? -The author writes about her recovery from MH as a consumer of services. Having experienced receiving services, she advocates for the recovery model which empowered by. No detail provided of her professional identity and how her consumer experiences shape her professional experience or practice. No personal background or context provided to gain a better sense of her as a person. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -The author writes about her experience as a user of MH services drawing on the recovery model as a framework. She describes drawing strength from music and the necessity for her to take control of her care rather than being empowered by professionals to do so. She maps her experiences onto Young & Ensing's (1999) tri-phase model of recovery, which seems to distance the reader and herself from the
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-identity of survivor of MH system -Historical context to survivor movement provided in the context of minority liberation movements in the 1970's – 'shared sense of anger and a hope that they could bring about change' Notion that people do recover from serious mental illness backed up with research – beginnings of recovery model. - context provided as diagnostic labels, being hospitalised and given medication.	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-Peer-reviewed journal publishing articles about psychosocial treatments and recovery of people with MH. -Journal states to be aimed at researchers, policy makers and practitioners.	

				immediacy and intensity of her experiences. The impact of these on her professional practice is not known. Relevance to practice? -The author states that she hopes to legitimise prosumers' experiential knowledge and lend credibility to the idea of recovery from MH. Does the account fit/ not fit with what we already know? Are these links made explicitly? -The account links personal experiences to the recovery model but remains broad in the impact of LE of distress and the impact of this on clinical practice so that conclusions are difficult to draw.

Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research),	-reason: citing recovery model literature and relating this to personal experience of MH,	What are the aims of the account?

Lees (2014)		emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	but mostly relating literature to author’s experiences of clinical work -interesting to note: no literature is cited for chemical imbalance theory of schizophrenia and the medical model -some emotion used to describe experience of growing up as an ‘abnormal child’ – ‘distressed’, ‘scared’, ‘isolated’, ‘ashamed’ – this is linked to Repper & Perkins’ (2003) work on acceptance – the author surmises she did this work during her childhood rather than when she received the diagnosis, though the rest of the account appears more detached from emotion	-a reflection of the author’s personal recovery journey and the difference between her own journey through recovery and those she works with. -reflecting on her evolving understanding of recovery as a result of acknowledging difference in personal journey and the journey of others. Is the author’s perspective described and taken into accounted/ reflected on? -Authors perspective introduced as having grown up with sense of being different/abnormal and this being OK – adjustment to diagnosis of schizophrenia/bipolar disorder easier because of this; also adopting a medical model understanding of MH (‘chemical imbalance’, ‘illness’) which had ‘simplicity’ – impact of this perspective on author’s clinical work in wanting people to follow her path to recovery as the right path – the author reflects on her journey realising that recovery is a unique path for each individual.
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or	-Epideictic: personal account which aims to link author’s personal recovery journey with the recovery literature and the author’s clinical experiences of recovery in service users she works with; a reflection of the author’s process of changing beliefs re recovery from trying to convince SUs of her point of view of recovery to recognising that recovery is a uniquely different process for everyone.	

		accepting a particular point of view		Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -The author speaks from a position of having been accepted for her ‘abnormality’ and having a good support network and the impact of this on helping her adjust to her MH diagnosis. She further reflects that, whilst enjoying the simplicity of the medical model’s view of MH as ‘illness’ and ‘chemical imbalances’, this is not the only view of how people accept and make sense of their MH and that each individual’s experience is uniquely valid. Little background information provided of the author (which wouldn’t be the most important from a medical model perspective) or how recovery came about despite taking medication (again in line with medical model treatment recommendation of MH). Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this?
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-jargon: language used within the recovery model, humanistic psychology and the medical model	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-growing up ‘abnormal’ and that being ok -psychotic episode led to diagnosis of schizophrenia-impact of label on identity perceived as less as identity is one of ‘being abnormal’ -own experience of recovery as framework for others’ recovery – learning that recovery is a unique, individual process	
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-Peer- and editor-reviewed journal focussing on social inclusion of people with mental health conditions and the publishing of papers with practical implications including applied research, case studies, commentaries, interviews, service user points of view.	

				-The author describes her own personal experience and the process of coming to realise that the recovery process is personal and unique to each individual. Although a personal reflective account describing an evolving understanding of recovery, it is unclear what meaning the author attaches to this personally, whilst implications for practice are discussed (‘respecting diverse nature of recovery’). She describes the process of reflection and reappraisal as painful, but the reader is left feeling unclear what about the process caused this pain. Relevance to practice? -The article emphasises the importance of seeing service users as unique individuals with their own unique ways of understanding their experiences. Does the account fit/ not fit with what we already know? Are these links made explicitly? -Author’s own experience of recovery compared and mapped onto existing recovery literature. The author concludes that people have different and unique ways of

				making sense of their experiences which needs to be supported by professionals – which fits with the recovery model ethos.
Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
Olson (2002)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason- drawing on a variety of relevant diagnostic concepts proposed to him to make sense of his experiences alongside which treatment/intervention is indicated – this is to demonstrate the futility of the diagnostic process, which is presented to him as certain but experienced by him as uncertain and confusing -emotion – used to describe the impact of going through the process of attempting to make sense of his experiences through different clinicians ('grasping for any sliver of hope', 'desperate for answers and relief', '…added devastation I felt at being assigned a condition recently described as "one of the world's ten most burdensome illnesses"')	What are the aims of the account? -using own LE to illustrate discrepancies between personal meaning of experiencing mental distress and clinical practice, which the author perceives to be narrowly focused on clinicians' training, personal biases and a lack of awareness and humility in recognising the limits of one's practice. Is the author's perspective described and taken into accounted/ reflected on? -the author describes himself as a psychiatric nurse therapist and researcher who assumed separateness from the Sus he saw until he experienced his own MH difficulty which

	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-epideictic: highlighting current trend within psychology and psychiatry to narrowly focus on what is known through training. The author encourages reflecting on personal biases and humility in recognising limits of one’s own profession in order to allow for a more holistic understanding of the person. He calls for reflection on professionals’ ‘God complex’ of holding the one solution or cure and encourages services to draw on the wider network and community to meet a SU’s needs rather than assuming one clinician can meet them all.	challenged and changed identity as well as the mental health system and practice from the perspective of a patient which led him to re-evaluate his believe in psychiatry, psychology and mental health practice. -Nothing is said about the author’s background or specific experiences of MH. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -the author reflects on the privilege his position as a psychiatric nurse therapist holds alongside an assumption to be exempt from experiencing mental distress which drastically changes when his mental health deteriorates. Reflections provided as to his journey through the system and attempting to find adequate care. Nothing known about his wider background and how this would have impacted on his choice of career, experience of MH, what help he sought. Is the author writing on behalf of a certain group (e.g. MH professionals with depression)
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-professional jargon – diagnoses and interventions named without explanation suggest that the article is aimed at the mental health care professional community -indeed the article critiques unquestioning practice by professionals without reflection or self-awareness	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-the author gives context of being a psychiatric nurse and researcher who began to experience MH difficulties which seem to have challenged his sense of identity and self (‘As I closed the office door at the end of	

			my visit, I left behind not only expressions of gratitude and my insurance co-payment, but also the smugness and security of my previous self-image'). No information provided on details of his experience of mental distress or how he made sense of how they came about.	or about their own personal experience? What is the impact of this? -He writes from the position of a clinician who has an experience of mental health difficulties. The account calls practitioners to be reflective, humble and self-aware of practice and own limits. The account gives the impression that through the personal challenge of experiencing MH difficulties, the author was pushed to reconsider aspects of his professional practice and brought to light some uncomfortable aspects of himself ('paying homage to the idea that mental illness has no respect for occupational attainments, social status, or academic degrees.') The experience appears personally meaningful to the author and this comes across in the paper. Relevance to practice? -importance of reflection, self-awareness, humility and holistic and integrated care for practitioners; importance of clinician and client both holding hope. Does the account fit/ not fit with what we already know?
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-peer-reviewed journal reporting on issues related to psychiatric and mental health nursing -journal publishes both data-based and theoretical papers	

				Are these links made explicitly? -issue of ‘us-them’ dynamic – separateness – raised but the impact of this not explicitly discussed -need for integrated care and services -discrepancy between professional and experiential knowledge of MH – impact of this not discussed -MH difficulties can change sense of self – perceived as loss – impact of this on practice or perceived impact on SUs not considered
Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
Mack (2001)	Invention (finding arguments to support one’s point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason: not predominantly used in the form of literature and research. Reference is only made to specific models and tools the author draws on and finds helpful personally and professionally -emotion: personal story through experiences of mental illness; shame and blame are two emotions featured throughout the account amongst the distress the author feels about some of her experiences and not being	What are the aims of the account? -outlining the story of the author’s (OT) journey through mental illness during which she ‘discovered’ (as opposed to ‘recovered’) her ‘true talents and gifts (strengths)’ Is the author’s perspective described and taken into accounted/ reflected on? -the author describes herself as ‘living with a neurobiological

			understood by those around her.	brain disorder’ and provides a diary style account of her experiences growing up alongside the development of her difficulties. The author describes her struggles with her MH as well as getting the ‘right’ support to get better. As her condition worsens (more labels and diagnoses, hospital stays, impacted physical health, breakdown of relationships) she decides to study and read around the body and mind (OT, neurology, anatomy, and physiology) to try to understand herself. Throughout the account the author battles to ‘get better’, to ‘be well’ in a number of ways, all seem temporary; she experiences a lot of guilt and shame around this. The author concludes with the reflection that recovery is a life-long process (‘not a process of “atoning”, but a journey of discovering one’s true colours and letting them shine on through in spite of the fog that sometimes clouds the rainbow’). She acknowledges the important role of medication, relationships and a supportive employer play in keeping her well. Is the author able to acknowledge the position from
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group) Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	-article most closely resembles matches a forensic discourse in the timeline that is provided, though the style of writing is not attempting to present facts in an objective way but captures the author’s experience. This is not an account attempting to convince its audience of a particular point of view but as the author states is to provide hope, insight and courage to others to feel empowered and advocate for themselves.	
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-layperson’s language predominantly though some concepts (psychosis, hyperthyroidism etc.) not explicitly defined. -the author writes from the perspective of a consumer of services, who enters professional training and practice as an OT in an attempt to make sense of her own experiences and find ways of managing them.	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-The account is written almost as a diary presenting a timeline of the author’s life, development, progression of MH difficulties and the	

			process of learning how to manage these.	which they speak and the impact this has on what they bring? -Not much is known about the author’s family background apart from being the third girl in the family. The author describes struggling with her experiences from an early age and, it seems, often feels alone and misunderstood. The impact of her experiences on family relationships is unclear. Not much is known about the author’s socioeconomic background and the impact this may have had on her difficulties. The account is written from the perspective of a user of services and the struggled in receiving support that is meaningful and helpful and feeling understood. The author labels her experiences as ‘neurobiological’ which may explain the lack of social context provided in the account, though no description is provided of what this means to her. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this?
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	Published simultaneously in two articles. -1. Journal specifically aimed at OTs publishing articles pertinent to the profession ranging from philosophical and conceptual pieces to practice innovation and treatment developments. 2.Book also aimed at OT practice -likely accessed by OTs and other professionals	

				-The author writes an account of her own personal experiences in some detail, so that the reader gets an impression of her struggles and the hardship she experienced. Relevance to practice? -The author emphasises the importance of helping people to understand and make sense of their experiences. She writes about the impact of stigma in not wanting to engage with services and treatment (‘I don’t believe the hospital will help – I believe I will be over medicated and not listened to. I believe that staff will treat me with disdain and punish me for having an illness that displays itself so emotionally and behaviourally.’). She talks about the impact of having a job she enjoys, a good support network and feeling empowered on staying well. She also highlights the role “consumer providers” play in bringing different insights and experiences into MH services (being seen as capable vs incapable, being treated equally) as well as the challenges that come along with this (employers accommodating needs of consumer providers, potential conflicts arising as a result of

				being both a user and employee in services). Does the account fit/ not fit with what we already know? Are these links made explicitly? -Yes – in terms of SU's need to understand themselves and be understood by others; and in terms of meaning making and recovery being a process unique to the individual as well as needing services to see the whole person rather than parts. These are not explicitly linked to literature or research. The importance of peer support also emphasised and detailed, though not linked to relevant research/ literature.

Paper	**5 canons of rhetoric**	**Assessment criteria**	**How the paper met them**	**Additional considerations**
May (2000)	Invention (finding arguments to support one's point of view)	Did the author use: reason (defined as citing literature/evidence/research), emotions or confidence in his character (as a professional/service user or other) as a tool of persuasion?	-reason: relating own experience to relevant research and literature -emotion: appears to be somewhat absent. Emotional impact described as feeling emasculated and isolated (this is put in the context of Western expectations of normal development of men)	What are the aims of the account? -personal story of recovery from psychosis and how these experiences influence clinical practice as a clinical psychologist. Is the author's perspective described and taken into accounted/ reflected on? -author describes himself as critical of the medical interventions he received though acknowledges the
	Disposition (organisation of discourse – written language – for rhetorical effect)	What kind of persuasive discourse is this? Forensic – nature and cause of past events (e.g. discourses seeking to condemn or defend an individual or group)	-epideictic: the author puts his experience of psychosis into the context of current predominantly medical treatments available and challenges this discourse by	

		Epideictic – current issues; defining of social norms of acting, speaking or thinking; seeking to strengthen the audience’s commitment to a selected set of values or increasing its inclination to act in accordance with those values Deliberative – convincing others to do something and/or accepting a particular point of view	suggesting alternative ways of engaging with people with psychosis which aided his own recovery.	need for inpatient treatment as a safety net for patients. He describes his own difficulties and experiences of psychosis, the treatment he received consisting of hospitalisation and medication and what helped him recover. This is in the context of the author having completed training as a clinical psychologist, who believes that ‘madness’ cannot be separated from the social context it developed in, including medical treatment received. He reflects that having witnessed ‘inhumane practice’ motivated him to advocate for better mental health services, which also gave his life meaning and purpose. Is the author able to acknowledge the position from which they speak and the impact this has on what they bring? -The author writes from the position of someone with a diagnosis of psychosis and a clinical psychologist. The author reflects that his recovery was in part possible as a result of having ‘privileges
	Style (choice of words, their arrangement, figurative language, conventions of reading, interpreting and representing)	What kind of language does the author use: jargon, layperson’s language? (Mental health system survivor vs the system as saviour/helpful vs any other position)	-draws on jargon relating to psychiatric treatment (diagnosis, medication) -the rest of the account mostly written in layperson’s language, although in the description of power issues and inequalities, some pre-existing knowledge of these would be necessary for understanding. -seeing ‘good’ and ‘bad’ in psychiatric hospitals – balanced account	
	Memory (use of shared cultural memories as rhetorical strategy)	Is the account contextualised? If so, how? Where does the author place him/herself within the context (survivor, professional, other)?	-brief context provided that led to author’s hospitalisation and experiences of this. -although not explicitly stated, the author seemsDe to see himself as a survivor of hospitalisation, which in many ways he describes as detrimental to his wellbeing and in fact adds to his difficulties.	

			-the author states he trained as a clinical psychologist in order to ‘encourage more springiness’ in mental health services.	and opportunities’ that others don’t have – no detail on what these might be. He concludes that his battle was mostly against ‘dominant social expectations’ more so than with psychosis itself. This leads him to conclude that in order to support recovery from severe mental illness, the social context within which they occur needs to be considered. Is the author writing on behalf of a certain group (e.g. MH professionals with depression) or about their own personal experience? What is the impact of this? -The author describes his own personal experience of psychosis, what helped him recover and how these experiences have shaped his desire to become a clinical psychologist and advocate for empowerment of those suffering from severe mental illness. He extrapolates from his experience, citing relevant literature, in suggesting implications for practice. The description of his personal experience of psychosis through the lense of social exclusion is powerful and raises questions around what
	Delivery (relationship between the dissemination of rhetoric and content)	Type of journal article was published in; likely audience which will have access to it?	-Peer-reviewed journal aimed at clinical psychologists. It aims to serve as a discussion forum for any issues pertinent to clinical psychology.	

				gets in the way of practices changing. Relevance to practice? -Relevance to practice explicitly discussed within the context of needing social change to take place. This includes a focus on empowering SUs (in being considerate of language use – survivor vs sufferer) and focusing on their abilities, connecting with their experience of distress, promoting relationships between staff and SUs, which allow SUs to discuss their experiences and being "real" with clients (being oneself to avoid further alienation) and openly discussing power issues in the therapeutic relationship and wider system. Does the account fit/ not fit with what we already know? Are these links made explicitly? -The author describes his experience of and recovery from psychosis linking this to relevant research and literature. He emphasises the need for a holistic approach to treatment, and awareness of social context and the impact of power, stigma and inequality on people's ability to recover

				from severe mental health. The impact of all these is known within the literature as well as reports from service users.

