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Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy

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Abstract

Insights gained from lived experience of mental health issues are increasingly utilised in the delivery of mental health services, reflecting a growing recognition of the value of experiential knowledge. Despite this recognition, there is a dearth of literature on the lived experience of counsellors and psychotherapists, and as such, insight into how counsellors and psychotherapists understand and experience their dual patient-therapist identity is limited. This study explores the role of practitioner-lived experience in counselling and psychotherapy. Semi-structured interviews were conducted with two counsellors and one psychotherapist, and transcripts were analysed using interpretative phenomenological analysis. Four themes were identified: (a) identity as a practitioner; (b) self-disclosure as enhancing therapeutic relationships; (c) importance of supervision; and (d) healing and recovery. This study adds to a growing body of research on the value of experiential knowledge in the production of mental health services, providing insight into how lived-experience practitioners experience their dual identity within their practice, and how they can be supported in exploring and valuing their experience.

KEYWORDS

mental health, self-disclosure, stigma, therapeutic relationship, wounded healer

1 | INTRODUCTION

To modernise and promote user-centred health care, service users have an increasingly active role in the production and delivery of mental health services. This is seen through the creation of Peer Support roles within the NHS (Perkins et al., 2010), while clinical training programmes routinely involve the input of “experts by experience,” situating service users as both sources and producers of knowledge (Toikko, 2016). The value of experiential knowledge continues to be recognised across mental health services and is enshrined within the Health and Care Professions Council's Standards of Education and Training (HCPC, 2017). Yet relatively little attention

has been directed to the experiences of practitioners who hold the dual identity of patient and therapist, with much of the literature focusing on the experiences of service users.

1.1 | Dichotomy of patient and therapist

The emphasis on service user involvement and consultation of experts by experience may paradoxically deepen the distinction between patient and therapist (Gough, 2011). Locating emotional distress and mental health issues as being external to the organisation reinforces a sense of the service user as “other.” The “othering”

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of service users and mental health issues may be a crucial issue for those who are both patient and therapist. From this perspective, lived-experience practitioners navigate spaces in which they cannot fully belong, being neither only therapist nor only patient. Yet a substantial body of research indicates a high prevalence of mental health issues within mental health professions (Harris et al., 2016; Sherring, 2019). This raises the question of how lived-experience practitioners disclose and explore their lived experiences.

Lived-experience practitioners across mental health disciplines largely experience their professional and patient identity as being separate, drawing from constructs created by available social discourse (Richards et al., 2016). The difficulty in integrating patient and therapist identities is heavily influenced by the social constructs of therapist and patient, and the use of “them-and-us” dynamics. Such dynamics are seen throughout several previous studies. Adame (2011) noted survivor-psychiatrists (which she defined as psychiatrists who have previously experienced iatrogenic harm and/or oppression in their contact with psychiatry services) have felt incompletely accepted in either psychiatric or survivor contexts. Similarly, Joyce et al. (2007) found that nurses with lived experiences of mental health issues had a patient identity imposed upon them during periods of distress.

Lived-experience practitioners may therefore struggle to integrate their identities due to the assumed dichotomous nature of “therapist” and “patient” identities. Per social categorisation theory (Turner et al., 1987, 1994), salient personal and social identities guide behaviour and group conformity. This has implications for lived-experience practitioners whose incomplete identity integration means that they alternately shift between identifying as therapist and patient (Goldberg et al., 2015; Richards et al., 2016). Identity salience and this shifting self-concept thus have the potential to significantly impact the therapist's practice and the therapeutic relationship.

1.2 | Impact of lived experience on therapeutic practice

Bassman (1997, p. 238) discussed how the “impotent rage” he felt as a patient oppressed by psychiatric services has driven him to challenge how mental health services avoid acknowledging “its own participation in its failures and lack of understanding.” By using their lived experiences of mental health issues to improve the care provided by mental health services, service-user professionals challenge the dominant psychiatric-medical discourse (Adame, 2011; Byrne et al., 2016). Lived-experience practitioners are uniquely situated to understand the difficulty involved in engaging in therapy and may use their experiential knowledge to connect with patients. Their insights into suffering allow them to become highly understanding, compassionate, and empathetic practitioners (Adame, 2014; Gelso & Hayes, 2007; Gilbert & Stickley, 2012; Goldberg et al., 2015). The therapists' lived experiences may therefore greatly influence their practice and can be beneficial for the patient, promoting healing and

Implications for Practice and Policy

- Previous contact with mental health services influences how lived-experience practitioners shape their practice.
- Personal therapy and theoretical knowledge gained throughout training were highlighted as key contributory factors for participants' healing and recovery. Personal therapy was understood as enhancing the practitioner resiliency required to manage countertransference. Trainees may benefit from engaging in personal therapy prior to undertaking supervised practice.
- Therapist self-disclosure facilitates the development of a strong alliance between therapist and client. This may foster a sense of solidarity between lived-experience practitioners and their clients.
- Participants reflected on organisational cultures of non-disclosure and experienced trepidation prior to disclosing lived experience during supervision due to concerns regarding their perceived competency. There is a need for the publication of clear guidance on working with practitioner disclosure during supervision which explicitly values experiential knowledge.

recovery. Similarly, the act of practising counselling and psychotherapy may itself be healing for the therapist.