Appendix C

Content analysis of first person written accounts of experience of distress (Erlingsson & Brysiewicz, 2017)

Preliminary codes, categories and themes

Study	Condensed meaning units	Codes	Code number	Theme – category
Fox (2015)	Exploring role of experiential wisdom	Exploring role of experiential wisdom	1	LE – exploring role of LE (1)
	Being a social worker with a diagnosis of schizophrenia	MH and prof role defining identity	2	Reconciliation of self – dual identity (2)
	Trigger of mental distress (failed love affair)	Describing onset of mental health	3	Journey through MH care – trigger (3)
	Describing symptoms experienced (paranoia, voices, intrusive thoughts)	Psychotic symptoms	4	Journey through MH care – clinical symptoms (4)
	Deciding treatment in consultation with psychiatrist	Deciding treatment collaboratively	5	Journey through MH care - active participation in treatment (5)
	Being mad as opposed to special sowing the seeds to recovery	Starting recovery process through understanding	6	Recovery – understanding self (6)
	Understanding side effects of medication	Describing side effects of treatment	7	Journey through MH care – side effects (7)
	Re-learning to concentrate	Relearning skills to recover	8	Recovery- relearning skills (8)
	CBT enabling to become expert in own mental health	Therapy developing expertise in MH	9	Journey through MH care- develop expertise in own MH (9)
	Experiencing partnership working and collaboration during recurrence of mental distress	Deciding treatment collaboratively	5	Journey through MH care - active participation in treatment (5)
	Valuing SU experience to reconnect professional and experiential wisdom	Combining professional and experiential knowledge	11	LE – Integrating prof knowledge and LE (10)
	Own recovery experience impacting on PhD – emphasising importance of hope, optimism,	LE impacts practice; LE impacts recovery	12;378	LE – impacts practice (11); Recovery – impacts practice (12)

	encouragement, building independence and confidence		13	
	• Recovery is cyclical and a life-long journey	• Recovery as on-going journey	14	• Recovery – ongoing (13)
	• User participation (in research) still in infancy	• Current state – early stage of participation	15	• Participation – early stages (14)
	• Austerity impeding delivery of effective system-wide recovery-oriented practice	• Impact of social and economic context on MH care	16	• Social and economic context – impacts MH care (15)
	• Effective and safe practice measured by partnership working, not compliance	• Measuring success of practice through partnership working	17	• Professional practice - success measured through collaboration (16)
	• SUs involvement in teaching and training influencing education by challenging stereotypes	• Using involvement to challenge stigma	18	• Stigma – challenging stigma (36)
	• Empowerment of SUs through sharing stories – sense of reciprocity between professionals and SUs	• SU empowerment through sharing	19	• Power – empowerment through sharing (18)
	• Difficulty in integrating experiential wisdom into practice frameworks based on academic research/knowledge	• Difficulty integrating professional and experiential	20	• LE – Integrating prof knowledge and LE (10)
	• SU recovery movement replicating movement that led to social model of disability – precedent of how experiential knowledge can be incorporated into professional frameworks	• Using social model of disability as framework to incorporate LE into practice	21	• Social model of disability – frameworks to integrate LE into practice (19)
	• Redefining relationship between professionals and SUs – breaking down of these boundaries – recognition that professional knowledge and			

	experiential expertise are not separable		22	
	Rebalancing of power as to what constitutes valid knowledge	Breaking down boundaries of ‘personal’ and ‘professional’	23	LE – Integrating prof knowledge and LE (10)
	Needing to acknowledge role SUs have in developing theoretical evidence base	Rebalancing power	24	Power – rebalancing what constitutes valid knowledge (20)
	Recognising value of expert knowledge – implementing shared decision-making in clinical care	SUs have role in establishing evidence base	24	Power – sharing power in establishing evidence base (21)
	Professionals needing to recognise primacy of user expert knowledge	Recognising value of LE expert knowledge	22	LE – as form of expert knowledge (22)
	Professionals needing to abolish differential power imbalances	Recognising value of LE expert knowledge		LE – as form of expert knowledge (22)
		Rebalancing power		Power – onus on prof to rebalance (23)
Kottsieper (2009)	Struggling with mild dysthymia since young adulthood	Describing onset of MH; Experiencing depression	3	Journey through MH care – clinical symptoms (4)
	Acute experience of mental disorder – felt like ‘I had gone crazy’	Having gone crazy	379	Journey through MH care-Experience of MH (24)
	Triggered by personal event	Naming trigger	26 380	Journey through MH care-trigger (3)
	Feeling terrified	Terror/fear	27	Journey through MH care-Experience of MH (24)
	CBT techniques providing temporary relief from psychic pain	Describing therapy process		Journey through MH care-therapy (25)
		Describing therapy process	27	

	• Caught up in vicious cycle – feeling as though I had failed at therapy		381	• Journey through MH care-therapy (25)
	• Considering suicide as only way to end pain	• Suicidal	28	• Journey through MH care-Experience of MH (24)
	• Therapy providing structure – doing something to try to 'help myself'	• Factors facilitating recovery – therapy structure	29	• Recovery – factors facilitating recovery (27)
	• Knowing that therapist cared about me	• Factors facilitating recovery – therapist care	30	
	• Therapist not disclosing LE when asked directly, just saying that she knew I could get better and had seen it before	• Not experiencing therapist self-disclosure in treatment	31	• Journey through MH care - lack of prof self-disclosure (28)
	• Terrified that medication wouldn't help either	• Worrying if medication will work	32	• Journey through MH care – doubting medication (29)
	• Antidepressant helped in reducing symptoms	• Factors facilitating recovery – medication	33	• Recovery – factors facilitating recovery (27)
	• Completing Dr in clinical psychology amongst other qualifications	• Choosing career in MH	32, 34,35,36	• LE – influencing career choice (30)
	• Recovery due to MH professionals, medication, social support network and supportive employer	• Factors facilitating recovery – medication, support network, employer, professionals	37	• Recovery – factors facilitating recovery (27)
	• Most important: value as a person and place in society were never questioned	• Factors facilitating recovery – having value as person/having strengths	57	• Recovery – factors facilitating recovery (27)
	• Receiving hope for recovery kept me going	• Factors facilitating recovery – therapist holding hope	39	• Recovery – factors facilitating recovery (27)
	• Shift towards recovery paradigm, rehabilitation and inclusion of consumer perspective	• Practice shifting towards recovery paradigm	40	• Recovery –factors facilitating recovery (27)

	Feeling like I had to hide experiences from university	Hiding LE	41	Stigma – LE remains taboo (32)
	Fear of stigma	Fear or stigma	19	Stigma – fear of (33)
	Experiential knowledge lacking during professional training	Difficulty integrating professional +experiential knowledge	42	LE – Integrating prof knowledge and LE (10)
	Lack of use of first-person stories	Lack of use of 1st person stories	43	LE-Personal narratives as tools (34)
	First-person stories providing insight into unique experiences and remembering person behind illness	1st person stories useful for understanding MH	44	LE-Personal narratives as tools (34)
	Stereotyped beliefs and stigmatising attitudes continue to exist within MH practitioners	Continued existence of stigma in professionals	45	Stigma – in MH professionals (35)
	First person stories important in challenging beliefs that people with serious MH do not recover	1st person stories to challenge stigma	38, 46, 47, 48, 49, 50	Stigma – challenging stigma (36); LE- personal narratives as tools (34)
	Recovery dependent on both internal (hope, healing, empowerment) and external (implementation of human rights, culture of healing, recovery-oriented practices) condition	Factors facilitating recovery – internal (having hope, healing, empowerment); external (human rights, culture of healing, recovery-oriented practices)	51	Recovery – factors facilitating recovery (27)
	First person stories as main source of information of study participants with MH conditions	1st person stories as main source of information for people with MH	52	
	Stories provide normalising of experiences both to participants and author of the paper		53	LE-Personal narratives as tools (34)

	- Using first person stories in own practice (passing them on to patients) - Omission of first-person stories born out of Psychology's desire not to be a pseudoscience - Power of psychology found in its scientific leanings - Empirical method should not be the only method on which to build knowledge - Vitality of therapeutic relationship during acute stage of symptoms – therapist explicitly expressing hope for recovery - Same message from friends and families - Research findings: active fostering of hope for recovery largely absent in helping relationships - Other accounts report that best help received from least trained staff - Author experiencing hope as most crucial intervention - Notion that most professionals experience significant personal issues to overcome - Assertion that those may make better therapists though lack of literature and research around this	- 1st person stories as normalising - Passing 1st person stories to patients - LE seen as 'unscientific' by Psychology - Psychology having powers as 'science' - Acknowledging other ways of building knowledge - Factors facilitating recovery – therapist holding hope - Factors facilitating recovery – support network - Linking own experience of being given hope to empirical findings - Helpfulness of staff not dependent on prof qualifications - Factors facilitating recovery – therapist holding hope	54 55 56 57 34 59 60 57 61 62 63 64 65	- LE-Personal narratives as tools (34) - LE-Personal narratives as tools (34) - LE – not a science (37) - Power – within science (38) - Power – rebalancing what constitutes valid knowledge (20) - Recovery – factors facilitating recovery (27) - Recovery – factors facilitating recovery (27) - LE – link between own experience and research (39)

	• Professional knowledge concerned with truth finding vs. experience conveys meaning and human condition • Experiences as means of connecting • Good (e.g. advocating for clients' recovery, own experiences fuelling wish to do therapy work) and bad (e.g. overidentification with clients, thinking that I have a better understanding of them than colleagues) of lived experience • Experience fuelling to continue clinical work and to be the voice advocating for SUs' recovery when this may be lacking • Relating to SUs on a deep human level • Describing attempts to consolidate ideas of self-disclosure with therapeutic models, orientation and issues of boundaries in therapeutic relationship • Observing that association between self-disclosure and boundary violation put an end to the discussion of appropriate uses and benefits of self-disclosure • Personally valuing honesty and transparency, therefore	• Personal challenges faced by most professionals • LE makes better therapists in personal experience • Truth finding (professional knowledge vs finding meaning (experiential knowledge) • Using LE to connect • Pros and cons to using LE • LE as motivator for clinical work • Using LE to connect • Difficulty integrating professional +experiential knowledge	66 64 19 67 68 69	• Recovery – factors facilitating recovery (27) • LE – asset (42) • LE – Integrating prof knowledge and LE (10) • LE – asset (42) • LE – asset (42); barrier (43) • LE – influencing career choice (30) • LE – asset (42) • LE – Integrating prof knowledge and LE (10)

	more readily disclosing personal information taking guidelines re self-disclosure into consideration	• Association of boundary violation and self-disclosure as barrier to use of LE		• Barriers to sharing LE (44)
	• Using self-disclosure to client's benefit requires: on-going monitoring of one's motivation, self-reflection and consultation with colleagues/supervisors	• Practising in line with personal values as well as guidance	70;374	• Personal and professional values aligned
	• Own experience of GP's disclosure of experiencing panic attacks gave hope, felt helpful and authentic and normalised experience – contrasted by psychologist's evasiveness	• Using LE to SU benefit – requires monitoring and self-reflection on motivation; supervision	71	• LE – asset (42); Integrating prof knowledge and LE (10)
	• Awareness of clinician's right to privacy – though questioning on what theoretical assumptions we consider information as private	• Experiencing sharing of LE – giving hope, authenticity and normalised experience	72 73	• LE – asset (42)
	• More research needed within the area			
	• Sharing LE with colleagues and supervisors met with surprise of experiencing MH challenges and willing to share these – followed by cautioning to be careful in making those disclosures (taboo)	• Awareness of clinicians' right to privacy	74	
	• Refusal to talk about distress and MH challenges in practitioners has prolonged stigmatization which	• More research needed in LE • Sharing LE remains taboo	75	• LE – under researched area (81) • Stigma – LE remains taboo (32)

	professionals claim to want to address			
	• Challenge to change public perception of MH if professionals cannot talk about their experiences, successes and triumphs over MH	• Taboo prolonging stigmatisation	76 76	• Stigma – Taboo feeding stigma (48)
	• Fear of having one's own professional competency scrutinised/formally questioned			• Stigma – sharing LE to challenge it (49)
	• Asserting that mental health difficulties equate with professional incompetence – serious issue, though competence is a continuum as opposed to yes or no category	• Sharing LE to challenge stigma	77	
	• More literature on professional competence issues compared to papers examining benefits of LE in MH	• Barriers to sharing LE – fear of prof competency being questioned • Barriers to sharing LE – fear of prof competency being questioned	78	• Barriers to sharing LE (44) • Barriers to sharing LE (44)
	• Not suggesting that experience of serious MH necessary to work well in MH – focus needs to be on the person, not the disorder.			
				• Bias in published research
		• Bias in literature: more papers on competence issues than on benefits of LE		• LE – asset (42)

		LE as an asset, not necessity		
Pirrie (2013)	Completing training as MH nurse followed by diagnosis of major depression with psychotic features	Experiencing depression; psychotic symptoms; Receiving diagnosis	4;168;391	Journey through MH care – clinical symptoms (4)
	Setting off on a new journey of understanding as a result	Journey to understand self	79	Recovery – understanding self (6)
	Learning about medication side effects and importance of collaborative therapeutic relationship from position of patient	Combining professional and experiential knowledge	11	LE – Integrating prof knowledge and LE (10)
	Making transition from nurse to patient – should I disclose MH dx to clients	Transition from prof to patient – considering use of self-disclosure	81	MH and identity – transition prof – SU (50)
	Highlighting literature advocating for professionals to maintain personal and professional distance from clients – unfairness in asking professionals to be experts in MH without having had experience of it	MH expertise without LE of MH?	82	Power – held in ‘expertise’ (51)
	Highlighting literature stating that a therapeutic alliance improves with use of self-disclosure	Sharing LE improves therapeutic relationship (literature)	83	LE – asset (42)
	Describing personal experience of finding measured self-disclosure from other practitioners helpful	Experiencing other prof sharing LE as helpful	84	Journey through MH care –profs sharing LE helpful
	Not having disclosed own experiences yet	Not yet having used self-disclosure	85	LE – not having used SD
	Emphasising role of medication in own recovery		32	Recovery – factors facilitating recovery (27)

	• Identifying stigma and side-effects as a barrier to medication compliance • Insights informing relationships with clients – being more empathetic • Believing that experiential knowledge can enhance service provision.	• Factors facilitating recovery – medication • Factors impeding recovery – stigma • LE giving insights – LE giving capacity to empathise • LE as asset to inform service provision	86 375;376 88	• Recovery – factors impeding recovery (57) • LE- asset (42) • LE – informing service provision
Frese (2009)	• Personal and professional knowledge of MH – two parts of life closely intertwined • 'I'm a person with schizophrenia' • Onset of illness whilst serving in US military during Vietnam war • Being diagnosed with schizophrenia followed by interesting life-time journey • Being introduced to wonder drug 'thorazine' • Not being told to carry on taking medication lead to illness recurrence • 'I told no one about my schizophrenia' • Functioning well – graduate program in international business • Illness recurrence – describing progression	• MH and prof role defining identity • Defining identity as person with diagnosis • Describing onset of MH • Recovery as ongoing journey • Factors facilitating recovery – medication • Factors impeding recovery – lack of information • Hiding LE	2 89 3 13 32 91 40 92 93	• Reconciliation of self – dual identity (2) • MH and identity – person with diagnosis (54) • Journey through MH care – onset (104) • Recovery – ongoing (13) • Recovery – factors facilitating recovery (27) • Recovery – factors impeding recovery (57) • Stigma –LE remains taboo (32) • Recovery – Pursuing aspirations (55)

	Feeling out of control Discharged, no job, nowhere to go Bouncing in and out of hospital Schizophrenia as degenerative, lifelong brain disease Repeatedly advised not to disclose LE in MH job Continuing studies and managing employment alongside on-going MH challenges Gaining doctorate in psychology and securing senior position 15 years as hospital director of psychology despite several breakdowns Schizophrenia thought of as chronic due to individuals who do recover not talking about it Speaking about LE at a lecture was a surprise to author – not planned Fear of stigma followed disclosure during lecture Many more presentations re author's recovery followed Improved more holistic treatment available had led to drop in patients with schizophrenia being detained in hospital	Pursuing career Describing relapse Out of control Factors impeding recovery - Lack of support Factors impeding recovery – Lack of support Diagnosis for life Being advised not to share LE Pursuing career Pursuing career Pursuing career despite breakdowns MH seen as chronic Unplanned disclosure of LE in public Fear of stigma Becoming braver	382 94 94 95 96 92 92 92 97 98 41 100 101 102 103	Recovery – setbacks (56) Journey through MH care-Experience of MH (24) Recovery – factors impeding recovery (57) Recovery – factors impeding recovery (57) Stigma – MH chronic (58) Stigma – LE remains taboo (32) Recovery – Pursuing aspirations (55) Recovery-Pursuing aspirations (55) Recovery-Pursuing aspirations (55) Stigma – MH chronic (58) Stigma – fear of (33) Power – empowerment through sharing (18)

	• ‘Early hopes for social integration haven’t been fulfilled’ • Public portrayal of mentally ill people as ‘nuts’, ‘wackos’, lunatics in the media contributing to continued stigma • Pointing out exclusionary injustices necessary for process of inclusion to begin • Stopping being ashamed of ‘who we are’ • ‘coming out’ when in a position of power and security – being far enough along in career means the risk of revealing can be afforded • ‘We must stand up, identify ourselves, and be proud that we have been able to overcome…’ • Self-identification especially important for professionals – concealing their conditions perpetuates negative views • This process has begun by publishing recovery stories in peer-reviewed journal • Necessity of challenging stigma • Necessity of collaboration and co-production in development of government policies re care for and work with people with MH	• Improvements in treatment • Continued lack of social integration • Media portrayal of MH contributing to stigma • Awareness of injustice must come before process of inclusion • Stopping being ashamed of MH • Needing power of senior position to ‘come out’ • Responsibility to ‘come out’ • Self-identification to redress stigma	104 105 106 107 108 45 109 110 111 103	• Journey through MH care – treatment more holistic presently (59) • Stigma – leads to social exclusion (60) • Stigma – due to media portrayal (61) • Power – naming of issues crucial (62) • Stigma – fighting shame of MH (63) • Power – using seniority to disclose LE (64) • Stigma – responsibility to challenge stigma (65) • Stigma – self-identification to challenge stigma (66)

	Call for professionals with LE to 'speak for themselves'	1st person stories to challenge stigma		Stigma – challenging stigma (36); LE-personal narratives as tools (34)
	Continuing battle with stigma and public perception of 'psychos'	Necessity of challenging stigma		Stigma – challenging stigma (36)
		Necessity of collaboration and co-production in developing MH care policies		Participation – develop MH care and policies (67)
		Professionals with LE to speak for themselves		Power –prof creating own narrative about MH (68)
		Media portrayal of MH contributing to stigma		Stigma – due to media portrayal (61)
Deacon (2015)	Reading personal experience accounts and attempting to take learning into clinical work	Using 1st person stories to inform training and practice	112	LE-Personal narratives as tools (34)
	Reading literature which proposes that personal accounts sensitize practitioners to better understanding of SU's experiences	1st person stories as means of connecting with empathy	113	LE-Personal narratives as tools (34)
	Writing about 'my depression' in the hope that someone can learn from it	Using own story to inform others' learning and practice	112	LE-Personal narratives as tools (34)
	Having experienced depression being minimised by colleagues as he 'coughs and colds of psychiatry'	Minimising experience of depression adds to stigma	114	Stigma – minimising MH adds to it (69)
	Arguing that treating depression as a non-priority adds to stigma people experience	Minimising experience of depression adds to stigma	114	Stigma – minimising MH adds to it (69)

	‘going public’ at time when author has retired and suffers terminal illness	‘Coming out’ with MH in retirement and terminal illness	41	Stigma – taboo feeding stigma (48)
	Feeling ‘terrorised’ by the idea that colleagues may find out about MH difficulties	Fear of stigma	41	Stigma – fear of (33)
	Being an expert at hiding difficulties – performing despite them	Fear of stigma	118 118	
	Feeling sadness for herself for feeling not good enough and ashamed of MH difficulties	Internalising stigma	118	Stigma – fear of (33)
	Admitting internalisation of stigmatising views	Internalising stigma		Stigma – self-stigma (70)
	Seeing mood disorder as ‘character flaw’ – indication of weakness and lack of resilience	Internalising stigma	234	Stigma – self-stigma (70)
	Feeling guilty and worthless in experience of depression – ‘I shouldn’t feel like this, I have a good life’	Holding self-stigmatising views	119	Stigma – self-stigma (70)
	Having experienced psychotropic and psychological treatment	Experiencing treatment	25	Stigma – self-stigma (70)
	Noticing pattern of ‘life event’ which is managed ‘admirably’ – then follows episode of depression	Describing experience of MH – noticing patterns	120	
	Pointing out difference between objective experience (‘moderate depression’) and subjective experience (‘close to psychotic’)	Highlighting difference between clinical language and subjective experience of MH		Journey through MH care-Experience of MH (24)
	Unsure of cause of depression but drawing on stress-		131	

	vulnerability model and ‘loss, humiliation and entrapment’ model to understand own experience	• Prof training to understand MH	33	• Journey through MH 151ante– therapy (25); medication (71) • Journey through MH care – trigger (3)
	• Acknowledging that a different profession may have helped but wouldn’t have played into strengths	• Choosing career in MH	122	• Experience of MH – subjective vs clinical language
	• Experiencing depression as worse than the knowledge that author will die of cancer soon	• Own experience of MH worse than cancer	123	
	• Experiencing depression as physical condition which are experienced as ‘torturous’	• Suffering mentally and physically	124	• Reconciliation of self – Prof training to understand self (72)
	• Experiencing asking for help as agitating as vulnerability is exposed	• Asking for help seen as vulnerability	44	
	• Citing research around the impact of work stress on MH and stigma on help-seeking in professionals			• LE – influencing career choice (30)
	• Concluding that assumption of MH being a problem for others needs to be challenged; as well as exploring self-stigmatising thoughts and feelings; and reflect on personal impact of stigma on those they care for	• Continued existence of stigma within MH professionals • Challenging assumptions around MH as well as self-stigmatising views	125	• Experience of MH – miscellaneous (26)
	• Highlighting importance of refraining from minimising others’ experiences of MH.		126	• Journey through MH care-Experience of MH-(24) • Stigma – being seen as vulnerable