Bidirectional healing processes between patients and lived-experience practitioners have been identified by several researchers (Adame, 2014). Although it cannot be assumed that lived-experience practitioners become therapists primarily to self-heal, they almost certainly benefit from the therapeutic relationship. As Reissman (1965, p. 27) summarised, “while it may be uncertain that people receiving help are always benefited, it seems more likely that the people giving help are profiting from their role.” Healing is, in part, the result of the understanding of one's lived experience gained throughout training, which is then explored in tandem with the patient's experiences (Adame et al., 2017). This process is supported by the therapist's self-disclosure. The decision to disclose facets of the therapist's self must involve consideration to ensure boundaries within the therapeutic relationship are maintained; however, disclosure of the therapist's experience can facilitate meaningful connections between therapist and patient (Berry et al., 2011).

Knowledge of their therapist's experience has several benefits for the patient. Knowing their therapist has experienced and healed from mental health issues may enhance the patient's belief in their ability to heal, providing hope for recovery (Kottsieper, 2009). Lived-experience practitioners are, therefore, embodiments of possibility (Conchar & Repper, 2014), helping the patient to form connections between woundedness and healing (Jung, 1966a; Kirmayer, 2003; Miller & Baldwin, 2000). Jung (1966a, p. 167) suggested service-user professionals form similar connections, noting it is the therapist's “own hurt that gives

him the measure of his power to heal." Disclosure also informs the patient of their therapist's willingness to engage in difficult or painful material, further building meaningful connection (Zerubavl & O'Dougherty-Wright, 2012). Moreover, having shared experiences may redistribute power within therapy, normalising and de-pathologising the patient's experiences (Adame et al., 2017; Zerubavl & O'Dougherty-Wright, 2012).

While there are clear benefits to practitioners being able to draw from their own lived experience, several concerns must be addressed. Lived-experience practitioners risk overidentifying with their patients and may struggle with countertransference (Gelso & Hayes, 2007; Goldberg et al., 2015). They may also make assumptions regarding the patient by interpreting their stories through reference to their lived experience, allowing the therapist's view to dominate (Zerubavl & O'Dougherty-Wright, 2012). Furthermore, should the service-user practitioner's salient identity shift from therapist to patient, they may experience a heightening of mental health symptoms due to their identification with a stigmatised group (St. Claire & Clucas, 2012; Turner et al., 1987). This may impact their competency, increasing their risk of compassion fatigue or vicarious trauma (Rothschild, 2006). It is therefore essential that lived-experience practitioners bring their experiences to supervision to help them disentangle their experiences from those of their patients and to maintain the facilitative nature of woundedness while balancing the vulnerability it can bring. However, therapists may face barriers preventing meaningful disclosure during supervision.

1.3 | Barriers to disclosure

A key theme across literature on lived-experience practitioners is the trepidation felt when disclosing their experiences to colleagues. Concerns commonly relate to fears of being stigmatised and judgements regarding professional competency (Adame, 2011; Harris et al., 2016; Huet & Holttum, 2016). In considering the broader social context of stigmatising beliefs, these fears are well-founded. While mental health professionals may not espouse stigmatised views towards their patients' struggles, they may do so towards those of their colleagues (Zerubavl & O'Dougherty-Wright, 2012). Moreover, research indicates that mental health professionals are resistant to stigma reduction (Harris et al., 2016). This may be, in part, due to the belief that mental health professionals should be strong and devoid of weakness (Conchar & Repper, 2014).

The expectation to be free of weakness may cause lived-experience practitioners to hide or deny their lived experience, resulting in self-stigma and shame, limiting support or treatment (Zerubavl & O'Dougherty-Wright, 2012). Lived-experience practitioners may deliberately avoid or resist self-reflection for fear of uncovering perceived weakness. This is an important issue for counsellors and psychotherapists who work in pressurised environments and must be attuned to their own emotions to mitigate countertransference and maintain their mental well-being. As Jung (1966b,

p. 650) noted, "certain psychic disturbances can be extremely infectious if the doctor himself has a latent predisposition in that direction." It is therefore critical that counsellors and psychotherapists are provided with space to freely discuss and explore their lived experiences of mental health difficulties.

1.4 | Current study

While there is a growing body of research on the experiences of professionals with patient-therapist dual identities, research on how patient-therapists make sense of their identity in the context of their work is limited (Adame, 2014). Moreover, the experiences of counsellors and psychotherapists are typically overlooked in the literature. This study therefore makes a meaningful contribution to the literature by exploring how counsellors and psychotherapists experience their dual identities. This study aims to explore the ways in which lived experience of mental health issues influence counselling and psychotherapy practice, and how lived-experience practitioners may be supported in disclosing and valuing their experience.