		• Highlighting importance of not minimising experiences of MH		• Stigma – in MH professionals (35) • Stigma – challenging stigma (36); challenging self-stigma (17) • Stigma – minimising MH adds to it (69)
MacCulloch & Shattell (2009)	• Observing change in position of those experiencing MH difficulties from recipients of treatment to consumers and participants in mental health treatment context	• Observing shift in MH care from treatment compliance to partnership working	127	• Journey through MH care – shift from treatment compliance to partnership
	• Reflecting that individual experience has a contribution to make to evidence-based practice if it can be valued similarly to RCTs	• Combining professional and experiential knowledge	11	• LE – Integrating prof knowledge and LE (10)
	• Reflecting on 'wounded healer' idea and how it relates to why psychiatric nurses enter MH work	• LE as motivator for clinical work • Identifying as wounded healer	66 128	• LE – influencing career choice (30) • LE – asset (42)
	• 'Confessing' to 'wounded healer' identity – understanding and healing own woundedness	• Identifying as wounded healer	128	• LE – asset (42)
	• Highlighting possibility of making such a confession now with less fear of judgement and stigma	• Reduced fear of judgement and stigma	129	• Stigma – comparatively reduced

	Being more aware of colleagues who also have MH challenges – not being alone	Not feeling alone with MH challenges	130	Less alone with MH challenges
	Entering nursing profession unconscious of own woundedness but being drawn to it in hope that mutual support and empathy could be provided	Choosing career in MH	33	LE – influencing career choice (30)
	Receiving training in the understanding of signs, symptoms and diagnostic labels and treatment of these	Prof training to understand MH	131	
	1970's context – existence of asylums which provided respite to those with MH struggles from 'a not very understanding society' and attempts to relieve and manage symptoms	Impact of social and economic context on MH care	15 132	Reconciliation of self - prof training to understand self (72) Social and economic context – impact MH care (15)
	Not finding evidence of ability to cure or encouragement for nurses to consider possibility of also being 'emotionally damaged' and seeking support for this	Lack of encouragement for MH staff to reflect on self	3	Professional practice – importance of reflection
	Describing own 'breakdown' in the mid 70's – failure of first marriage followed by 'severe depression and anxiety'	Describing onset of MH	133	
	Struggling in exploring treatment options as voluntary admission leads to 'role change' and colleagues finding out	Struggle with transition from prof to patient	3	Journey through MH care MH – trigger (3)

	Creating own ‘rich blend of liberated and hopeful cure options’ in engaging in psychotherapeutic training and receiving treatment and consultation as well as medication	Receiving treatment and consultation	393	Journey through MH care – active participation in treatment (5)
	Over 12 months – finding relief and cure – developing understanding of self – breakdown of marriage as trigger of longer standing ‘emotional damages’	Understanding self as ‘cure’	134	Recovery – understanding self (6)
	Highlighting continued lack of encouragement for MH professionals to explore own emotional wellbeing – related to stigma around acceptance that MH struggles are a universal experience?	Lack of encouragement for MH staff to reflect on self	132	Professional practice – importance of reflection (74)
	Observing that own woundedness can get in the way of responding with empathy if woundedness isn’t attended to	‘Unattended’ LE can get in the way of empathy	135	Barriers to sharing LE (44)
	Observing that motivation to enter MH work may be based on altruism and need to understand self	Motivation to become clinician to benefit self and others	136	Reconciliation of self - Prof training to understand self (72)
	Reflecting that mix of own personal experiences and professional training have turned author into a more compassionate, less judgmental, better person	Combining prof and experiential knowledge; lead to more compassion; less judgement	11;137;377	LE-Integrating prof knowledge and LE (10)
			138	

	Believing that MH professionals have obligation to tend to own wounds – disregarding these can cause damage to SUs	Having an obligation as prof to tend to own wounds		Professional practice – importance of reflection (74)
Peterson (2016)	Searching for meaning in both own symptoms experienced and in treatment by others	Searching for meaning of own experiences	139	Recovery – understanding self (6)
	Discovering meaning and identity as nurse with depression	MH and prof role defining identity	2	Reconciliation of self – dual identity (2)
	Using autoethnography to do so – active, reflexive approach to generate conversation with reader	Defining approach used in paper	141	
	Author explores in the paper the sociocultural experience of MH whilst acknowledging biological aspects to MH	Integration sociocultural and biological aspects of MH	142	Reconciliation of self - Prof training to understand self (72)
	Attempting to make sense of experience of depression and finding relief in being able to attach familiar label to experience	Prof training to understand MH	131	Reconciliation of self-Prof training to understand self (72)
	Choosing not to seek help due to belief that as nurse, I should be able to take care of myself – failure to do so – 'bad nurse' (self-stigma)	Holding self-stigmatising views	234	Stigma – self-stigma (70)
	Reflecting on impact of nurse training on treatment preference – pharmacological – medical model implies lack of culpability	Professional training impacts on treatment preference	144	
			385	

	Describing experience of depression as inability to feel happy or interested	Unable to feel happy or interested	145	Journey through MH care-Experience of MH (24)
	Being able to observe symptoms and understand that they belong to depression but being unable to act on this knowledge	Prof training does not allow curing self	146	
	Describing treatment by others as most painful and angering part of depression	Painful experience of stigma	147	Stigma – causes pain (77)
	Separating “well me” and “sick me” in the mind as different selves thinking and feeling differently, having different perceptions and relationships with others	Separating ‘well’ and ‘sick’ self as different parts of identity	148	MH and identity – separate selves (78)
	Differentiating between those two different identities – feeling good about “well me”, feeling in pain when “sick me”	Preferring ‘well’ self over ‘sick’ self	34	MH and identity – separate selves (78)
	Emphasising importance of support personally and professionally in case of loss of “well me”	Factors facilitating recovery – support network	149 149	Recovery – factors facilitating recovery (27)
	Experiencing wariness around possibility of relapse	Worrying about ability to stay well	13	Recovery – staying well (79)
	Messy, heavy baggage as nurse with MH challenges	Worrying about ability to stay well	150	Recovery – staying well (79)
	Having learnt to monitor own MH and to seek help as soon as possible	Recovery as on-going journey Learning to seek help	151	Recovery – ongoing (13)
	Linking own experience of feeling empowered by being able to understand ‘illness			

	experience’ to previous research	• Feeling empowered by understanding own MH through literature	131	
	• Finding solace in being able to draw on professional training and knowledge to approach own ‘illness’ in the same way as with SUs	• Prof training helps to understand MH	152	• Reconciliation of self-Prof training to understand self (72)
	• Using medical language to describe ‘illness experience’ as a framework to make meaning of it	• Using medical language to make sense of MH	153	• Reconciliation of self-Prof training to understand self (72)
	• Using medical language to legitimize suffering and have it taken seriously	• Medical language legitimises suffering	154	• Reconciliation of self-MH training to understand (72)
	• Accepting patient role leading to acceptance of necessity to take medication – knowledge around how they work helped in viewing them as tool as opposed to defining feature of identity	• Acceptance of MH and profession as tools to get better	155	
	• Being a nurse as key role identity – this comes with expectations about carrying out role functions	• Prof key role identity leads to expectation to function	156	• MH and identity – conflicting identities (80)
	• Describing conflict between patient and nurse identity – leading to sense of failure in aspects of each role – negative impact on emotional experience	• Conflict of identities – struggling to reconcile patient vs prof	157	• MH and identity – conflicting identities (80)
	• Describing impact of and struggle to integrate different and conflicting parts of identity – drawing on research which mirrors own experience		156	

	Struggling in straddling fence between patient and nurse identity – how can this be reconciled?	Using literature to integrate conflicting parts of identity	118; 158	MH and identity – conflicting identities (80)
	Blaming self for letting stigma (of having a patient friend and being a nurse-patient) get in the way of supporting friend	Conflict of identities – struggling to reconcile patient	159	Stigma – self-stigma (70)
	Placing identity struggle outside of self – worries about others' responses	Internalising stigma; Stigmatising views held by others getting in the way of supporting others Identity struggle also related to responses from others	72	MH and identity – conflicting identities (80)
	Concluding that literature around shifting meanings and identities within nurses with MH challenges is needed to support thinking about this	More research needed in impact of LE		LE – under researched area (81)
Sawyer (2011)	Using article to explore own experience of recovery from severe mental illness	Using article to explore own recovery	160	
	Using own story as cautionary tale against diagnostic fads and careless practice	1st person stories to inform training and practice	112	LE-Personal narratives as tools (34)
	Wanting to provide a source of hope and inspiration for clinicians and SUs – not to give up	1st person story to provide hope and inspiration	162	LE-Personal narratives as tools (34)
	Exploring questions of which aspects of psychotherapy are 'healing'	How does treatment work?	163	
	Confronting deep-seated fear of stigmatisation through publication of story and face possible loss of professional standing	Fear of stigma	41	Stigma – fear of (33)
			164	

	• Wanting to counteract loneliness stemming from secret past and share own knowledge	• 'Coming out' to reduce loneliness	165	
	• Describing professional role as one of psychologist in USA	• Describing prof role	381	
	• Describing first admission as teenager when feeling 'intensely suicidal'	• Suicidal	386	• Journey through MH care-Experience of MH (24)
	• Describing being 'sinful' and 'bad' for reasons of wanting to drown herself	• Being sinful and bad	166	• Journey through MH care-Experience of MH (24)
	• Feeling as though author irritated psychiatrist with 'frightened, cringing stance and barely audible voice'	• Describing difficult experience with psychiatrist	167	
	• Gaining access to own hospital notes to illustrate above impression	• Gaining access to hospital notes	168	
	• Receiving diagnosis of schizophrenia	• Receiving diagnosis	169	• Journey through MH care -Diagnosis (82)
	• Describing treatment offered: psychotherapy, ECT and medication	• Describing treatment offered – ECT, therapy, medication	7	• Journey through MH care – Therapy (25); medication (71); ECT (84)
	• Describing side effects of receiving ECT – seizures, hallucinations, stuttering, disruptive clumsiness	• Describing side effects of treatment	170	• Journey through MH care – side effects (7)
	• Describing development of additional symptoms during admission	• Treatment leading to development of additional symptoms	171	
	• Describing struggle to engage in psychotherapy – re-enactment of past trauma reinforcing ideas of being bad and sinful		172	• Journey through MH care – treatment not helpful (85)

	Experiencing setbacks in recovery during extended home visits	Struggling to engage with treatment	173	Recovery – setbacks
	Describing lack of improvement with ECT and further deterioration following departure of psychiatrist, whom author trusted and had a good relationship with	Setbacks in recovery	174	Journey through MH care – treatment not helpful (85)
	Describing lack in faith from professionals in author's ability to get better	Struggling to get better with treatment offered	175	Recovery – factors impeding recovery (57)
	Developing relationship with new psychiatrist experienced as reducing isolation and shame and be replaced by gratitude	Factors impeding recovery – lack of belief in recovery from prof	176	Recovery – factors facilitating recovery (27)
	Highlighting importance of feeling understood and making meaning of symptoms	Factors facilitating recovery – therapeutic relationship	177, 178	Recovery – factors facilitating recovery (27)
	Reflecting that best psychotherapists were collaborative and fearless in joining SUs on their journeys	Factors facilitating recovery – being understood	176, 179	Recovery – factors facilitating recovery (27)
	Being met with understanding and respect led to respecting staff; listening to their advice; being loyal towards them	Factors facilitating recovery - collaboration; fearless profs	180	Recovery – factors facilitating recovery (27)
	'Feeling understood is the essence of connection. It is connection that heals.'	Factors facilitating recovery – being understood; being respected	180	Recovery – factors facilitating recovery (27)
	Arriving at understanding of self through honest interactions with psychiatrist, patients and friends	Factors facilitating recovery – Understanding self through therapeutic relationship		Recovery – factors facilitating recovery (27)

	• Meeting husband through college and shared educational interests • Disclosing MH difficulties to future husband • Thriving at University as a result of having superseded own expectations • Successfully finishing undergrad degree at Yale opening doors which otherwise may not have opened due to history of MH difficulties • Working towards training as clinical psychologist with help of other professionals • Journeying through 21 years of therapy in total • Learning about self through learning as professional psychologist • Choosing to go into marriage counselling when feeling successful personally and professionally • Not having made sense of experience of being hospitalised leading to another spell of therapy – which led to decision to request hospital records • Concluding that author was misdiagnosed with schizophrenia and instead had been sexually abused by men within family	• Factors facilitating recovery – Understanding self through therapeutic relationship • Meeting husband • Sharing MH difficulties with husband • Thriving as a result of exceeding own expectations • Academic success opening doors for career opportunities • Support network allowing to realise career aspirations • Recovery as ongoing journey • Prof training helps to understand MH • Having space to address other relationship difficulties • Recovery as ongoing journey	181 182 183 13 131 13 184 131	• Recovery – Pursuing aspirations (55) • Recovery – Pursuing aspirations (55) • Recovery – ongoing (13) • Reconciliation of self-prof training to understand self (72) • Recovery – ongoing (13)

	• Drawing again on professional knowledge to make sense of trauma responses • Staying true to professional commitment helped in surviving recovery process • Having to summon ‘competent adult self’ pulled author out of ‘obsessive immersions into own condition’ • Work with patients providing courage for own therapy • Reflecting on characteristics shared by all three long-term therapists – excellent ability to establish positive and durable collaborative therapeutic alliance • Feeling treated as individual alongside compassion and attention to strengths • Own experience of being seen as reasonable, rational human being forming foundation for author’s own clinical work • Appreciating assertiveness and realness in own therapists • Therapists stepping out of role and using self-disclosure communicating being real people which led author to feel respect for them • Remaining connected to former psychiatrists – not having to stay sick to know them	• Misdiagnosis led to wrong treatment • Prof training helps to understand MH • Factors facilitating recovery – own prof commitment to clinical work • Factors facilitating recovery – ‘competent adult self’ • Factors facilitating recovery – courage from clinical work • Factors facilitating recovery – therapeutic relationship • Factors facilitating recovery – Having value as a person/having strengths • Recovery impacts practice	185 186 187 175 37 378 190 191 192 168;184 118	• Journey through MH care-Diagnosis (82) • Reconciliation of self-Prof training to understand self (72) • Recovery – factors facilitating recovery (27) • Recovery – factors facilitating recovery (27) • Recovery – factors facilitating recovery (27) • Recovery – factors facilitating recovery (27) • Recovery – factors facilitating recover (27) • LE – impacts practice (11); Recovery – impacts practice (12) • LE – asset (42)

	• Misdiagnosis and mistreatment making MH condition worse – in addition to stigma and self-stigma of condition • Respect and ongoing help from professionals key in making change • Highlighting role of perseverance in pursuing recovery • Describing ongoing challenge as clinician to remain humble and open – having awareness of personal defensiveness about schizophrenia so as not to dismiss the experience in SUs • Hiding history of hospitalization out of shame and fear of stigma • Personal experiences of being a patient considered as most valuable asset – 'Madness doesn't frighten me' • Calling for stigma to be addressed by respected, seasoned therapists being forthright about their own struggles • Experiencing speaking out as a positive experience – feeling embraced by professional community which leads to change in prejudice within self	• Appreciating therapists' realness and assertiveness • Prof self-disclosure led to respecting them • Remaining connected to treating clinicians without staying sick • Receiving diagnosis; Misdiagnosis led to wrong treatment • Experiencing stigma; Internalising stigma • Factors facilitating recovery – being respected; support network • Factors facilitating recovery – perseverance • LE impacts practice • Fear or stigma; shame due to LE • LE as an asset– not scared of madness • Needing power of senior position to 'come out'	34; 179 193 12 41; 195 78 106 196	• LE – asset (42) • Journey through MH care – diagnosis (82); • Stigma-self-stigma (70) • Recovery – factors facilitating recovery (27) • Recovery – factors facilitating recovery (27) • LE – impacts practice (11) • Stigma – fear of (33); self-stigma (70) • LE – asset (42) • Power – seniority to disclose LE (83)

		• Positive experience of coming out – feeling accepted and reducing self-prejudice		
SA (2018)	• Realising extent of ‘psychotic symptoms’ following participation in research study • Receiving diagnosis of bipolar affective disorder type I not enough to explain experience of developing, living and recovering from psychosis • Wanting to give insight into experience of psychosis and accessing help • Describing quick illness progression • Naming mere list of symptoms not enough to describe terror felt by author • Feeling as though all control is lost and the world was ‘impenetrably confusing’ • Having moments of insight and clarity – desperation for psychosis to cease • Likening first episode to horrific nightmare with knowledge of being awake • Describing EIP service as beacon of hope in dark months • Having informal and compassionate team • Professionals not appearing phased by bizarreness of symptoms or distress	• Describing onset of mental health; clinical symptoms • Receiving diagnosis • 1st person story to give insight into own experience of MH • Quick illness progression • Terror/fear • Feeling out of control; confusing • Desperation to get better; moments of insight • Terror/fear • Describing EIP service as helpful	3;4 168 197 387 380 382;388 389;390 380 198 199	• Journey through MH care –clinical symptoms (4) • Journey through MH care-Diagnosis (82) • LE-Personal narratives as tools (34) • Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care – treatment helpful (86)