2 | METHODOLOGY

2.1 | Research design

Interpretive qualitative research is overtly social, relying on social interaction between researcher and participant. As the primary research instrument within qualitative research is the researcher, they will inevitably influence the research process and how data are interpreted (Frost & Bailey-Rodriguez, 2019); we acknowledge this is a feature in the process of this study.

This study utilises a qualitative design, allowing for the exploration of the meaning and complexity of participant experience. Data have been collected through semi-structured interviews which have been subjected to interpretative phenomenological analysis (IPA; Smith, 1996).

First conceptualised in the mid-1990s, IPA has been developed as a distinctive theoretical and procedural framework for conducting qualitative research. IPA has been frequently utilised for psychological inquiry, providing researchers the opportunity to explore and understand the lived experience of each participant (Alase, 2017). IPA is grounded within hermeneutics and phenomenology, seeking to understand the individual's subjective reports by gaining an "insider's perspective" (Conrad, 1987). It recognises research as being a dynamic process, in which the interplay between the researcher and the participants forms a double hermeneutic: "the participants are trying to make sense of their world; the researcher is trying to make sense of the participants trying to make sense of their world" (Smith & Osborn, 2008, p. 53). The term interpretative phenomenological analysis therefore reflects a layering of interpretive processes, signalling the joint reflections formed by both participant

and researcher from the analytical account (Osborn & Smith, 1998). As the current study aims to explore the experiences of counsellors and psychotherapists with lived experience of mental health issues, IPA is an appropriate analytical tool.

2.2 | Participants

In line with IPA guidelines, a small, homogeneous sample (Smith, 2004) has been selected, enabling the generation of in-depth data and to engage with the question at an idiographic level (Smith et al., 2009; Smith & Osborne, 2015). Participants ($N = 3$) were qualified counsellors or psychotherapists with lived experience of mental health issues who have previously engaged with mental health support services. See Table 1 below for participants' demographic characteristics.

2.3 | Procedure and data collection methods

Purposive sampling was used to recruit participants. Participants were recruited by seeking permission from counselling organisations to circulate an open call via email to counselling staff.

Semi-structured interviews are an established means of generating high-quality in-depth data for analysis. The open nature of semi-structured interviews provides the interviewer with flexibility to conduct the interview in a conversational style, responding to the interviewee's answers in ways natural to the interaction (King & Hugh-Jones, 2019). In setting a balance between guiding and leading the interviewee, Smith et al. (2009) advised that interview schedules should be short, beginning with broad questions to allow the interviewee to shape the interview. Such an approach ensures that participants are given the opportunity to voice what they feel is important and is helpful in preventing the interviewer from imposing their understanding of the phenomenon on the interviewee's narrative (Smith et al., 2009). This guidance has been used when developing the interview schedule for this study.

Interviews were conducted via Microsoft Teams. The interview aimed to explore how participants experience their dual patient-therapist identities, how their experiences have shaped their practice, and their experiences of sharing their histories with other professionals. Each interview lasted between 30 and 60 min ($M = 45$). Participants were provided with a debrief sheet following their interviews and were given the opportunity to review their transcripts prior to analysis.

2.4 | Ethics

The current study was approved by the Faculty of Engineering and Physical Sciences Research Ethics Committee (EPS 21_98), and has been conducted in line with the BPS Code of Human Research Ethics (BPS, 2021).

As this study aimed to explore the impact of lived experience of mental health issues, it was understood from the outset that participants may disclose highly sensitive or personal information that may cause distress. Every effort was given to prioritise the rights and dignity of all participants. Participants were assured that their transcripts would be fully anonymised using pseudonyms, and they were encouraged to disclose only what they felt safe and comfortable to do so. Careful consideration was also given to the Interview Schedule. Participants were not asked questions relating to the nature of their lived experience, and the questions contained no labelling language that may have resulted in labelling by the participant, such as "I am/have been ill." Moreover, a distress protocol was developed to minimise psychological harm should participants exhibit any signs of discomfort. All participants completed their interview without use of the distress protocol.

2.5 | Data analysis

Data were analysed using IPA. Each transcript was individually read and analysed through a process of phenomenological (descriptive) and interpretive coding. Initial themes were identified for each transcript before continuing to the next, in line with IPA's idiographic commitment (Smith et al., 2009). Analysis produced one table of themes per case, allowing connections to be identified across cases, resulting in a table of master themes for all cases.

2.6 | Reflexivity

Alongside the data collection and analysis processes, researchers engaged in reflexivity in the form of a reflective journal. Reflexivity involves a continual internal dialogue and an awareness of one's positionality as a researcher (Berger, 2013). This allowed the primary researcher to distinguish between their voice and those of the participants and has helped to examine how the researcher filtered what they heard through the lens of their own experiences of being a mental health professional with lived experiences of significant mental health issues (Padgett, 2008). Finally, the use of a reflective journal has allowed the primary researcher to provide a transparent

Participant	Gender	Age (years)	Ethnicity	Profession
"Seamus"	Male	32	White Irish	Counsellor
"Lisa"	Female	58	White British	Counsellor
"Róisín"	Female	38	White Irish	Psychotherapist

TABLE 1 Demographic characteristics of participants

Note: Pseudonyms have been used.

record of decisions made throughout this project, enhancing the trustworthiness of the research (Frost & Bailey-Rodriguez, 2019).

3 | ANALYSIS

Four themes were identified following data analysis. These are: (a) identity as a practitioner; (b) self-disclosure as enhancing therapeutic relationships; (c) importance of supervision; and (d) healing and recovery. In this section, each theme is interpreted in turn and evidenced by excerpts of participant transcripts.

3.1 | Identity as a practitioner

Participants identified several key factors contributing to their identity as a practitioner, most frequently referencing the influence of their previous experience in engaging with mental health services. These experiences provide a foundation on which participants modelled their practice, shaping their values as practitioners. This is identified through Seamus' account of his personal therapy. Seamus began working with his therapist during his training and was offered a reduced session fee as a student counsellor. Without this reduction he would have been unable to attend sessions and expresses gratitude towards his therapist for providing accessibility to therapy. This has instilled in Seamus a desire to enhance accessibility to future clients:

If he hadn't of done that I wouldn't have been able to afford it ... it would have just been "no," you know? And so then if I, in the future, am able to provide that to somebody else. Like, I think I would consider that a very rewarding thing.

Throughout his interview, Seamus frequently referenced the importance of recognising one's privilege, noting the privilege he holds as a white male (McIntosh, 1998), and acknowledging the interplay between stigmatised identities and health outcomes (Marks et al., 2018). This understanding of privilege extends to recognise the privilege inherent in accessing private therapy:

If I'm dealing with someone who is perhaps like, a different ethnicity to me, or a different gender to me ... they're going to have more challenging experiences based on that ... There's almost an argument to say that in a lot of cases, like, counselling and psychotherapy can be quite a privileged thing, both in terms of practising it and accessing it. And I kind of want to try to do everything I can ... to try and lessen that.

This has shaped Seamus' career path, as he discusses the moral dilemma of working within charity organisations or private practice, noting how private practice may exclude clients with limited financial resources: "If someone can afford private work, then they're

necessarily better resourced than a lot of others." Seamus resolves this by modelling his practice on his therapist's, offering reduced fee sessions and continuing charity work alongside this. Seamus' existing views on privilege are therefore compounded by the experience of support from his own therapist in getting access to therapy, contributing to his identity as a socially minded practitioner.

Participants also reflected on the influence of negative outcomes they had experienced as patients of mental health services on their identity as practitioners. Like Seamus' desire to shape his practice after his own therapy experience, negative outcomes with mental health services inform practitioner identity through consciously strengthening the alliance between practitioner and client. Seamus points to this when reflecting on which client experiences resonate with him:

A lot of the clients that I would deal with are people who have had bad experiences with statutory mental health services. And therefore, as a person who has been a client of mental health services ... that certainly resonates as well.

This is also seen throughout Róisín's account, where she describes experiencing feeling dismissed by her therapist. This experience was formative with regards to her identity as a practitioner, recalling it when working with clients:

I always hold that in my mind, and I just try to ensure that I stay with the client no matter what they tell me, or where their story goes, so that they don't feel dismissed as I did that time.

Róisín notes that while she was able to transcend this experience to obtain greater support, for many clients this may have presented a barrier to therapy. From this perspective, prospective clients understand a poor experience within therapy as the dominant experience:

With other professions if a client has a bad experience, they're able to put it down to the practitioner. If an electrician does a terrible job, you shrug it off and hire a better one, but with therapy... It's not like, "Oh this therapist was terrible, I should find a better one," it's taken to mean "therapy itself is terrible, this isn't for me."

Róisín feels a sense of duty towards her clients and to psychotherapy as a profession. She views herself as holding a responsibility in terms of upholding psychotherapy in a positive light for prospective clients, and so ideals surrounding competency form a core element of her identity as a practitioner. Róisín expressed a firm belief that this alliance with clients should be present in the identity of all psychotherapists: "I doubt it's the kind of profession many go into without a sense of duty to their clients ... people without that have no business working in this area."

Seamus and Róisín's accounts highlight the importance their identity as practitioner has on their sense of self. Whilst this was clear throughout their interviews, all participants expressed experiencing

a fluctuating sense of self, whereby their identity as patient becomes salient. This is particularly clear in Róisín's account of her experience as a survivor of sexual violence, facing victim blaming comments from her colleagues. Róisín describes feeling compelled to challenge her colleague's use of rape scripts (Ryan, 2006) by disclosing her status as a survivor: "If they hold opinions like this, telling them that you disagree without your reasoning, they're unlikely to actually hear it." Despite her discomfort in disclosing this, describing this experience as being a "catch-22," Róisín feels a sense of duty towards other survivors, mirroring her sense of duty towards psychotherapy. This responsibility of representing both survivors and practitioners is, at times, difficult to balance, leaving her to experience a reduced sense of self in which neither survivor nor practitioner identity are fully integrated:

You're always balancing this idea of being both a survivor and a practitioner...but in that moment, I don't know, it was like I was somehow both a survivor and practitioner and yet neither at the same time.