	• Most importantly: team believing in certainty of recovery when author felt unable to	• Experiencing service as compassionate	200	• Journey through MH care-compassionate treatment (87)
	• Feeling hopeful about targets for people to access EIP services early	• Experiencing profs as able to manage distress	57	• Journey through MH care-containing (88)
	• Exploring impact of experiences on identity with clinical psychologist	• Factors facilitating recovery – therapist holding hope		
	• Crucial: Taking time to get to know one another to establish trust	• Feeling hopeful about access targets for EIP	201	• Recovery – factors facilitating recovery (27)
	• Returning to education following recovery to become clinical psychologist	• Exploring impact of LE in therapy	202	
	• Reflecting idea of 'wounded healer' and considering self as 'healing healer': "someone who uses my own positive experience of seeking help for mental health problems as a starting point for a career as a clinician"	• Importance of taking time to establish relationship • Training as MH prof following recovery	12	• Therapeutic relationship – takes time to establish (89)
	• Experiencing psychosis changes people who experience it but does not continually wound them	• LE impacts practice	230	• LE – impacts practice (11)
	• Feeling that healing process continues – being curious about my state of mind		13	
	• Struggling to separate own experiences from work – supervisor's compassion and humanity helped to integrate personal and professional self		69	• Journey through MH care – LE change not wound

	• Feeling that experiences give great insight and capacity to empathise • Reflecting on unhelpful aspects of service set up – fragmentation and waiting lists seen as unhelpful • Not wishing experience of bipolar disorder away despite experiences being terrifying • Experiences helped in realising good health is a privilege, not a right • Believing that recovery journey would have been more traumatic without EIP service – and calling for more services to adopt inclusive, positive and flexible approach	• Experiencing psychosis does not wound but changes a person • Recovery as on-going journey • Using LE to SU benefit – requires monitoring and self-reflection on motivation; supervision • LE giving insight; LE giving capacity to empathise • Fragmentation of services and waiting lists unhelpful • LE as an asset • Appreciating value of good health • Appreciating support from services	375;376 203 78 204	• Recovery – ongoing (13) • LE – asset (42); LE – Integrating prof knowledge and LE (10) • LE – asset (42) • Journey through MH care –treatment unhelpful (102) • LE – asset (42)
Burnard (2007)	• Describing aims and methods to conduct autoethnograpic research • Context of paper – visiting psychiatrist for third time in author’s life	• Defining method used in account – autoethnographic • Context – third visit to psychiatrist		

	Author identifies as healthcare professional, researcher, author, educator and sometimes as patient or consumer	MH and prof role defining identity	2	Reconciliation of self - dual identity (2)
	Having diagnosis of bipolar spectrum condition for more than 40 years	Defining identity as person with diagnosis	89	Reconciliation of self – person with diagnosis (54)
	Describing position as insider (healthcare professional) and outsider (belonging to group of people with MH difficulties which is still stigmatised)	Positioning self as insider and outsider	205	Reconciliation of self – dual identity (2)
	Stating own experience of stigma which may have been less for him than for others down to ability to 'pass as normal'	Experiencing less stigma due to passing as 'normal'	206	
	Wanting to remain detached and objective about appointment rather than self-indulgent	Wanting to observe own appointment in a 'detached and objective way'	229	
	Knowing psychiatrist prior to visit but being placed in new 'patient role'	Knowing psychiatrist professionally	207	
	Being met by psychiatrist's secretary and being ushered into nearest room available as opposed to being sat in waiting area	Feeling treated differently to 'normal' patient	208	Power – dual identity affords better treatment from profs (91)
	Observing own questions around whether author is getting 'special treatment', 'professional perks' due to his position as professional	Questioning 'special treatment' as 'professional perk'	209 210	Power – dual identity affords better treatment from profs (91)

	• Having found some basis to this notion from other colleagues who pay more attention on time as a 'professional courtesy' to other medical colleagues	• Having observed 'professional courtesy' in other instances	211 212	• Power – dual identity affords better treatment from profs (91)
	• Experiencing psychiatrist as 'easy, natural and encouraging'			
	• Noticing successful and reassuring personal device ("That was very useful, thank you") which was felt to serve establishing and developing empathy	• Having good experience with assessing clinician • Feeling reassured helps in feeling empathised with	213	
	• Feeling that there is lots of time to elaborate issues and raise questions		214	
	• Wondering if request to be sent letter of outcome of appointment would change its content	• Being given time to ask questions	215	• Power – profs having access to more info that SUs (92)
	• Wondering if patients feel able to ask for these correspondences and why the sharing of letters isn't the norm	• Will request to receive outcome letter change content?		• Power – profs having access to more info that SUs (92)
	• Experiencing process of appointment in arriving at same diagnosis as 'objective'	• Is sharing prof info the norm?		
	• Noting that process of diagnosis relied on subjective report of symptoms, no 'scientific' approach as yet to diagnosis – wondering if this was sufficient – acceptable/realistic to base	• Process of appointment in arriving at same diagnosis 'objective'	216	

	treatment plan on only one subjective account			• Diagnosis – subjective process (93)
	• Questioning of what Dr is treating when diagnosis is subjective	• Process of diagnosis ‘subjective’, not scientific	217	
	• Wondering what different treatment and advice would have been given if conclusions were different		5	
	• Feeling able to express view of not wanting to take long-term medication, which was accepted	• If diagnosis is subjective, what is being treated?	5	• Journey through MH care – active participation in treatment (5)
	• Discussing therapy but feeling more inclined to access ‘drug therapy’ as and when needed – also accepted	• Deciding treatment collaboratively	218	• Journey through MH care – active participation in treatment (5)
	• Noticing sense of pulling out of patient role and back into a more equal one	• Deciding treatment collaboratively	219	
	• Wondering whether relationship will have changed following appointment when he meets psychiatrist again professionally	• Pulling out of patient role back into equal one • Does role of patient impact prof relationship?	220	• LE – impact on prof relationships? (94)
	• Wondering to what degree the change will be caused by either party in the appointment (unknowable)		221	• LE – impact on prof relationships? (94)
	• Feeling need to tell own story to someone when this story can’t be told to many people whilst living with a part of yourself unknown to most others you work with	• Who impacts change in relationship unknowable	222	
			223	

	- Being aware of the importance of ‘real’ listening as a skill to engage	- Wanting to tell own story to someone outside of work		
	- Receiving letter with line describing patient as ‘well turned out, pleasant and cooperative’ – wondering how the interview had been if he had presented as scruffy, unpleasant and uncooperative	- Appreciating ‘real listening’	224	
	- Wondering if ‘being cooperative’ was still fundamental to everyday psychiatric practice	- Wondering impact of being ‘cooperative’ vs ‘uncooperative’, ‘well turned out’ vs ‘scruffy’	225	
	- Observing that psychiatry makes moral judgments and prescriptions about what constitutes ‘normal behaviour’ – reinforcing feeling of being an outsider	- Being ‘cooperative’ fundamental aspect of getting along with psychiatry	5	
	- Experiencing following conversation with GP as one of negotiating and coming to joint agreement – not feeling as though any of the psychiatrist’s recommendations need to be implemented	- Psychiatry judging what is normal reinforces feeling of being an outsider	226	- Journey through MH care – active participation in treatment (5)
	- Feeling like an active player in future treatment planning – wondering in how far this is again due to professional role in MH system	- Deciding treatment collaboratively	209	- Power – participation in own treatment due to prof status? (95)
	- Wondering to what degree other mental health patients would be treated differently/coercively	- Active participation in treatment due to prof role?	227	- Power – dual identity affords better treatment from profs (91)

	• Reflecting on position and power of doctor – being an expert of MH, needing to be prescriptive – difficult position when diagnoses feel more subjective • Feeling need to defend doctors – wondering whether this is out of compliance with medical view or gratitude for compassionate care • Sensing expectations from doctors to know what treatments are available and which is the best choice – being responsible for own choice of treatment can be a burden • Identifying themes of account: - setting up interview in ‘comforting and comfortable manner’; concerned about meeting colleagues, yet comfortable to write about account in journal, noting snobbishness, wanting to be treated differently to other patients and believing he was; noticing own stigmatising views re mental health applying these to self and how these arise from ‘bumping up against other people’s attitudes’ which stops conversation about own MH • Realising that in writing article, he is open to further stigma	• Questioning ‘special treatment’ as ‘professional perk’ • Reflecting on power given to doctors as MH experts given subjectivity of diagnosis • Compliance with medical model or gratitude for compassionate care? • As prof feeling burden of being responsible for own care and wanting Drs to make choice • Themes of account: feeling comfortable during interview; reflecting on stigma of being patient, yet disclosing LE in journal; wanting to be treated differently due to professional status; holding stigmatising and self-stigmatising views	228 231 226; 232; 233; 234 235 236	• Power – participation in own treatment due to prof status (95); Stigma – LE remains taboo (32); Stigma –self- stigma (70)

	• Experiencing subjective shift into patient role at the beginning of appointment and stepping out at the end – patient-practitioner role is not an equal one • Being impressed with interview – observing it from two perspectives: - from PoV of what might help him; - from PoV of the skill of psychiatrist • Question of ethics and fairness – is it OK to feel to be treated differently due to status as healthcare professional? • Reflecting on impact of MH label on how 'conditions' are understood – MH challenges as way of being rather than an add-on to 'normal life' • Highlighting that reflection can involve looking at the past which author feels is of little value due to creating fictional accounts of own lives • Highlighting pitfall of autoethnographic method as not being able to verify his account • Finding the notion of writing about self for the self, difficult – indulgent • Noting that in writing about own experiences there's no way of detaching self from process	• Article opens author up to stigmatisation • Acknowledging patient – practitioner is not equal • Combining professional and experiential knowledge • Questioning 'special treatment' as 'professional perk' • Reflecting on impact of labels – MH as way of being rather than 'add on' to life • Feeling that reflecting on past of little value • Autoethnographic method not verifiable	11 209 238 239 240 243 241 242	• Power – held in expertise (51) • LE – Integrating prof knowledge and LE (10) • Power – dual identity affords better treatment from profs (91)

	Seeing use in having service user perspective of services as a lot of literature comes from professionals Worrying about being ‘misinterpreted’ or ‘misjudged’ by those who read article for putting up with mental health problems – highlighting tension that fear of being judged may point towards judging others with MH difficulties as well as yourself Submitting paper hoping to break out of traditional mould of writing and with trepidation – ‘we can only know we have gone too far by going there’	Autoethnographic method self-indulgent Impossibility of detaching self when writing about own experiences Having SU perspective is valuable Fear of being stigmatised by others may point towards holding self-stigmatising views Publishing paper in hope of breaking traditional mould	41; 234 99	Participation – develop MH care and policies (67) Stigma – fear of (33); self-stigma (70) Personal narrative as tools (34)
Coodin Schiff (2004)	Recovery movement belonging to SUs	Recovery model belongs to SUs	244	
	Using paper as safe place to reveal and discuss SU aspect of identity	MH and prof role defining identity	2	Reconciliation of self – dual identity (2)
	Discussing recovery model considering psychosocial perspective and humanistic ideology	Discussing recovery model drawing on own valued perspectives	246	Recovery –defining paradigm (31)
	Examining question: What is recovery – considering how own recovery was possible	Examining what recovery is and how own recovery was possible	247 248	

	• Recovery: highly personal and unique process	• Recovery as highly personal and unique process	249	• Recovery – unique and personal process (96)
	• Contrasting perspective of full recovery being possible to the perspective of learning to live with illness and reaching one's full potential within these limits	• Different recoveries possible – full vs limited	250	
	• Introducing history of recovery movement from having 'patients' to forcing 'society to examine and renegotiate its current discourses of mental illness'	• History of recovery movement – change in discourse	251;375	
	• 'Prosumer' (professional with lived experience) in a unique position to educate professionals about lived experience and can be taken seriously by professionals because of their credentials	• Role of prosumer – LE and prof experience giving insight into both worlds	252	• LE – asset (42)
	• Prosumers as only professional a consumer will trust	• Prosumers having SU's trust	376	• LE – asset (42)
	• Reflecting profound empathy in behaviour based on own experience	• LE giving capacity to empathise	254	
	• Describing challenge of recovering from MH as well as multiple traumas experienced in the course of treatment (insufficient help, negative professional attitudes, medication side effects) and discrimination from within society	• Challenge to recover from MH and trauma of treatment	255	• Journey through MH care – treatment traumatic (99)

	Psychosocial model: importance of social role and the extent to which this role can be held whilst experiencing mental illness	Drawing on psychological theory to understand own and others’ experiences	256	Reconciliation of self-Prof training to understand self (72)
	Humanistic ideology bringing common humanity into relationship between professional and SU	Drawing on humanistic ideology to bring common humanity into prof relationship	257	
	Author’s definition of recovery: feeling at peace, being happy, feeling comfortable in the world and with others and feeling hope for the future	Personal definition of recovery – happiness, at ease with others, peace, having hope –lacks mention of MH symptoms	258	
	Drawing on negative experiences to ‘make me a better person’	‘Bettering self’ through -ve experiences	259	
	Not being afraid of who I am and what I feel	No fear to be self	260	
	Having felt trapped in the ache of mental illness – focussing on exit rather than causes of this	Focussing on getting better rather than causes of MH	261 261	
	Wish to get better kept author going			
	Driven by desire to leave state of torment and ache and to pursue music career	Driven by desire to get better	37	
	Music and singing as a means to feel, to be grounded and connected	Driven by desire to get better	263	Recovery – factors facilitating recovery (27)
	Importance of taking charge of own care where possible – researching medication to understand Drs	Factors facilitating recovery – having value as a person/having strengths	264	Journey through MH care- active participation in treatment (5)
		Importance of active participation in treatment	265	

Lees (2014)	• Recognising that author will remain ill if she doesn't change 'something'	• Recognising need for change to get better	266	• Recovery – unique and personal process (96)
	• Author's recovery journey: acceptance of illness; self-empowerment – taking charge of own care; improving quality of life	• Recovery as acceptance of MH, empowerment and better quality of life	267	
	• Illness moving into past allowing to feel more comfortable with self	• Distance to illness improves comfort with self		
	• Noting that in 'our culture' sickness is seen as 'not feeling like self' – chronic illness therefore necessitates a renegotiation with ill self as self	• Chronic illness necessitates renegotiating sense of self		
	• Having a history of being told that author wasn't 'normal' – crucial to self-esteem that 'abnormality' was OK	• Having history of being 'abnormality' which was accepted	268	
	• Identifying self as having psychosis	• Defining identity as person with diagnosis	89	• MH and identity – person with diagnosis (54)
	• The messages of 'being abnormal but that's OK' having had a massive impact which is still in the process of being understood to this day	• Message of being 'abnormal' having impact which still needs to be understood	269	
	• Having a life changing psychotic episode followed by diagnosis of schizophrenia aged 20 – followed by bipolar diagnosis	• Psychotic symptoms; Receiving diagnosis	4, 168	• Journey through MH care-Experience of MH (4); Diagnosis (82)
	• Being unwell was very scary and hard to process	• Terror/fear	380	• Journey through MH care-Experience of MH (24)
	• Immersing self in simplicity of medical model – chemical		270	

	imbalance, an illness, doesn't go deeper than that	• Seeking simple 'medical model' explanation for experiences	271		• Reconciliation of self-Prof training to understand self (72)
	• Comparing own experience of process of acceptance of receiving MH diagnosis to those of others who wrote about experiencing loss, shame, grief, terror isolation –	• Experience of growing up 'abnormal' helped acceptance of diagnosis	37		
	• Author's experience lacked shame as receiving dx did not change belief that she is a valuable human being		272		• Recovery – factors facilitating recovery (27)
	• Feeling blown away in other aspects – medication, losing job and driving licence	• Factors facilitating recovery – having value as person/having strengths	273		• Stigma – causes pain (77)
	• Process of feeling distressed, scared, isolated and ashamed experienced during childhood when given message of 'being abnormal'	• Experiencing struggles as a result of MH diagnosis	273		
	• Having been through process of acceptance during childhood rather than when diagnosed	• Being 'abnormal' as child helped in adjusting identity back then	274		
	• Feeling that foundations for recovery process laid during childhood		275		
	• Wondering about link between early labels and subsequent diagnoses – self-fulfilling prophecy	• Being 'abnormal' as child helped in adjusting identity back then • Foundations of ability to recover laid during childhood	276		
	• Processing diagnosis quickly and moving on to self-management	• Early labels as self-fulfilling prophecy for subsequent diagnoses	78		
	• Drawing on own experience in role of OT assistant and tutor at recovery college				• LE – asset (42)

	• Drawing self-esteem from work and ability to support others	• Digesting diagnosis quickly to move on to self-management	277	
	• Changing understanding of self and own recovery confronting with the fact that practice may have been misguided	• LE as an asset	278	• Recovery – factors facilitating recovery (27)
	• Mental health work starting in environment valuing lived experience in supporting those suffering from MH	• Factors facilitating recovery – Clinical work increases self-esteem • Changing understanding of self and recovery challenges practice	12	• Recovery – understanding self (6)
	• Being influenced by training in counselling – unconditional positive regard and belief in every individual's ability to lead a self-fulfilled life – contrast with medical model which posits that 'patients' are in need of expert help	• LE impacts practice	280	• LE – impacts practice (11)
	• Experiencing knowledge as being power – holding knowledge lessened power divide between self and professionals	• Counselling training influencing practice – contrast with medical model in which patients need help	281	
	• Own experience linking with belief in other people's ability to recover and come with strengths and talents	• Holding knowledge about own MH decreases power divide between self and prof	282	• Recovery – impacts practice (12)
	• Conflict arising in own approach to work in MSc in recovery – being told that there is no 'one way' to recover but many valid one – author did not share this belief and thought that her way was the 'right one' – fear this had shown in her work	• Own experience of recovery strengthens belief in others' ability to recover • Discovering there is no 'right way' to recover	283	• Recovery – unique and personal process (96)

	Describing process of learning as a process of loss – losing understanding of something – losing the way we saw it previously	Process of learning as process of loss of previous understanding	284	Recovery – unique and personal process (96); factors facilitating recovery (27)
	Being at stage of watching certainties and simplicities of medical model falling away – continuing to experience challenge in new learning	Continuing learning beyond simplicities of medical model	285	
	Despite own one-dimensional understanding of recovery having managed to build relationships with SUs – having hope, regard and compassion allows for this	Having hope, regard and compassion allows building of relationships despite medical model view	286	
	Holding hope and regard in behalf of SUs until they can hold it for themselves	Holding hope on behalf of SU	287	
	Having come to understand the importance of diversity within recovery and fundamental value of relationships	Understanding diversity of recovery and value of relationships and support networks	288; 34	
Olson (2009)	Feeling comfortable in own separateness from clients	Comfort in being separate from SUs	289	Stigma – 'Them-and-us' (83)
		Terror/fear	380	

	• Experiencing terror and deepening despair suddenly		234	• Journey through MH care- Experience of MH (24)
	• Battling with shame of being client	• Holding self-stigmatising views	168; 290	• Stigma – self-stigma (70)
	• Being offered diagnoses alongside prescriptions following seeing psychiatrist	• Receiving diagnosis; treatment through medication	291	• Journey through MH care- Diagnosis (82); medication (71)
	• Leaving behind smugness and security of own self-image	• Leaving behind past self-image following LE of MH		• MH and identity – transition prof to SU (50)
	• Having views about self and MH, treatment and care permanently changed following own experience	• Leaving behind past self-image following LE of MH	291	• MH and identity – transition prof to SU (50)
	• Using account as attempt to describe some of these changes by exploring own experience of MH critically	• Using account to explore own experience of MH critically	292	
	• Acknowledging own biases and preconceptions in exploring own experience – not being objective	• Acknowledging biases in own experiences	293	
	• Acknowledging pitfalls of sharing lived experience in 'competitive academic environment' – feeling the benefits outweigh these	• Benefits of sharing LE outweigh pitfalls	294	
	• Benefits including: deepening clinicians' understanding of the personal meaning of having to face MH challenges; challenging stigma; highlighting positives and negatives of psychiatric care	• Benefits of LE: asset to understanding of personal meaning of MH challenges; challenging stigma; highlighting +ves and -ves of psychiatric care	78; 295 234	• LE- asset (42)
	• Feeling shame at imagined weakness		118	• Stigma – self-stigma (70)

	Realising patronising own views regarding MH portrayed as ‘like any other illness’	Holding self-stigmatising views	44; 297	Stigma – self-stigma (70)
	Having illusion of stigma-free illness shattered and having to cast aside beliefs about psychiatric diagnostic process	Internalising stigma	216	Stigma – in MH professionals (35); Diagnosis – subjective process (93)
	Realising reality of psychiatric diagnoses as imprecise hypotheses posed by caring yet biased clinicians – could be seen as patient, not as professional	Continued existence of stigma in professionals; having to let go of beliefs about diagnostic process	298	Diagnosis – subjective process (93)
	Struggling to find ‘perfect therapy’, instead being faced with contradictions	Process of diagnosis ‘subjective’, not scientific	299	
	Raising issue of giving informed consent to therapy if the process with its implications isn’t fully understood by SU	Struggling to find ‘perfect therapy’	300 216	
	Continuing to have hope for ‘cure’	Issue of consenting to treatment without understanding		
	Facing continued discrepancies and conflict in diagnosis and treatment process as suggested by a variety of professionals	Hoping for ‘cure’	301	Treatment of MH – wanting a cure (100) Diagnosis – subjective process (93)
	Recognising limitations of professional training in narrowing diagnostic and treatment focus	Process of diagnosis ‘subjective’, not scientific	302	
	Having missed professional who can respond to author’s experience and needs holistically casting own preferences aside		303 304	Journey through MH care – wish for holistic,

	• Realising and experiencing complexity of MH first-hand • Highlighting importance of clinicians ‘cultivating greater self-awareness and humility through recognising constraints of their disciplinary training and personal biases’ – hopefully leading to greater willingness to work together and to coordinate care • Revealing ‘professional ego’ as barrier to working together • Being aware of limitations of therapy may lead to more integrated care within community and drawing on other sources of support • Wanting access to various other resources, e.g. peer support, but having to find these alone • To find real hope, author had to trust own intuition and ideas about recommendations amongst struggling with MH • Finding real hope in looking for ways to help self • Learning that real hope is as much about the clinician as the client	• Prof training can narrow focus of diagnosis and treatment • Wanting holistic, person-centred care • First-hand experience of MH complexities • Highlighting importance of clinicians’ self-awareness to promote joint working • ‘Prof ego’ barrier to collaboration • Being aware of limitations of therapy allows drawing on community resources • Wanting access to multiple resources –organising access autonomously • Trusting own intuition to find hope	305 306 307 308 309 38; 57	person-centred care (101) • Professional practice – importance of reflection (74) • Recovery – factors facilitating recovery (27)

		• Finding hope in way to help self • Factors facilitating recovery – having hope; therapist holding hope		
May (2000)	• Considering own experiences of recovery from psychosis and their influence on work with MH in role as clinical psychologist	• LE impacts practice; LE impacts recovery	12; 378	• LE – impacts practice (11)
	• Being critical of medical treatment but appreciating that hospitals act as safety net with lack of springiness to help SUs get back on tightrope	• Being critical of medical model whilst acknowledging its necessity	310	
	• Wondering whether diagnosis of schizophrenia given as result of family history of schizophrenia	• Receiving diagnosis; Diagnosis of schizophrenia impacted by family history?	168;311	
	• Obstacles to recovery presenting as under-resourced, over-medicalised services	• Factors impeding recovery to recovery: lack of resources; over-medicalised services	312	• Recovery – factors impeding recovery (57)
	• Experiencing ‘treatment’ as minimal interaction with staff, being highly sedated	• Experience of treatment: being sedated; minimal interactions with staff	313	• Journey through MH care – treatment unhelpful (102)
	• Not addressing ‘disturbing beliefs’ led them to develop further	• Not addressing ‘disturbing beliefs’ worsened them	314	• Journey through MH care – treatment unhelpful (102)
	• Experiencing hospital stay as endurance test rather than respite and rehabilitation	• Experience of hospital stay unhelpful	315	• Journey through MH care – treatment unhelpful (102)
	• Resulting readmissions because of stopping medication leading to mania – interpreted as relapse rather than medication withdrawal	• Medication withdrawal interpreted as relapse	316	

	• Finding it impossible to separate madness from social, medical context once interventions were offered – can't disentangle underlying mental processes from institutionalisation and effects of medication	• Mental processes can't be separated from treatment context	317	
	• Battling against social exclusion as a result of medication and stigma of diagnosis – e.g. not being able to work	• Social isolation and exclusion due to experience of MH	343	• Stigma – leads to social exclusion (60)
	• Defining recovery as improving self-esteem, adjustment to disability, empowerment and self- determination	• Defining recovery as: improving self-esteem; adjustment to disability; empowerment and self-determination	319	
	• Finding it tough to change people's expectation of what could be achieved – stigma?		320 321	
	• Combating disempowerment of being undervalued needed access to alternative stories about self	• Stigma lowering expectation of person with MH • Creating alternative stories to challenge stigma	322	• LE-Personal narratives as tools (34)
	• Telling positive stories about: believing in being valued and able to achieve (as reinforced by staff member); story of parents being supportive rather than oppressive; having accepting and supportive friends helped in regaining social autonomy; importance of personal will and effort in making a better than expected recovery; rediscovering past positive stories about self	• Factors facilitating recovery – telling +ve stories about being valued and able, supportive network to regaining social autonomy, personal will and effort to recover, rediscover +ve stories about self		• Recovery – factors facilitating recovery (27)

	Avoiding social contexts where author was not valued	Factors impeding recovery contexts where one isn’t valued	323	Recovery – factors impeding recovery (57)
	Starting employment, not too demanding, important part of recovery	Factors facilitating recovery – Employment	35	Recovery – factors facilitating recovery (27)
	Finding work where author was trusted with carrying out responsible and challenging work which he was valued for also helped in giving confidence – making long-term plans to become clinical psychologist	Factors facilitating recovery – Employment	35 325	Recovery – factors facilitating recovery (27)
	Developing greater sense of autonomy and independent living skills by finding own flat	Factors facilitating recovery – Greater sense of autonomy and independence	326	Recovery – factors facilitating recovery (27)
	Relaxation and physical exercise helpful in managing stress as well as healthy diet	Factors facilitating recovery – Physical wellbeing	327	Recovery – factors facilitating recovery (27)
	Engaging in political struggle for better MH care gave life sense of purpose and meaning	Political activism gave life purpose and meaning	328	
	Seeing need to treat client with psychosis as whole person from own experiences	Calling for holistic, person-centred care	328	Journey through MH care – wish for holistic, person-centred care (101)
	Highlighting importance of creating continuity for clients with psychosis – feeding back previous sessions, listening, feeding back	Calling for holistic, person-centred care	329	Journey through MH care – wish for holistic, person-centred care (101)
	Promoting interpersonal relations between SUs and ward staff		330	
	Being ‘real’, being ‘myself’ in order to avoid contributing to		12;282	

	alienation process SUs experience			
	• Being optimistic about SUs' potential and abilities – knowing importance of this when helped by people who were 'mad'	• Promoting relationships between staff and SUs • Being 'self' as prof to avoid alienating SUs	331	• LE– impacts practice (11); Recovery-impacts practice • Recovery – factors facilitating recovery (27)
	• Building SUs' agency and support development of alternative stories		332	
	• Recognising importance of language in disempowerment – illness, sufferer vs survivor	• Own experience of recovery strengthens belief in others' ability to recover; LE impacts practice	333	• Power – naming of issues crucial (62)
	• Discussing power issues is crucial		334;340	
	• Importance of identifying forms of social exclusion – stigma – and challenging 'them-and-us' ideas	• Factors facilitating recovery – stories about MH to build SU's agency	335	• Stigma – leads to social exclusion (60); challenging stigma (36)
	• Recognising own fear of losing freedom in SUs – obstacle to collaborative MH care	• Recognising importance of language in disempowerment of SUs	336	
	• Own battle involving challenging dominant social expectations – experienced as more challenging than recovery from psychosis	• Naming power issues crucial	337	
	• Recognising power in subscribing to 'sick role' – which would have worsened outcomes	• Focusing on identifying forms of social exclusion (stigma) and challenge 'them-and-us'	338	• Recovery – factors impeding recovery (57)
	• Recognising own privileges and opportunities which other SUs may not have – these make recovery more straightforward	• Barriers to collaboration – Fear of losing freedom • Battle of challenging dominant social expectations	339	• Recovery -Factors facilitating recovery (27)

	• Own experiences and clinical observations suggesting that key to recovery in social contexts in which MH occurs • Seeing own experience of psychosis as asset – allowing positive focus on SUs' whole lives and having hopeful view of their future and abilities • Encouraging employment of survivor workers to bring valuable insights into work and to challenge 'them-and-us' – contributing to learned hopelessness in MH system	more challenging than recovery • Factors impeding recovery – Subscribing to 'sick role' • Factors facilitating recovery – Holding privilege • Key to recovery – social context in which MH occurs • LE as an asset • Employing PSWs to bring insights; challenge 'them-and-us	78 340	• Recovery – factors facilitating recovery (27) • LE – asset (42) • Stigma – challenging stigma (36)
Mack (2001)	• Identifying as living with neurobiological brain disorder (known as mental illness) • Describing own birth and family background	• MH as neurological brain disorder • Making sense of experience of MH	341 342 342	• Journey through MH care-Experience of MH (24)

	• Describing own early difficulty in relating 'calmly' to environment	• Making sense of experience of MH	342	• Journey through MH care-Experience of MH (24)
	• Describing unusual experiences throughout childhood – difficulties in letting mother know what's going on	• Making sense of experience of MH	343	• Stigma – leads to social exclusion (60)
	• Being withdrawn at school and struggling to make friends due to unusual experiences	• Social isolation and exclusion due to experience of MH	388	
	• Describing getting used to 'weird things' happening – until big 'out of body thing' happens	• Confusing	290	• Journey through MH care-Experience of MH (24)
	• Having medication prescribed which is very sedating		343	
	• Feeling isolated from others in family who don't seem to want to talk about and understand experiences	• Treatment of MH with medication – sedating • Social isolation and exclusion due to experience of MH	344	• Journey through MH care–medication (71)
	• Keeping experiences in leads to inner angst and isolation and major depression eventually	• Keeping experiences to self leads to isolation and depression	345	• Stigma – leads to social exclusion (60)
	• Learning not to trust doctors as they don't understand and only talk to parents	• Factors impeding recovery – lack of trust in Drs and feeling excluded from treatment	382	• Journey through MH care-Experience of MH (24) • Recovery – factors impeding recovery (57)
	• Feeling 'ravaged' by unpredictability and viciousness of inner turmoil – being robbed of childhood without realising	• Feeling out of control	25 346	
	• Experiencing mania following depression – finding this 'more fun'	• Describing experience of MH	347	• Journey through MH care-Experience of MH (24)
	• Difficulty in distinguishing normal adolescence from MH	• Experience of MH or adolescence?	300	

	• After being spiked fearing outside world – life becoming smaller • Praying for cure • Starting to become afraid of food – anorexia diagnosis – labels instead of understanding • Fighting off demons alone • Continuing MH struggle into college – broad variety of symptoms • Psychiatric symptoms overwhelming but having learned not to talk about them – attracting labels which attract treatment of derogatory cynicism and neglect • Physical symptoms disregarded which later are identified as mono • Being very afraid of symptoms – not understanding self • Experiencing 'them-and-us' during hospital stay • Describing significant mental and physical suffering • Losing career and marriage over symptoms • Engaging in own research to find out 'what's wrong with me' • Experiencing shame and blame around own condition leads to further isolation	• Isolation • Hoping for 'cure' • MH expanding – taking over life • Fighting MH alone • Continued struggle; range of symptoms • Receiving diagnosis; Staying silent about MH • Prof focusing on MH at expense of physical health • Terror/fear • 'Them-and-us' • Suffering mentally and physically • Losing career and marriage due to MH • Attempting to find out 'what's wrong with me' • Holding self-stigmatising views; social isolation and	348 349 350;392 168;351 352 380 354 123 356 357 234; 343 131 360 361	• Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care – wanting a cure (100) • Journey through MH care-Experience of MH (24) • Journey through MH care-Experience of MH (24) • Journey through MH care-clinical symptoms (4) • Journey through MH care-Diagnosis (82) • Journey through MH care-Experience of MH (24) • Journey through MH care – Experience of MH (24)

	• Entering training as OT – journey of discovery of self and ability to help others	exclusion due to experience of MH	362	• Stigma – 'Them-and-us' (83) • Journey through MH care-Experience of MH (24)
	• Feeling that OT fills the gap in MH care provision – it examines body as integrated self	• Prof training to understand MH	363	
	• Experiencing profession as building partnership with others instead of barricades	• OT filling gap in MH care for author – integrating whole person	375;376	• Recovery – understanding self (6) • Stigma – self-stigma (70); leads to social exclusion (60)
	• Feeling too unempowered to not feel blame for own condition – reiterating neurobiology of own condition	• Experiencing OT as building partnerships	365	• Reconciliation of self-Prof training to understand self (72)
	• Continued struggle with negative attitudes from peers in class	• Feeling disempowered	366	
	• Finding that author relates deeply to emotional and transitional role changing impacts of clients' struggles	• Stigma lowering expectations of person with MH	375;377	• Reconciliation of self-Prof training to understand self (72)
	• Struggling to give full attention to clients whilst struggling herself – making best effort	• LE giving insight; LE giving capacity to empathise	367	
	• Receiving diagnosis of cancer following qualification as OT		368	
	• Having high level of compassion with SUs due to own experiences	• LE diverting attention from clients	369 370	• LE – asset (42)
	• Feeling as though being seen as malingerer or hypochondriac	• Other life struggles in addition to MH		
	• Entering 'consumers as providers' training program – hired as consumer with special insights	• LE giving insight; LE giving compassion	371	• LE – barrier

	• Experiencing boundary issues firsthand – role change from consumer to employee • Experiencing role confusion when treating professionals become colleagues • Defining recovery as journey of discovery of 'one's true colours and letting them shine through in spite of the fog that sometimes clouds the rainbow' • Having privilege of returning to work with accommodations made and support in place • Hoping that own story provides hope and insight – lending courage to people	• Experiencing others as dismissive of MH struggles • Finding place in PSW • Boundary issue in role change from consumer to employee • Role confusion – treating prof become colleagues • Recovery as discovery of one's true colours and accepting these • Privilege of working and being supported • LE giving hope; LE giving insight • 1st person story to provide hope; 1st person story to give insight	372 374; 375 162; 197	• LE – asset (42) • Journey through MH care-Experience of MH (24) • Professional practice-boundary issues in role change (103) • Professional practice-boundary issues in role change (103) • Recovery – unique and personal process (96) • LE-Personal narratives as tools (34); LE-asset (42)

Themes, categories and codes identified in content analysis (code numbers in brackets)

Themes	Categories	Codes
Recovery	1. Factors facilitating recovery 2. Recovery as ongoing	1a. Medication (32) 1b. Support network (34) 1c. Having value and strengths as a person (37) 1d. Hope (38) 1e. Therapist holding hope (57) 1f. Employment (35) 2a. Recovery as on-going journey (13)
Stigma	1. Self-stigma 2. Fear of Stigma	1a. Internalising stigma (118) 1b. Holding self-stigmatising views (234) 2a. Fear of stigma (41)
Lived experience	1. Lived experience as an asset 2. Lived experience impacting practice 3. Integrating professional knowledge and lived experience 4. Personal stories as tools	1a. Lived experience as an asset (78) 1b. Lived experience giving hope (374) 1c. Lived experience giving insight (375) 1d. Lived experience giving capacity to empathise (376) 1e. Lived experience giving compassion (377) 2a. Lived experience impacts practice (12) 3a. Combining professional and experiential knowledge (11) 3b. Difficulty integrating professional and experiential knowledge (19) 4a. 1st person stories to challenge stigma (45) 4b. 1st person stories to inform training and practice (112) 4c. 1st person stories to provide hope (162) 4d. 1st person stories to give insight (197)
LE of MH vs diagnosis	1. Individual experience of mental health 2. Diagnosis	1a. Terror/fear (380) 1b. Suicidal (381) 1c. Feeling out of control (382) 1d. Suffering mentally and physically (123) 1e. Confusing (388)

		2a. Receiving diagnosis (168)
Reconciliation of identity	1. Mental health training to understand self 2. Mental health and dual identity	1a. Prof training to understand self (131) 2a. MH and prof role defining identity (2)

Appendix D. Letter of HRA approval

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Appendix E. Service user and staff consent form

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Sharing is caring? – How mental health staff and service users perceive the impact of sharing lived experience on recovery

Name of Researcher: Inke Schreiber

1. I confirm that I have read and understood the information sheet dated 11/11/2018 (version 3) for the above study. ☐
2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
3. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview without giving a reason. This won't affect any care I am receiving. ☐
4. I understand that once the data analysis has begun, I will no longer be able to withdraw my interview from the research. ☐
5. I agree for this interview to be audio recorded and understand that anonymous verbatim quotes from my interview may be used in published reports of the study findings. ☐
6. I understand that relevant sections of data collected during the study may be looked at by the lead supervisor Dr Sue Holttum. I give permission for these individuals to have access to my data. ☐
7. I understand that my fully anonymised interview transcript might be looked at by members of Canterbury Christ Church University's service user consultation group, some of whom are affiliated with [host trust], in the process of data analysis. I understand that all information which could reveal my identity will be removed from the transcript to ensure I remain anonymous. ☐
8. I understand that the researcher has a duty of care to contact relevant parties if there is cause for concern for my mental and physical wellbeing as well as others. I understand that any action taken would be discussed with me before and I would be informed of who would be contacted. ☐

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

Name of Participant____________________ Date________________

Home address (only if interviewed via Skype or phone) ____

Signature ___________________

Email address (only include if you wish to be sent the final report) ______________________________________

Name of Person taking consent ______________ Date_____________

Signature ____________________

Participant Identification Number for this study:

CONSENT FORM

Title of Project: Sharing is caring? – How mental health staff and service users perceive the impact of sharing lived experience on recovery

Name of Researcher: Inke Schreiber

Please initial box

1. I confirm that I have read and understood the information sheet dated 11/11/2018 (version 3) for the above study. ☐

2. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

3. I understand that my participation is voluntary and that I am free to withdraw at any time during the interview without giving a reason without impacting my employment. ☐

4. I understand that once the data analysis has begun, I will no longer be able to withdraw my interview from the research. ☐

5. I agree for this interview to be audio recorded and understand that anonymous verbatim quotes from my interview may be used in published reports of the study findings. ☐

6. I understand that relevant sections of data collected during the study may be looked at by the lead supervisor Dr Sue Holttum. I give permission for these individuals to have access to my data. ☐

7. I understand that my fully anonymised interview transcript might be looked at by members of Canterbury Christ Church University's service user consultation group, some of whom are affiliated with Sussex Partnership NHS Foundation Trust, in the process of data analysis. I understand that all information which could reveal my identity will be removed from the transcript to ensure I remain anonymous. ☐

8. I understand that the researcher has a duty of care to contact relevant parties if there is cause for concern for my mental and physical wellbeing as well as others. I understand that any action taken would be discussed with me before and I would be informed of who would be contacted. ☐

9. I understand as a health professional, who is a member of a regulated profession, I must adhere to my own professional codes of practice and if I suspect information discussed (for example bad clinical practice) could put or have put clients or others at risk this must be reported to the appropriate authority. I understand that the interviewer may discuss concerns with their supervisor and report those in line with their own professional code of conduct. ☐

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

Name of Participant____________________ Date________________

Home address (only if interviewed via Skype or phone)
____

Signature ___________________

Email address (only include if you wish to be sent the final report)
____

Name of Person taking consent ______________ Date_____________

Signature ____________________

Appendix F. Information sheets service users and staff

Information Sheet

Project Title: Sharing is caring? How mental health staff and service users perceive the impact of sharing lived experience on recovery

Hello,

My name is Inke Schreiber and I am a trainee clinical psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University. As part of my doctorate I, along with my supervisors, Dr Sue Holttum and Dr Nick Grey, would like to invite you to take part in a research project looking at the possible impact of sharing lived experiences on recovery from mental health difficulties. This information sheet summarises information about the project to allow you to make an informed choice about whether you would like to participate. Please read the following information carefully and do not hesitate to get in touch with myself or either of my supervisors, should you have any questions (contact details at the end of this document).