Seamus and Róisín's accounts provide insight to their identity of practitioner as one involving tremendous responsibility, with Seamus experiencing responsibility in enhancing accessibility to psychotherapy, and Róisín experiencing responsibility in providing an appropriate representation of psychotherapists and survivors of sexual violence. Despite their strong practitioner identities, both participants expressed periods of difficulty in balancing the dual identity of service-user and practitioner.

3.2 | Self-disclosure as enhancing therapeutic relationships

Participants expressed using self-disclosure to enhance the therapeutic relationship by fostering connectivity. By sharing facets of their lived experience, participants provide clients with a sense of understanding, enabling the client to explore and make sense of their experiences without fear of judgement. This connectivity building is seen in Lisa's account of her work with a client presenting with issues relating to substance misuse. This presentation resonated strongly with Lisa, whose son passed away following a heroin overdose.

Lisa states her client had engaged with counselling services previously, but reported that these experiences have left him feeling dismissed and judged. He initially appeared disengaged and guarded, physically closing himself off through body language. As their sessions continued, Lisa disclosed her lived experience, discussing her son's addiction, experience of stigmatisation and death, creating a relational bond with the client: "I wanted him to know that, on some level, I understood where he was coming from." Lisa identified visible relief within her client following her disclosure:

That absolutely flipped the whole therapeutic relationship. The lad's hood came down, he sat back in the

chair, and he began to open up, and it developed into an absolutely amazing therapeutic relationship where he has changed beyond recognition.

This disclosure had a profound influence on the therapeutic relationship, redistributing power and allowing the client to engage in therapy on a level he was previously unable to reach. Lisa's account demonstrates an attunement to her client's needs of acceptance and unconditional positive regard (Rogers, 1957), and views this as resulting from the loss of her son: "That was one really vibrant instance, you know, where my lived experience was, I was able to map that on to a client's experience." This enhanced therapeutic relationship was also impactful for Lisa, who describes it as having a "deep emotional effect" on her. Lisa's reference to mapping her experiences onto those of the client, and the emotional effect of this disclosure, may suggest bidirectional healing. In essence, Lisa tended to her wounds whilst supporting her client through identification with her son.

The influence of practitioner self-disclosure is also evidenced throughout Róisín's account, where she discusses her time working with a survivor of sexual abuse presenting in distress, reporting experiences of isolation, loneliness and feeling unclean. In contrast to Lisa's direct disclosure, Róisín reflects on alluding to shared experiences to create a therapeutic alliance with her client: "I just told them that I had an understanding, that I had felt that same pain. They just asked me, like, 'you have?', and I nodded, and that was that." This disclosure was followed by a period of silence, with both Róisín and her client "just taking it in, you know, sitting in the feeling." Róisín identifies her decision to disclose as being partially motivated by a desire to reassure the client that she was not alone. She can, therefore, be understood as having aligned herself with her client, providing both herself and her client with a sense of acknowledgement and solidarity. Róisín comments on a sense of relaxation identified in her client following her disclosure:

Before, they would often use disclaimers when they spoke about their feelings, you know, "I know this is stupid, but...", and they faded quite quickly after that session. I think they no longer needed to justify or explain their feelings because they no longer felt they would be judged.

This change in presentation suggests that Róisín's disclosure informed the client of her ability and willingness to engage in painful material, whilst simultaneously providing hope for recovery:

You know, when you're coming in for therapy you often feel trapped in your current circumstances and for a lot of us, the idea of healing seems like such an impossibility. But you, as the therapist, it's like, you can act as a marker for possibility for the client when you draw parallels between your experiences because the client's no different than you are. So you're telling the client, "if I can heal, you can heal."

While participants reflected on the facilitative nature of self-disclosure, the potential risk of inappropriate disclosure was highlighted by Lisa, who reflects on her work with a client whose son struggled with substance misuse. Lisa identified similarities between her son's early substance misuse and her client's son, producing countertransference: "Obviously my mind went back to [my son], you know, when he started off on his road to drug use, he'd started off with cannabis." Lisa attempted to form a relational bond with her client by reassuring her that she understands her position, normalising her frustrations. Crucially, however, Lisa was unprepared for further probing from her client, causing her to disclose her son's death:

I'd said to her, you know, "I have a bit of an idea of ... what you're going through." And she sort of perked up and said, "Oh, really? Have you experienced it, too?" And I said, yes, thinking that would be the end of it. And she said, "and how is your son now?" And then I'm thinking, I'm gonna have to tell her he's dead.