Background of the project:

Recently, there has been a shift within the NHS towards recovery-focused practice. This is to support people who access services to manage their difficulties more independently and in line with their values. Recovery-focused practice views recovery as a unique journey, drawing on people's abilities and strengths to reach their goals. Some research shows that staff with lived experience of mental distress have felt that these experiences can be helpful in building good relationships with people who use services.

Purpose of the project:

The aim of this research is to explore the possible impact of staff using their lived experiences on the recovery of people with mental health challenges. To do so, we are recruiting participants with an experience of using services within Sussex

Partnership NHS Foundation Trust to volunteer to be interviewed for about 1 hour to think about this topic.

Participation:

Participation in this project is completely voluntary and you have the right to withdraw from the study at any point. Withdrawal from participation will not have any impact on the treatment you receive.

If you agree to take part, I will get in touch with you to arrange a date, time and place to meet for 1 hour for the interview. Travel costs to an agreed service location within [host trust] can be reimbursed to up to £10. There is also the possibility to speak via Skype or phone, should you wish to take part but have difficulties travelling.

The interview will be audio recorded and transcribed. The recording of your interview will be stored on a password protected memory stick only the interviewer has access to. Written extracts of the audio recordings may be shared with both supervisors and anonymous verbatim quotes of your interview may be used in the published report of the findings of this study. All information collected from or about you during the course of the research will be kept strictly confidential, and any identifying information about you, e.g. your name, will be removed so that you cannot be recognised. Your consent form with your signature will be kept in a sealed envelope in locked storage at Canterbury Christ Church University for 5 years and then shredded. This is required by the university's Research Governance Framework to ensure that informed consent is obtained for all research projects. The envelope would only need to be opened if a former participant later complained and disagreed that consent had been obtained.

What will happen to my interview material?

I will type up the interview to form a transcript (written version). In doing this, I will disguise any names of people or places to keep you anonymous. I will look for themes across transcripts from different participants and then write a summary of participants' views about the sharing of lived experience. My summary of views will be checked by two service users belonging to a university service user consultation group who will look at one transcript each and offer their own summaries of the

views expressed in them. Some members of the university group and its facilitator also have affiliations with [host trust]. To ensure your anonymity, members with connections to [host trust] will only read a full transcript after any information that might reveal your identity, has been disguised. A report will be sent to a scientific journal for publication, and this will contain short anonymous quotes from the interviews.

Protecting your data

Canterbury Christ Church University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Canterbury Christ Church University will keep identifiable information, in this case your signed consent form, for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about the university's research code of conduct here: https://www.canterbury.ac.uk/research-and-consultancy/documents/code-of-conduct.pdf

Canterbury Christ Church University will collect information from you for this research study in accordance with our instructions.

Canterbury Christ Church University will keep your name and contact confidential and will not pass this information to other organisations. We will use this information as needed, to contact you about the research and to oversee the quality of the study. Certain individuals from Canterbury Christ Church University and regulatory organisations (including both supervisors, whose contact details are provided at the end of this document) may look at your research records to check the accuracy of the research study. Canterbury Christ Church University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

What are the benefits of participating?

Though you may not directly benefit from participating in this project, we are hoping that your contribution will help us better understand the impact of staff sharing lived experiences with service users. Improving our understanding around this can hopefully lead to better relationships between staff and service users in the future.

Are there any drawbacks to taking part?

The project has the potential to bring up painful memories of difficult times for people who have used mental health services. Therefore, you may wish to consider this before deciding whether to take part. The interview would not be about your distress but could touch upon your encounters with staff at a difficult time for you. You may wish to consider whether there is someone you could have available to talk to after the interview if you felt the need.

Considerations for Skype and phone interviews

Should you choose to be interviewed via Skype or phone, please be mindful that this may be a different experience to a face-to-face interview. You may wish to arrange support in addition to what I can offer, should you experience distress or upset during or after the interview. This might include making those close to you aware of your participating in this project and arranging to speak or see them following the interview.

Limits of confidentiality

If you were to say something in the interview that led me to be concerned about the possibility of significant harm to yourself or someone else, then I would have a duty of care to contact relevant parties. If this were to happen, any action I would take I would discuss with you beforehand if at all possible and explain the rationale. Please also refer to the list of contacts provided along with this information sheet should you wish to seek additional support following your interview.

I will write a shorter summary of the results that is intended specifically for participants of this study, which I will send to you via email unless you let me know that you are not interested in receiving this summary. You may also be interested in receiving a notification should the findings be published in an academic journal.

This project has been reviewed and approved by London Surrey Research Ethics Committee and Canterbury Christ Church University Ethics panel and is funded by Canterbury Christ Church University.

Complaints

If you have concerns about any aspect of this study, please do not hesitate to contact me in the first instance and I will do my best to address your concerns (email address below). Alternatively, you can contact either of my supervisors through email if you so wish. If you remain unhappy and would like to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology: paul.camic@canterbury.ac.uk; or by contacting [host trust] patient advice and liaison service (PALS) via [email address] or on **[telephone number]**.

Thank you for your time,

Inke Schreiber (Trainee Clinical Psychologist)

Dr Sue Holttum (Lead Supervisor)

Dr Nick Grey (Second Supervisor)

Information Sheet

Project Title: Sharing is caring? How mental health staff and service users perceive the impact of sharing lived experience on recovery

Hello,

My name is Inke Schreiber and I am a Trainee Clinical Psychologist at Salomons Centre for Applied Psychology, Canterbury Christ Church University. As part of my doctorate I, along with my supervisors, Dr Sue Holttum and Dr Nick Grey, would like to invite you to take part in a research project looking at the potential impact of sharing lived experiences on recovery from mental health difficulties. This information sheet summarises information about the study to enable you to make an informed choice as to whether you would like to participate. Please read the following information carefully and do not hesitate to get in touch with myself or either of my supervisors, should you have any questions (contact details at the end of this document).

Background/Context of the project:

Recently, there has been a shift within the NHS towards a recovery model focused on greater service user self-determination and management of their own difficulties. Recovery is seen as an individual journey, which 204anterbu one's unique abilities and strengths. Within this shift, we are beginning to think about how lived experience can be used within a clinical context to benefit service users and there is some evidence that staff with lived experience of mental distress have felt this experience has been helpful in developing therapeutic relationships with service users.

Purpose of the project:

The aim is to explore together with service user and staff volunteers the possible impact of staff sharing lived experiences with service users on service users' recovery. To do so, we are recruiting members of staff working within [host trust] to volunteer to be interviewed for about 1 hour to think about this topic.

Participation:

Participation in this project is completely voluntary and you have the right to withdraw from the study at any point. Withdrawal from participation will not impact your situation as an employee in any way. If you agree to take part, the interviewer Inke Schreiber will get in touch with you to arrange a date, time and place to meet for 1 hour to answer a few questions. Travel costs to an agreed service location within [host trust] can be reimbursed to up to £10. There is also the possibility to speak via Skype or phone, should you wish to participate but have difficulties travelling.

To get an idea about the views that staff hold around this topic we are looking to recruit staff with a wide range of opinions. This means that even if you have not used your own lived experience in your clinical work, we would like to hear from you.

The interview will be audio recorded and transcribed. The recording of your interview will be stored on a password protected memory stick only the interviewer has access to. Extracts of the audio recordings may be shared with both supervisors and anonymous verbatim quotes of your interview may be used in the published report of the findings of this study. All information collected from or about you during the course of the research will be kept strictly confidential, and any identifying information about you, e.g. your name, will be removed so that you cannot be recognised. Your consent form with your signature will be kept securely in a sealed envelope in locked storage at Canterbury Christ Church University for 5 years and then shredded. This is required by the university's Research Governance Framework to ensure that informed consent is obtained for all research projects. The envelope would only need to be opened if a former participant later complained and disagreed that consent had been obtained.

Protecting your data

Canterbury Christ Church University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Canterbury Christ Church University will keep identifiable information, in this case your signed consent form, for 5 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

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Canterbury Christ Church University will collect information from you for this research study in accordance with our instructions.

Canterbury Christ Church University will keep your name and contact confidential and will not pass this information to other organisations. We will use this information as needed, to contact you about the research and to oversee the quality of the study. Certain individuals from Canterbury Christ Church University and regulatory organisations (including both supervisors, whose contact details are provided at the end of this document) may look at your research records to check the accuracy of the research study. Canterbury Christ Church University will only receive information without any identifying information. The people who analyse the information will not be able to identify you and will not be able to find out your name or contact details.

What will happen to my interview material?

I will type up the interview to form a transcript. In doing this, I will disguise any names of people or places to keep you anonymous. I will look for themes across transcripts from different participants and then write a summary of participants' views about the sharing of lived experience. My summary of views will be checked by two service users belonging to a university service user consultation group who will look at one transcript each and offer their own summaries of the views expressed in them. Some members of the university group and its facilitator also have affiliations with [host trust] To ensure your anonymity, members with connections to [host trust] will only read a full transcript after any information that might reveal your identity, has been disguised. A report will be sent to a scientific journal for publication, and this will contain short anonymous quotes from the interviews.

What are the benefits of participating?

Though you may not directly benefit from participating in this project, we are hoping that your contribution will help us understand the possible impacts of staff sharing lived experiences with service users on recovery. Bettering our understanding around this hopefully can improve therapeutic relationships between staff and service users in the future.

Are there any drawbacks to taking part?

The project has the potential to touch on distress you may have experienced, given the nature of the area it investigates. However, the interview will not focus on distress as such.

Considerations for Skype and phone interviews

Should you choose to be interviewed via Skype or phone, please be mindful that this may be a different experience to a face-to-face interview. You may wish to arrange support in addition to what I can offer, should you experience distress or upset during or after the interview. This might include making those close to you aware of your participating in this project and arranging to speak or see them following the interview.

Limits of confidentiality

If you were to say something in the interview that led me to be concerned about the possibility of significant harm to yourself or someone else, then I would have a duty of care to contact relevant parties. If this were to happen, any action I would take I would discuss with you beforehand, if at all possible, and explain the rationale.

Please also refer to the list of contacts provided along with this information sheet should you wish to seek additional support following your interview.

I will write a shorter summary of the results that is intended specifically for participants of this study, which I will send to you via email unless you let me know that you are not interested in receiving this summary. You may also be interested in receiving a notification should the findings be published in an academic journal.

This project has been reviewed and approved by London Surrey Research Ethics Committee and Canterbury Christ Church University Ethics panel.

Professional responsibilities

Health professionals, who are a member of a regulated profession, must adhere to their own professional codes of practice and if they suspect information discussed (for example bad clinical practice), that could put or have put clients or others at risk, this must be reported to the appropriate authority.

Complaints

If you have concerns about any aspect of this study, please do not hesitate to contact me in the first instance and I will do my best to address your concerns (email address below). Alternatively, you can contact either of my supervisors through email if you so wish.

If you remain unhappy and would like to complain formally, you can do this by contacting Professor Paul Camic, Research Director, Salomons Centre for Applied Psychology: paul.camic@canterbury.ac.uk; or by contacting [host trust] patient advice and liaison service (PALS) via [email address] or on **[telephone number].**

Thank you for your time,

Inke Schreiber (Trainee Clinical Psychologist)

Dr Sue Holttum (Lead Supervisor)

Dr Nick Grey (Second Supervisor)

Appendix G

Interview Schedule

Staff:

1. What, if anything, interested you in participating in this project?
2. In your time working for the NHS, have you ever shared any personal experiences of distress or difficulties with a service user? If so, could you tell me a little bit about how this came about? If not, what do you think might have stopped you from sharing an experience with a service user?
3. [If applicable] What helped you to decide that this was the right time to share this experience with the service user?
4. [If applicable] What, if any, changes did you observe in the relationship with the service user after sharing this experience?
5. What, if any, are the possible effects of sharing a personal experience of distress?
6. What about sharing other kinds of personal experience or aspects of yourself? What sort of circumstances, if any, might prompt you to do so?
7. [If applicable] What is your impression of the response of service users when you share personal information, not necessarily of distress?
8. Can you think of anything more generally about possible outcomes of sharing personal experience with a service user? Tell me more – in why/how do you think this outcome happens? What are the implications for the service user in the short or long term, if any?

Service users:

1. What, if anything, interested you in participating in this project?
2. Can you remember a time when a member of staff mentioned a personal experience of distress or difficulties to you? If so, could you tell me about what that was like for you?
    a. If not, have there been any times when you would have liked a staff member to share something of their own experience with you? What made you feel that might be helpful?
3. [If applicable] How was it for you to hear a member of staff talking about a personal experience of distress or difficulties with you?
4. [If applicable] What, if any, changes did you observe in the relationship between yourself and the member of staff after they shared this experience with you?
5. What, if any, are the possible effects of a member of staff sharing a personal experience of distress with you?
6. What is your view of staff members sharing other kinds of personal experience or information about themselves with you?
7. [If applicable] What has it been like when a staff member shares other kinds of personal experience or information about themselves with you?
8. Can you think of anything more generally that you might find helpful or unhelpful about staff members sharing personal experience with service users? Tell me more about that – what makes t helpful/unhelpful?

Questions added as adaptation/ follow-up question after the first few interviews:

1. What is your role currently within the trust?
2. How would you describe your recovery journey?
    2a. What impact does sharing this have on your work?

3. If you haven’t shared your lived experience with service users you work with, have you told colleagues about it?
4. Do you think stigma is an issue in the NHS?

Appendix H. Newsletter advert

Sharing is caring – A potential role for mental health staff's lived experience on service user recovery?

Hi,

My name is Inke and as part of my doctorate training in clinical psychology at the Salomons Centre for Applied Psychology, I am looking for volunteers to participate in my research project looking at the potential impact of sharing lived experiences on recovery from mental health difficulties.

As the NHS is moving towards a recovery focussed model of mental health, we are beginning to think about how lived experience can be used within a clinical context to benefit service users. For example, some research has found that staff with lived experience of mental distress have felt these experiences can be helpful in developing therapeutic relationships with service users. However, this is a developing area and more research is needed to understand how lived experience can be used to aid recovery.

Therefore, the aim of this research is to explore together with service user and staff volunteers their views on the possible impact of staff sharing lived experiences with service users on service users' recovery. To do so, would like to interview between 10 to 15 participants, both staff and service users, who are willing to give me between an hour and 90 minutes of their time to think about this.

If you are interested in participating, please get in touch with me via email or with my supervisor Dr Nick Grey and I will send you more detailed information as to how you can take part.

I look forward to hearing from you,

Inke Schreiber

Inke Schreiber
Trainee Clinical Psychologist
Salomons Centre for Applied Psychology
Canterbury Christ Church University
1 Meadow Road, Tunbridge Wells TN1 2YG

Appendix I. Selected memos

I have chosen a selection of memos here to demonstrate my reactions and thinking during the process of data analysis. Memos focus on aspects of interviews that attracted my attention, whilst I attempted to hypothesise about links and relationships between categories. Some of my thoughts captured in the memos also informed my positioning statement as I noted some of my thoughts and reactions to interviews.

05/11/19 **Assuming that issues can be presented in an academic (objective) way**

Participant 1 relays an assumption that ideas can be relayed 'objectively' and this may somehow lead to a 'better' debate than expressing personal views and values. He seems to hold the belief that stating a preference or value will shut down those conversations as people won't feel able to disagree. I'm not sure what I make of this at the moment, but I wonder whether underlying this is actually a fear of exposing oneself and making oneself vulnerable. If we voice values we hold dearly, we open them up for scrutiny and attack. Exempting personal experiences from being debated also means they remain can remain unchallenged and may not be reflected upon. Particularly when it comes to the use of LE that seems to be a real issue as we do need to reflect on our personal views and values to come to an understanding of why we personally want to draw on LE (is it to help or gain some containment from the other?). I find the assumption that personal experience can't be challenged interesting, a bit silly really. Respect should always underpin debates where differing views are voiced. Why does this not seem to apply when LE is concerned?

06/11/19 **A blessing in disguise?**

This is an interesting point the participant makes. It seems that he feels service user empowerment, which supposedly should be a positive thing, in allowing people a say over their care, can have other hidden agendas, for example in justifying providing less to those people who need mental health care. In the context of cuts to mental health funding, it then appears that the focus isn't really about empowerment but about not wanting to invest/ save money on services. This then isn't a service user led agenda but a government-led one in disguise and not empowering but depriving. This idea of empowerment then it seems can very quickly be turned into blame to the individual for the distress they experience and enables public services to wash their hands of those individuals using empowerment as the 'slogan' to justify lack of action, support, help funding etc.