Lisa recognised her error immediately and attempted to prevent client distress by suggesting her son had additional circumstances in his life contributing to his death, illustrating how practitioners may experience a sense of being trapped by disclosures made without careful consideration. While Lisa worked through this disclosure to build a positive relationship with her client, she addresses the damage this may have caused to the therapeutic relationship: "That really did have the potential for a major rupture in the relationship there." Lisa's account thus highlights the importance of consideration of the client's needs and self-reflection before self-disclosing.

3.3 | Importance of supervision

Participants frequently referenced the importance of the supervisory relationship, highlighting its role in providing support and reassurance while promoting reflective practice. As Seamus reflects on his relationship with his supervisor, he expresses his gratitude in being able to share his experiences openly: "I've had my supervisor for about three years, so we know each other very well, and I don't know that there's much that I would feel uncomfortable sharing with them."

Seamus' ability to be open about his lived experience in supervision provides his supervisor with insight to his inner world and an understanding of the ways in which client presentations may produce countertransference. This has, in turn, allowed Seamus to identify a therapeutic element to his relationship with his supervisor and understand this dual role within supervision as providing protection for both himself and his clients. Seamus discusses the challenges he has faced when working with young people, acknowledging how deeply this work has affected him and seeking to understand the emotions it has produced through supervision. Seamus provides an account of bringing his experience of supporting a younger client to supervision:

The first thing they asked me was, "Do you think there might have been a bit of countertransference there?" and we just both laughed about it because of course, there was like a mountain of it. And so that's why I think that like, there is almost sort of a slightly therapeutic aspect within supervision, because you're supervising the person's practice, but you're also supervising how they are coping with that practice.

Seamus thus experiences his supervisor as supporting his development as a practitioner through the exploration of client work. Lisa also reflects on the supportive nature of the supervisory relationship, and, like Seamus, reports an ability to be honest with her supervisor: "She's really supportive. I really don't have an issue, you know, bringing anything up."

These positive supervisory relationships are facilitated by the supervisor's acceptance of Seamus' and Lisa's experiences. The provision of a safe space to explore their work and to engage in self-analysis relied on being heard without judgement. As noted by Gazzola and Theriault (2007), therapists internalise and draw from meaningful supervisory experiences to guide their practice. Both participants frequently referenced their desire to provide clients with nonjudgemental support, which may suggest an internalisation of their supervisor's support.

Understanding their supervisor as accepting and nonjudgemental allows participants to bring potentially challenging experiences to supervision, in which they can explore perceived failures. This is evidenced clearly in Lisa's account of bringing an inappropriate disclosure, as discussed in the previous theme, to supervision. With the support of her supervisor, Lisa explored the appropriateness of disclosure and the importance of understanding who the disclosure is for, thus enhancing her practice. Lisa expresses gratitude for her supervisor's ability to accept and learn from mistakes:

Even if you make a major screw up like I did, she was able to couch it in terms of, you know, it being a learning experience. And if it ever comes up again, this may be an alternative way.

This reframing of error as a learning experience may serve to reduce a sense of regret or guilt felt following poor interactions with clients. Supervision provides Lisa a space to unburden herself of these experiences, likening it to the cathartic effect of acknowledging perceived wrongs: "I actually like going [to supervision]. To me, it's like going to confession. Yeah, it's the clean slate."

While Seamus and Lisa highlight the value they see in the supervisory relationship, Róisín reflects on its limitations when the relationship is strained. She expresses her trepidation in engaging in honest self-reflection with her internal supervisor due to concerns regarding her perceived competency. This concern appears to be well founded as Róisín observes stigmatising and infantilising beliefs towards certain client presentations:

There was a sort of perceived fragility to the clients, and of course if you're hearing your clinical lead be dismissive or condescending towards clients with whom you have similar experiences, you know, the message you're coming away with is that they will also perceive you as being fragile.

This observation led Róisín to understand her internal supervisor as expecting her to be devoid of weakness, suggesting that they may view perceived woundedness as a liability. Seamus identified similar feelings of mistrust towards internal supervisory relationships, noting that lived-experience practitioners may be unable to request support:

I think that there is a big fear that ... if they're honest about the fact that they have, they have a history of, you know, mental unwellness ... that their proficiency is going to be called into question. And so, in a in a real way that they could be punished for, for speaking and asking for help.

The caution expressed by Seamus and Róisín in disclosing their experiences during internal supervision reflects the various responsibilities held by clinical colleagues in their supervisory role. Internal supervisors hold a responsibility towards both their supervisees and their organisation. Clinical colleagues are alert to organisational risk when providing supervision to their own staff, and so their dual role may not be best suited to supporting open disclosure by lived-experience practitioners. Seamus points to the potential outcome of a therapist's inability to reflect on their lived experience or to request support:

They're not going to be honest and it's going to stay within them, it's going to fester. And it's going to affect their health, their life, and it's going to affect the clients as well.

From this perspective, the therapist's self-reflection is an important element of ongoing recovery, providing protection for both therapist and client. This may be challenging for lived-experience practitioners and appears to have been particularly difficult for Róisín due to her sense of alignment with her clients.