10/11/19 **A hierarchy of power and sharing**

There appears to be an inverse relationship between one's position in the hierarchy (psychiatrists at the top, nursing assistants, cleaners at the bottom) between how much power one holds and how likely they may be to share lived experience. The psychiatrist being seen as holding the most power is also seen as least likely to share their LE, whilst nursing assistants at a lower banding are being seen as most likely to share something personal. The sharing of personal details appears to create a feeling of closeness whilst the holding of power without giving anything of oneself away creates a hierarchical distance.

10/11/19 **Being liked/kind vs being helpful**

The difference between being liked or being kind and being helpful has already been raised (participant 1) and this participant (10) appears to also differentiate between the two. Being kind and being liked seems to be to the benefit of the staff. Being helpful at times may mean some ‘tough love’, saying and asking difficult things (‘How could your life be better’), but doesn’t preclude being kind. Both is needed.

10/11/19 **Real human relationships**
This code made me think about what barriers are put up through professional training and titles, which then seem to get in the way of real human relationships and conversations. Participant 10 talks about how the untrained staff (nursing assistants) are the people she likes and gets along with as they are down to earth. In the context of these relationships she wouldn’t think it at all weird that someone might tell her about a tough time they’re going through (e.g. divorce).
Does it seem easier for staff members to employ blanket rules about not sharing personal stuff as a professional than thinking about the nuances of this, reflecting on their motivations to share (who it is for)? This makes me think of some psychoanalytic ideas around unconsciously employing defences and keeping a distance to SUs to not be infected with their madness. Being a professional separated from SUs through this status may serve as a defence against infection with madness and, maybe more importantly, stop us from getting in touch with our own madness.

10/11/19 **Knowing yourself**
I feel this has come up in a few memories, though I will need to check this. It sounds like what service users would like from staff going into professional training is to have a degree of self-awareness and ability to reflect on their own motives as to why they’re going into the job as opposed to hoping that they will accumulate knowledge or learn skills which they can apply once in the job.

19/11/19 **Who gets therapy offered and who doesn’t**
Participant 10, 12 and 13 all have a diagnosis of schizophrenia/psychosis/ bipolar, all have been hospitalised and all have received psychotropic medication as a treatment for their mental health. None of them seem to have been offered talking therapies. A few things about this come to mind:
1. There is more stigma attached to certain MH diagnoses compared to others
2. The hope that professionals hold re recovery from these diagnoses is diminished in comparison to other MH difficulties. I wonder what the impact of this is on service users. The three participants may be particularly resilient in having been able to make the recoveries they have?
3. I think there is also stigma attached in the assumptions professionals make around how well somebody with a severe mental illness will be able to make use of therapy. I feel that it’s up to the therapist to adapt interventions to the individual, rather than the individual not being ‘capable’ of utilising it.

24/11/19 **When staff feel able to share vs when SUs feel able to hear it**

Participant 5 says that she has more recollection of staff sharing their experiences of bipolar with her in the context of visits from the crisis team, whose involvement with SUs is very brief, reactive, with frequent staff changes. It seems that staff felt more comfortable disclosing LE in a context where they knew they may not have to see that person ever again, whilst SUs throughout this project have stated that it would be ‘weird’ if staff shared their LE with them outside the context of a therapeutic relationship – there seems to be a disconnect between when staff feel able to share and when SUs want them to share.

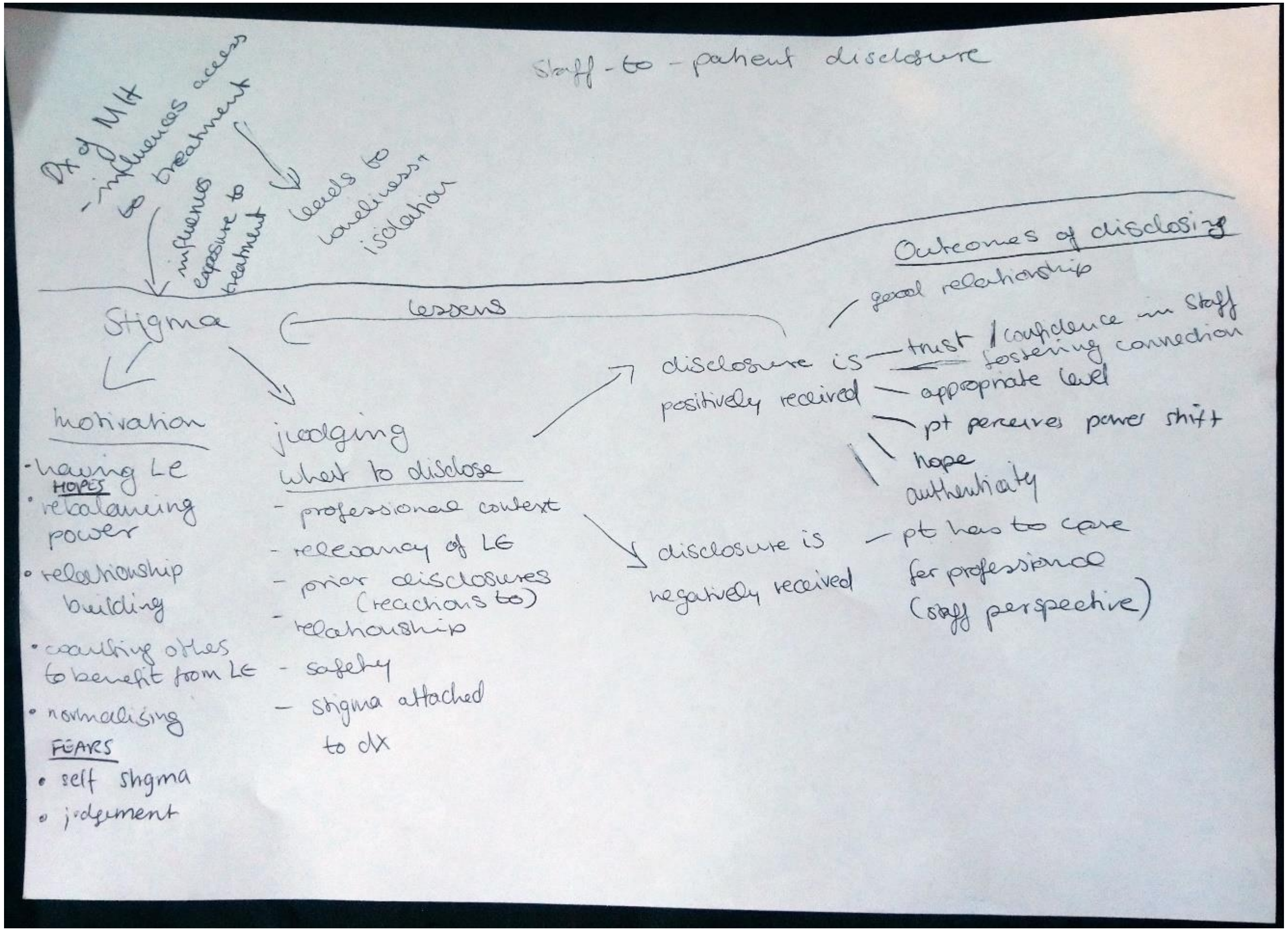
The explanation for SUs wanting staff to share in the context of a relationship makes sense: trust and respect have been named as ‘ingredients’ for them to be able to use staff’s LE. In a therapeutic relationship, things can be thought about, discussed (or not) and picked up again.

By contrast, in the context of brief crisis intervention, staff sharing with SUs in this way makes me question who the sharing is for. That’s not to say that staff don’t have the best intentions when they do share their LE in the context of a crisis intervention. However, it does allow staff to avoid the consequences of their disclosure. There isn’t an opportunity to think about it for a day or two, come back and ask questions or, indeed, criticise staff for making the decision to share. The information is more or less ‘dumped’ on the SU in the hope that it is helpful, but risking that it also may not be. I do wonder whether in the current system this is one of the few ways it does feel safe for staff to share LE with SUs. It does mean that on some level staff get to continue to avoid their own madness and in some shape or form still leave it with the SU rather than owning it as part of themselves. It’s like a glimpse of something that seems to get snuffed out again very quickly as the interaction between staff and SU ends as quickly as it came about.

02/12/19 **Worries of service user group mirrored in staff group**

It’s interesting that participant 15, qualified mental health nurse and CBT therapist, brings up and talks about the same issues as the service user group has: worrying that managers without lived experience can’t understand them, not wanting to be defined by their diagnoses, wanting to be seen as the whole person with strengths and weaknesses etc. I need to remember to try and include this in the diagram if possible.

Appendix J. Early model development



Appendix K

Categories	Subcategories	Example codes
NHS culture	Current challenges	Underfunding and lack of resources impacting employees and SUs The way power operates
	Stigma	Experiencing stigma as staff with LE Feeling stigmatised by services as user accessing them Normalising experiences helps address stigma from others and self
	Hopes and wishes for the future	Learning from past mistakes around participation and changing its implementation Changing views of role of LE
Context of therapeutic relationship	Context of clinician	Having close supportive relationships with team and colleagues Beliefs and values held by clinician about LE and use of SD
	Context of service user	Feeling understood by and connected to a support network is invaluable Beliefs held by SUs about LE Bringing previous experiences of therapeutic relationships
	Dynamics in therapeutic relationship	Wanting to relate to clinician on a human level Needing to be liked as therapist and being helpful as therapist are different Having superficial similarities of experiences of distress does not mean understanding the other’s experience
The process of sharing LE – mediating factors and outcomes	Defining LE is difficult	Looking at commonalities rather than difference with SUs Defining LE too narrowly is problematic and institutionalised Changing definitions of LE and self-disclosure throughout career
	Factors mediating SD of LE	Considering relevancy of and reason to share own LE before sharing Timing of sharing LE dependent on where SUs are at in their recovery Needing and wanting guidance around how to use LE

		Having a good therapeutic relationship Being mindful of boundaries and nature of therapeutic relationship Lacking time and resources hinders sharing of LE Fear of saying the wrong thing or giving wrong advice
	Outcomes of SD	Feeling trust, understood and heard Hearing about others’ LE whilst in distress yourself not always helpful Feeling more ‘normal’, less judged and stigmatised Feeling more hopeful Improving therapeutic alliance
The emergence of EBEs and PSWs	Defining and describing the role of EBE and PSW	Bridging the gap between staff and service users Having clarity around support in place and feeling able to do peer job Wanting to give hope for recovery and shaping what the trust offers
	Motivations to enter EBE or PSW role	Being meaningfully involved in service delivery, development, evaluation and staff training Enjoying EBE role Wanting an equal say and restoring the power balance
	Challenges in EBE or PSW work	PSWs and EBEs feeling less valued than other professionals, not seen as an asset Not ‘being one of us' staff + SUs Experiencing difficulties in maintaining boundaries within PSW and EBE work

Appendix L. Abridged reflective research diary

01/12/17	After FINALLY having received approval for my proposal, today was the first day that I met with my group of volunteers. I was massively nervous about how today would go. In the end, it seemed that it was a good idea to come with less structure to the meeting because there seemed to be a real wish and need for group members to share their experiences and thoughts with the group first. It was a good way of getting a sense of each other and what people have done so far, what they're passionate about, why they decided to join etc. There was a lot of very interesting discussion about what 'lived' experience' means to people and what work people have done so far. I'm now going to have to find a way of summarising the conversation in a coherent manner and send it out to people. Probably best to do that sooner rather than later to keep people engaged and interested. I really hope that people were keen enough to come back. I'm not sure whether one session is enough to really take ownership of a group, and I also wonder whether I did a good enough job explaining the idea of PAR, but that remains to be seen. This is also the first time that I mentioned about my own experiences of MH in a work setting. I thought it'd be weird, but it felt OK. I'm not sure I would like to say much more about my own experiences, but we will see how the group develops.
14/01/18	Feels like forever that I have sat down and worked on my MRP. Over Christmas I had lots of plans to work but it seems like I got carried away a little bit and trapped in a Christmas bubble. I need to make more of an effort to spend time on this. I am going to try to work on my NHS ethics proposal as much as possible, but it feels overwhelming to look at the form. I hope I won't take too long to complete it.
22/01/18	The next meeting with the group is set in a couple of weeks and I hope that I can get a bit more clarity in thinking with the group about the ins and outs of the design of the project, flesh out some ideas around

	recruitment and details on interview questions. It might help in making me feel a little less anxious about having to complete the IRAS form. It’s nice being able to work in a group, I feel that I can ask for support if I need it. At the same time the decision-making process does seem a bit slower. This is probably why the proposal approval panel were so keen on me being clear on decision-making powers and processes.
6/02/18	Sara is off sick, so we have moved the group to a date two weeks away from now. I am a bit disappointed about this as I was looking forward to the group.
12/02/18	Sara is still off sick. She said to go ahead with the meeting without her as she thinks she may be off for the whole month. As I have already had such a delay at the approval stage, I am very worried about getting delayed further and definitely feel anxious about this.
28/02/18	The group was cancelled in the end as many members couldn’t make it. Sara is still off sick and I feel I can’t go ahead with my IRAS application without having run my ideas past the group first. This isn’t great.
12/03/18	Sara is still off sick. She’s not replying to emails really anymore. I am not sure what to do now and am feeling the lack of guidance in how to manage this situation
01/05/18	Sara is long-term off sick. It is unclear when she will return to work. I have had one final consultation with the group but feel that I cannot manage the networking with them without having Sara’s support within the trust. I shared this with the group and was disappointed about having to do this. They were very kind though and offered help if I needed it. As a result of this, I have had to rethink and resubmit my research proposal to Salomons to simplify things for myself. I have a new supervisor now, who seems lovely but whom I have not met in person and who isn’t an expert in the area of research. This feels like it is getting really difficult.

08/01/19	It’s been 8 months since my last entry. This is probably a good reflection about how I have felt about my MRP. The past year has been somewhat of a nightmare. The last time I wrote an entry, Sara had gone off sick and I had been given a new supervisor. Sara is still sick and has not come back to work. I’ve gone through varying stages of despair and avoidance, often feeling so overwhelmed with the task it has meant that I have done very little. I’m going to take this as an opportunity to take stock and reflect: NHS ethics felt like a huge task and took me ages to complete. I felt lost in understanding the ins and outs of ethics and often found myself working things out on my own. I’m beginning to understand that I am not very good at asking for help. It took me the better part of 8 months to get through ethics and get my MRP approved. By mid-2018, things had come to a standstill for my MRP as the lack of entries reflect. I was juggling two tough placements whilst trying to find the space to think about this project that appeared to be falling apart. This was in the midst of my long-term relationship coming to an end, too, and with that even more uncertainty came into my life as I didn’t know where I would live. To say the least, NHS ethics was the last thing on my mind. I bounced between feeling alone and unsupported and beating myself up for my inability to sit down and work. All of this seemed to preclude the easiest solution, which would have been to sit down and plan my work and study days. Once the dust had settled from the break-up, a tricky placement and moving, MRP entered my conscious mind again Meeting with Sue on a number of occasions was helpful as I felt I became clearer again in my mind what it was I was working on and towards. I spent most of the summer and autumn completing the ethics form, trying to make sense of what I was doing and fitting it into a format that often didn’t feel as though it accommodated the type of

research I was doing. Going to ethics panel in September 2018 was nerve-wrecking though the panel was very kind and encouraging about my research. I met a number of other students there, mostly PhD, who all attended with their supervisors and this brought back feelings of loneliness and a sense of really not knowing what I was doing. How could I? These people had all brought along university professors to support. One professor looked at me in what felt very pitying and said: I advise all of my DClinPsy students to avoid NHS ethics, it’s a nightmare to get through in the time you are given. Wise words, which felt like they came too late. From September until December I battled with corrections and the minute detail of the panel’s feedback. Despite missing numerous deadlines (again), I felt like I was productive, and more importantly, was developing an understanding of what needed to be done. Despite this, as in many other aspects, too, the NHS is a confusing system to conduct research in. A lot of different systems to navigate, and those systems don’t appear to communicate with each other and, whilst the people within this system can be kind, there seems to be an implicit expectation that you know and understand their processes as well as they do.

So, where am I now? There seems to be some doubt as to whether I will manage to submit in April, and as much as I want to make it all my fault and sink into inactivity again, I can’t. Some of the circumstances around this were out of my control. I am now ready to start my data collection and have set up to meet some participants at the end of the month. I feel a little more organised having come up with a study plan, even if it turns out that I can’t stick to it. I am hoping that the meeting on Friday with Sue will be productive as I do have some concerns about the literature review for part A. I fear that again, I have chosen to do something that is fairly unconventional

	and I am not sure in how far it fits into the boxy world of academic research – bearing in mind that this was the problem with the initial idea for my MRP – that the idea of innovation, creativity and working together only reaches so far before it causes discomfort in this well-established system.
22/03/19	I found out today that I will be able to defer my MRP until December this year. I was torn between trying to push through and get it done by the April deadline but after a few participants requested to push the date of their interview back, it just all felt too much to do until the 12th. I thought I would feel relieved after and maybe less pressure would mean that I would find it easier to do some work, but the relief didn't seem to come. I decided I would recruit the maximum number of participants I received ethics approval for (15), now that I have a bit more time and to try to make sure that I am as conscientious as I can be. The decision to defer was a difficult one to make. I didn't feel that my supervisors really wanted to say much about what they thought would be the best thing to do. In the end, I made the decision what felt like on my own but after speaking to some friends and colleagues. I am trying not to take on all the blame and responsibility for the delay in getting it done but it's hard. The only thing to be done now is to finish it hopefully before the course ends and I start a job.
24/06/19	It's been almost 3 months to the day since I last wrote an entry hoping I would have made some progress by now. Very little has changed. I have transcribed 4 scripts. I haven't been able to do any work with the PPR deadline, critical review and placement at the same time. There just don't seem to be enough hours in the day for me to pay attention to all the work I should be doing.
23/09/19	Two weeks between finishing training and starting my job and I have way too much on my plate. I am almost done transcribing all my 15 (!) interviews. I can't say that I

	am enjoying the process much as of yet, although there are parts of re-listening to the interviews that make me smile and put me in touch with why I chose this area of research. There is so much strength and humour in my participants, it's admirable and humbling. It is hopeful to hear about the power of human connection persisting even with resource shortages and the strain NHS staff have to work under. It gives me hope that I can survive when I start my first qualified post.
15/11/19	I've finally finished coding. I thought using NVivo would be a good idea, but I am now looking at a list of 787 codes and am panicking. How I am supposed to condense all this information into a neatly packed analysis is beyond me. I am looking at codes and feel hesitant to merge them or group them together, or even delete them for fear that I will lose what makes the interviews special, gives them depth and nuance. I am stuck between this weird feeling of anxiety of getting the analysis wrong and never moving on.
19/11/19	It turns out that trying to write a thesis whilst working a full-time job isn't all that easy. I submitted another request for deferment today and I feel very sad and ashamed of myself. Like I just can't get this done and I will have to work on it forever. I am enjoying aspects of this piece of work when I can detach myself from the angst and stress it is causing me. At the moment I am fitting in periods of work here and there, getting up at 6 am to do two hours of work before work, then being at work, then trying to do a little bit more when I get home. The days are sort of merging into one and all feel more or less the same.
12/12/19	I've heard back that my deferment request has been accepted but it doesn't really feel like I can take the foot off the gas much. I am still battling with what feels like massive data sets for both my literature review and empirical paper. I am looking forward to the Christmas break where I will hopefully find some more time to dedicate to this and get a bulk of it done. It