3.4 | Healing and recovery

This theme developed as participants reflected on their experiences of personal therapy and the influence of their training programmes. All participants expressed a period of growth throughout their journey to becoming therapists, with personal therapy and theoretical knowledge contributing towards healing and recovery.

Seamus initially began working with his therapist whilst undertaking training. As he reflects on his time in therapy, he considers the different ways in which client presentations have affected him as his practice developed:

At the time I started my placement ... I hadn't been in personal therapy just yet. And so things were affecting me in terms of what clients were presenting within the dynamics of the organisation itself. Like that was definitely affecting me worse than it does now.

Seamus notes that he became better equipped in managing countertransference following his time in personal therapy, noting that client presentation no longer affected him as deeply as they once did. The healing experienced within therapy fostered a sense of resiliency for Seamus, contributing towards growth as a practitioner.

As Lisa considers the relationship she had with her therapist, she reflects on the profound impact it had on her mental well-being and life trajectory. Lisa struggled with severe depression in the years following her son's death. She expresses a sense of being trapped in these feelings and credits her therapist's ability to support her recovery: "he absolutely flipped everything that I had been thinking for the last three years on its head." The healing she experienced in therapy resulted in a shift in her sense of self, allowing her to consider new possibilities. This is seen in her final therapy session:

I actually had left on the last session and the counsellor had said to me about moving forward and what I wanted to do. He had said ... "With your life experience, I think, you know, you would be a good candidate to train in counselling." And that's actually what put me on the journey to become a counsellor.

Lisa's healing continued throughout her training and as her practice developed, fostering resiliency which, in turn, has empowered her to further advance her practice. While Lisa entered training with the goal of specialising in addiction, she recognised that she did not yet have the resiliency for this: "I couldn't have ... went into placement somewhere with drug and alcohol issues, because there was no way I would have been ready." Due to Lisa's sustained effort, however, she now considers herself ready to begin working towards this goal: "I have just signed up for some courses on drugs and alcohol ... And when I think that the time is right, that is perhaps the direction I will go."

Alongside recovery through therapy, the theoretical knowledge gained throughout training has contributed towards the participants' healing and recovery. This is evidenced in Seamus' account of learning about defence mechanisms in psychotherapy as providing self-insight: "I didn't feel like I was ever receiving any sort of new information. It felt as though I was receiving explanations for things I already knew." Like Seamus, Róisín reflects on the value of insight gained throughout training: "The theoretical knowledge gave structure to my inner world and a language with which to express it, and I found this to be really powerful." Having this frame of reference may contribute towards acceptance and de-pathologising of their experiences, further facilitating recovery. As Róisín reflects, "I think I'm doing much better now personally because of that education. It wouldn't have been useful without the therapy as well, but it's really enhanced it."

On reflecting on their time in personal therapy and their experiences throughout training, participants considered the needs of prospective trainees. Lisa discusses her experience of self-reflection during training and the sense of exposure this embodied within her: "You're left naked, mentally, I think when you do this, which can be quite frightening when you see parts of yourself that aren't necessarily nice." In acknowledging the painful element of this self-awareness, Lisa asserts that prospective trainees should be prepared to explore their unconscious personality which they would otherwise attempt to keep hidden, known as the "shadow self" (Jung, 1970). Similarly, Seamus and Róisín suggest prospective trainees may prepare themselves for training by firstly engaging in personal therapy:

Get personal therapy. I really, really can't stress that enough.

(Seamus)

would say to make sure you've dealt with any issues you have in personal therapy, really engage in self-analysis.

(Róisín)

The healing and recovery necessary for personal and professional growth thus seems an essential, if inevitable, element of training to become a therapist. By encouraging prospective trainees to engage in personal therapy, participants may thus be understood as seeking to nurture this growth, using their own journeys to guide that of the trainee's.

4 | GENERAL DISCUSSION AND CONCLUSION

4.1 | Discussion

The current study explored the role of practitioner-lived experience of mental health issues in counselling and psychotherapy. It examined the influence of practitioner-lived experience on therapeutic practice and the ways in which service-user professionals may be supported in disclosing and reflecting on their experiences. Participants reflected on the foundational nature that their lived experience has played in the development of their professional identity, with practitioner identity evolving throughout a process of growth and recovery. Participants drew meaning from personal therapy and the supervisory relationship, with their personal therapist and supervisor providing a guiding model. These foundational experiences allowed participants to form relational bonds with their clients and supported using self-disclosure. Despite the potential positive impact of self-disclosure, participants identified cultures of nondisclosure within their organisations. Participants, therefore, highlighted the need for positive regard and nonjudgemental support from supervisors and colleagues, understanding this as essential in ensuring practitioner and client well-being.