	has been a very stressful period although weirdly I feel that I have gained something from working on this particular area whilst starting my first qualified job. Reading first person accounts of MH professionals of their lived experience has called to the fore front of my mind the importance of being in the moment when I am with service users, focusing on their experience and being led by what they bring. Even though these are things that we covered during training, to me there is something more powerful about these ideas having an ‘experiential’ backing. It’s almost like I can observe the live impact of what I am reading in the room with the people I see. It’s a really strange but rewarding experience.
04/01/20	I spent most of Christmas analysing my data and finally feel like I got somewhere. I have managed to develop the first draft of a model and am feeling excited about that. It was really helpful to talk the analysis through with Isy, Dee and Jenna. I notice that I can get stuck with an idea and it is then difficult to change track with my thoughts. I also noticed that it could be hard to maintain flexibility in my thinking and be guided by my data and findings rather than trying to impose something I wanted to see onto the data. Talking it through with others really helped with that and gave me perspective. It was satisfying to work on my analysis and see how my findings might fit and fall into place with other literature in the field and what my research might add that gives a different or additional perspective on the findings out there already. Getting the analysis done and written up has felt like a huge task and I am so glad that it’s done!
27/01/20	I am still in the process of analysing first person accounts for my literature review. I thought a rhetorical analysis was a good idea (I still think it is) to offer a different take on appraising literature but I think with reviewing 15 papers I have set myself quite a task! The other issue I will have to address eventually is how to link what I have done in my analysis of rhetoric to a

	body of literature. I have not thought about this until now where Part A is beginning to develop a shape, and it is a bridge I will need to cross eventually.
22/02/20	STILL TRYING TO GET THROUGH ALL THESE PAPERS! Wow, I have set myself a mammoth task. Now having completed and summarised the rhetorical analysis I have moved on to the content analysis and, whilst a more familiar method to me, it's just as much data to go through and summarise and organise. I do feel overwhelmed with the size of the task at times. At the same time, I have noticed that bringing to mind some of the ideas communicated in the accounts at a time when I have just started my first job as a qualified psychologist has been really helpful and containing for me in some way. A lot of the accounts talk about the importance of the therapeutic relationship and the role of hope in helping those people I offer support to. I have found these really grounding ideas to hold on to when starting in a new team at a time where they are going through a lot of changes and challenges. At times, when I can feel myself getting filled with the anxious projections, I find myself drawing comfort from reviewing the accounts and helping me maintain focus in my own therapeutic work.
13/03/20	I have finally completed the results section of my literature review! This has felt like an even bigger task than my empirical paper result section. So much work has gone into this and I fear that I won't be able to showcase all of it due to lack of space! It was really rewarding writing up the results and beginning to develop ideas on how especially the content analysis might link with the extant literature and empirical research. I have also enjoyed writing my positioning statement in relation to the process of the write-up which has given me the chance to reflect on the last four years. Whilst I have definitely enjoyed working on a project, I feel passionate about and am interested in, it has also been draining as I have invested

	a lot of personal resource into this. I am sure that I will continue to reflect on this process over the next few weeks.

Appendix M. A coded transcript

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Appendix N. End of study summary to ethics panel and participants

Sharing is caring? – how mental health staff and service users perceive the impact of sharing lived experience on recovery

Dear participant,

I'm writing to you because you participated in a research study exploring the effects of mental health (MH) professionals sharing their lived experience (LE) of MH on service user recovery. Thank you again for taking the time to contribute to this study. I would like to publish the results in a journal to share my findings with other healthcare professionals with the hope of contributing to our understanding of what helpful MH care involves.

The study

I interviewed 15 participants, all identified as having lived experience and holding a role within the NHS either as a trained mental health professional or as expert-by-experience (EbE)/peer support worker (PSW).

I used grounded theory method (GTM) to analyse the interview transcripts. GTM is used to build a theory based on qualitative data like interview transcripts. My aim was to identify factors impacting professionals to self-disclose (SD) their LE or not. I was also interested in understanding the consequences of these disclosures for service users' recovery.

The results

It is important to note that the results are my interpretation of the content of the interviews. This kind of analysis is subjective, so that another researcher may have understood the transcripts differently and developed a different theory. Not everything in the theory will be relevant to all participants, but I hope that it represents an overall picture. Please see below a a diagram of the findings alongside a brief description.

Four categories were identified:

1. **The process of sharing LE – mediating factors and outcomes -** Factors mediating use of SD of LE within the therapeutic relationship included having a good therapeutic relationship; considering relevancy of and reason to share own LE; timing of sharing LE. Some fears were: saying the wrong thing; overstepping a boundary; LE being misused.
2**. NHS culture** -describes the culture within which both professionals and service users operate. Current challenges relate to delivering services with minimal resources, power imbalances and experiences of stigma. Hopes and wishes for the future are that views about LE and culture within the NHS would change and that learning from past mistakes around service user participation can take place.
3. **Context of therapeutic relationship** - comprises factors brought to the relationship by professionals and service user. For professionals, these include beliefs held about the use of LE and SD; personal values; the task of integrating personal and professional identity; drawing on both LE and professional knowledge to inform practice. For service users feeling understood by and connected to a support network, previous experiences of therapeutic relationships; and conceptualisation of recovery influence their experience of the therapeutic relationship. Dynamics in the therapeutic relationship are an interplay between those factors, for example: relating to each other on a human level; acknowledging difference and being open to understanding each other's perspective.
4. **The emergence of EbEs and PSWs -** Becoming an EbE or PSW was identified as a potential outcome of self-disclosure. Motivations to enter EbE or PSW role and the challenges faced within them are described. Participants wanted to contribute to MH care and restore power imbalances. This category is linked with and impacts on NHS culture and some of the challenges in EBE and PSW work are mirrored in the factors mediating SD of LE. For example, both professionals and service users talked about an awareness of boundaries and wanting guidance on how to use LE helpfully.

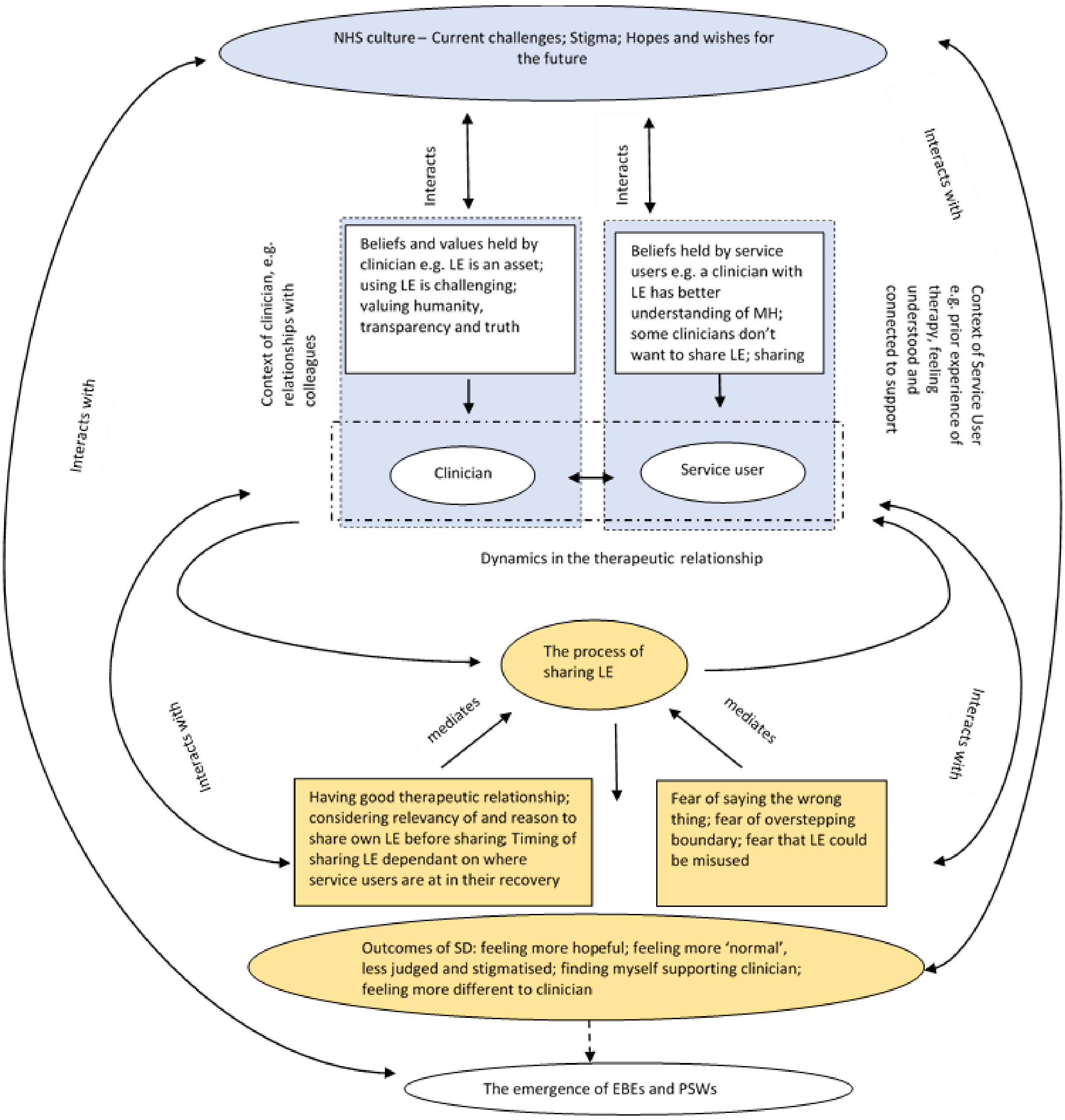

Figure 1. The process of sharing LE – beliefs, mediating factors and outcomes.

What were the conclusions?

Findings show the process of SD is facilitated by several factors, for example relevancy and motivation of sharing, timing, having a good therapeutic relationship and fear of saying the wrong thing. The diagram above highlights that the process of SD is linked to several individual and contextual factors. Shorter term outcomes of SD include service users feeling more hopeful, more normal, and less judged and stigmatised. Experience of service use also served as a motivator to enter roles as EbE and PSWs to be able to shape services and restore power imbalances. Challenges within the roles were identified as feeling less valued than professionals and struggling to ask for help when experiencing professional or MH difficulties. The problematic impact of culture on employees' experience of the NHS as a workplace, particularly in relation to stigma, should be noted and steps taken to address this.

I want to take this opportunity again to thank you for sharing your stories and insights with me. I hope that some of the above reflects the experiences you shared with me.

Yours sincerely,

Inke Schreiber

Appendix O. End of study summary to REC panel

Dear committee,

Study Title: Sharing is caring? – how mental health staff and service users perceive the impact of sharing lived experience on recovery

I am writing to inform you the above research project has now been completed. A thesis has been submitted for partial fulfilment of the degree of Doctor of Clinical Psychology at Canterbury Christ Church University. Please find below a brief summary of the study.

Study Background:

Research has found that a significant proportion of mental health professionals report having lived experience (LE) of mental health struggles. Studies further revealed that professionals struggle to disclose these experiences to colleagues and service users fearing stigma and feeling they should be able to manage their difficulties alone. Concurrently, professionals report drawing on those experiences in their clinical work as a means to empathise and instil hope for recovery. Presently, there is limited research to integrate professionals' and service users' ideas about the effects of self-disclosure (SD) of LE on recovery.

What were the aims of this study?

The aim was to develop a preliminary theory of factors influencing the likelihood of professionals using SD within the therapeutic relationship. We were also interested in identifying possible impacts following SD as perceived by both professionals and service users.

How was the study conducted?

15 participants were interviewed. All identified as having LE and holding a role within the NHS either as a trained mental health professional or as expert-by-experience/peer support worker. Interviews were analysed using grounded theory (GTM) methodology. GTM was chosen as it is particularly suited to developing preliminary theories involving exploration of intricate social dynamics.

What were the findings?

Four categories were identified:

1. **The process of sharing LE – mediating factors and outcomes -** Factors mediating use of SD of LE within the therapeutic relationship included having a good therapeutic relationship; considering relevancy of and reason to share own LE; timing of sharing LE. Some fears were: saying the wrong thing; overstepping a boundary; LE being misused.

2**. NHS culture** -describes the culture within which both professionals and service users operate. Current challenges relate to delivering services with minimal resources, power imbalances and experiences of stigma. Hopes and wishes for the future are that views about LE and culture within the NHS would change and that learning from past mistakes around service user participation can take place.

3. **Context of therapeutic relationship** - comprises factors brought to the relationship by professionals and service user. For professionals, these include beliefs held about the use of LE and SD; personal values; the task of integrating personal and professional identity; drawing on both LE and professional knowledge to inform practice. For service users feeling understood by and connected to a support network, previous experiences of therapeutic relationships; and conceptualisation of recovery influence their experience of the therapeutic relationship. Dynamics in the therapeutic relationship are an interplay between those factors,

for example: relating to each other on a human level; acknowledging difference and being open to understanding each other’s perspective.

4. **The emergence of EBEs and PSWs -** Becoming an EBE or PSW was identified as a potential outcome of self-disclosure. Motivations to enter EBE or PSW role and the challenges faced within them are described. Participants wanted to contribute to MH care and restore power imbalances. This category is linked with and impacts on NHS culture and some of the challenges in EBE and PSW work are mirrored in the factors mediating SD of LE. For example, both professionals and service users talked about an awareness of boundaries and wanting guidance on how to use LE helpfully.

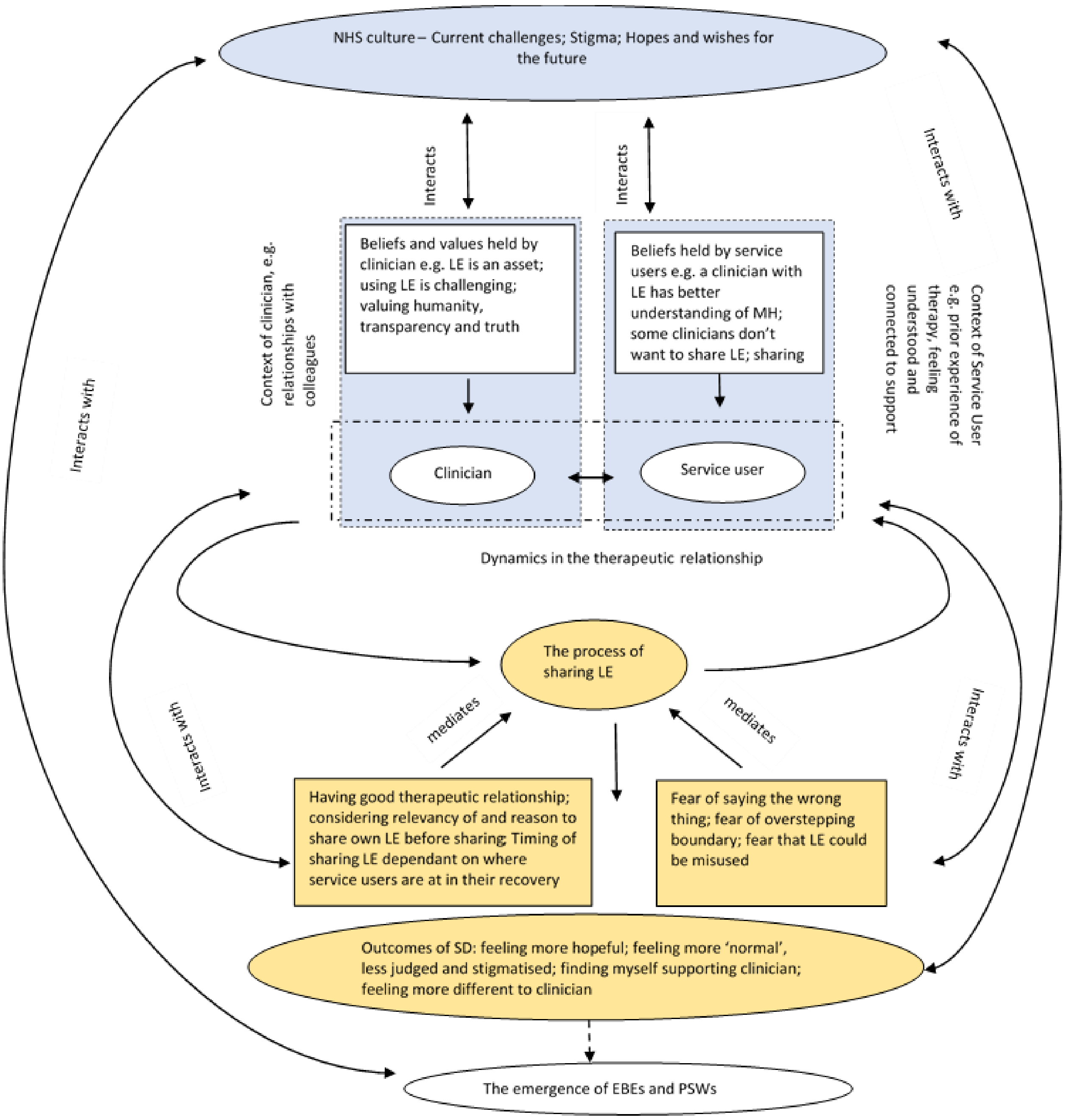

Figure 1. The process of sharing LE – beliefs, mediating factors and outcomes.

What were the conclusions?

Findings revealed the process of SD is mediated by several factors such as relevancy and motivation of sharing, timing, having a good therapeutic relationship and fear of saying the wrong thing. The resulting model highlights that the process of SD is linked to several individual and contextual factors as described above. Shorter term outcomes of SD include service users feeling more hopeful, more normal, and less judged and stigmatised. Participants also identified entering roles as EbE and PSWs because of their experience of service use to be able to shape services and restore power imbalances. Challenges within the roles were identified as feeling less valued than professionals and struggling to ask for help when experiencing professional or MH difficulties. The problematic impact of culture on employees' experience of the NHS as a workplace, particularly in relation to stigma, should be noted and steps taken to address this.

Regarding dissemination, I intend to submit these findings for publication in the journal of Social Science and Medicine. I have also sent out a separate summary of the findings to the study participants.

Yours sincerely,

Inke Schreiber

Appendix P. Capacity & Capability approval

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Appendix Q. R&D Letter of approval

This has been removed from the electronic copy.

Appendix R. Author guidelines for journal submission

SOCIAL SCIENCE & MEDICINE

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