These findings contribute to existing evidence suggesting that lived-experience practitioners are uniquely situated in enhancing counselling and psychotherapy practice. Participants understand themselves as compassionate and empathetic practitioners who work to hold the needs and experiences of their clients in mind, reflecting findings across existing literature (Adame, 2014; Gelso & Hayes, 2007; Gilbert & Stickley, 2012; Goldberg et al., 2015). Participants' use of self-disclosure serves to establish strong alliances with clients, redistributing power while depathologising client experiences. This is in line with previous findings indicating that lived-experience practitioners challenge dominant psychiatric-medical discourses (Adame, 2011; Byrne et al., 2016). This has implications for the development of mental health services, as lived-experience practitioners may be understood as being particularly attuned to client needs. The input of lived-experience practitioners throughout service development may, therefore, promote client-centred care.

The current findings align with previous research indicating the difficult nature of accessing support for lived-experience practitioners during periods of distress (Adame, 2011; Joyce et al., 2007). Concerns regarding competency present as barriers to therapist disclosure (Harris et al., 2016; Huet & Holttum, 2016), as informed by the expectation that counsellors and psychotherapists are devoid of perceived weakness (Conchar & Repper, 2014; Zerubavl & O'Dougherty-Wright, 2012). Participants frequently referenced trepidation felt prior to disclosure, fearing punishment should they seek support, and beliefs that their lived experience may result in their othering by colleagues. Counsellors and psychotherapists may then benefit from the publication of guidance explicitly valuing experiential knowledge, as is seen in similar professions, such as clinical psychology (BPS, 2020). Moreover, prospective lived-experience trainees may benefit from engaging in personal therapy prior to and throughout training, enhancing their readiness for training and ability to navigate countertransference.

4.2 | Limitations and future directions

Interpretation of data using IPA relies on the interplay between researcher and participant, where analyses are developed through joint reflections (Smith & Osborn, 2008). The interpretive process has therefore been informed by having a study interviewer who is a lived-experience mental health practitioner (Frost & Bailey-Rodriguez, 2019). The use of a reflective journal throughout this project enabled the primary researcher to identify pre-existing assumptions prior to analysis; however, this may have fostered a tendency to prioritise certain themes. Analyses are therefore subject to bias and may best be viewed in the specific context of insider research. Universality is similarly limited through the sample sizes used within IPA. IPA engages with material at an idiographic level, seeking to identify patterns across cases while recognising the unique perspectives of the individual participants, necessitating a small, homogeneous sample (Smith, 1996). Selection bias also presents a limitation, as self-nominating for this study may infer a particular

degree of insight into the benefits and challenges of having this particular dual identity. This would therefore be unlikely to represent the larger group of lived-experience practitioners. Interpretations should therefore be understood as applying to the recalled experience of the participants.

As the perspectives of minority groups are notably absent in literature concerning mental health research coproduction (Rose & Kalathil, 2019), further research may benefit from employing a diverse sample. This is of particular interest to this area of inquiry as it is likely that the experiences of those with other stigmatised identities differ significantly to those of the current participants. Participants within the current study frequently reported concerns of disclosing their lived experience of mental health difficulties, fearing that this will result in doubts regarding their competency. These fears may be heightened for minority ethnic groups. Minority ethnic groups may forfeit social support due to internalised stigma (Owuor & Nake, 2015), while experiences of racism are associated with higher levels of anticipated stigma (Williston et al., 2019). Previous research also suggests that minority ethnic groups experiencing suffering or distress may be hesitant to seek support due to systems of white supremacy and systemic racism. Mental health for racialised people has, for example, been referenced to support prosecution or indicate risk while mental health services are differentially accessed or imposed (Joseph, 2019). Therefore, it may be of interest to explore the experiences of minority ethnic groups in disclosing lived experience in this context.

5 | CONCLUSION

This study builds upon previous research exploring the influence and value of practitioner-lived experience of mental health issues in therapeutic practice. It addresses a gap in existing literature on experiential knowledge in mental health as the experiences of counsellors and psychotherapists have previously been neglected. The current findings reflect existing works, suggesting that practitioner-lived experience may be utilised to enhance therapeutic practice while being an important source of meaning in relation to professional identity. Lived-experience practitioners may, however, be prevented from exploring their experience due to cultures of non-disclosure and stigmatising beliefs held by other professionals. A cultural shift across mental health services, whereby experiences of mental distress are no longer understood as being external and isolated to service-users, is therefore necessary. Such a shift will better enable practitioners to seek support and engage in reflective practice throughout supervision, which, in turn, may assist them in optimally integrating their dual patient-therapist identities.

CONFLICT OF INTERESTS

The authors declare that there is no conflict of interest.

DATA AVAILABILITY STATEMENT

Full anonymised transcripts are available as [Supporting Information](#).

ETHICAL APPROVAL

Ethical approval has been provided by the Faculty of Engineering and Physical Sciences Research Ethics Committee at Queen's University, Belfast (EPS 21_98).

PATIENT CONSENT

All participants were provided with a participant information sheet and provided informed consent to participate in the interview.

PERMISSION TO REPRODUCE MATERIAL FROM OTHER SOURCES

Not applicable.

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SUPPORTING INFORMATION

Additional supporting information can be found online in the Supporting Information section at the end of this article.

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