"You wouldn't want to talk to someone who doesn't understand".

Mental Health Consumer Attitudes Towards Practitioner Lived Experience

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Submitted in partial fulfilment of the requirements for the Psychology Honours Program

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Submitted: October 26, 2023

Word count: 9,997

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Acknowledgements

Perhaps most importantly, I would like to thank the many participants who took time out of their busy lives to contribute to my study and, by doing so, trusted me with their stories and perspectives. Consumer engagement is so meaningful to me, but it was my participants that motivated me to dig deeper and work harder throughout these last nine months.

I would also like to express my immense gratitude to my supervisor Brett Scholz for his wisdom, encouragement, and joyful approach to research. Brett's trust and enthusiastic support of me has fostered my confidence as a student, academic, and general human in this world. Thank you so much Brett.

I would be remiss not to recognise the sacrifices of my brother Matt, my Nanna Shirley, and my parents Michelle and Kevin, who have faithfully supported me throughout my education. Mum – for the hours talked, wines drunk, living room dance sessions had… how can I ever thank you enough? To all my friends and family who have supported me this year, thank you – special mentions to Alex, Em, Mads, Imi, Charli, and Felix.

This year would not have been as remotely enjoyable (bearable?) without the wonderful friends I met in honours. Shout out to Cole, Chelsea, Cam, and Robbie for all the giggles, advice, and for dealing with my Turbulent ENFJ ways.

To my partner Ollie, who has dealt with his fair share of meltdowns and lived experience chat this year, thank you for still loving me! Your support goes beyond and you're my best friend… what a privilege it has been to grow up together these past seven years.

Finally, I would like to dedicate this thesis to my wise Grandfather John Morrison, who passed away last July. Thank you for being a quiet, yet relentlessly encouraging force in my life. I may have been your favourite (and only) granddaughter, but you were and will remain to be my favourite person ever.

Abstract

Research has found that practitioners with lived experience of mental illness are reluctant to disclose these experiences to colleagues and managers for fear of stigmatisation. However, little is known about the perspectives of mental health consumers towards practitioners' use or sharing of lived experiences. The present study aims to address this gap in the literature through a qualitative exploration of consumer attitudes towards seeking treatment from a practitioner with personal experience of mental illness. Semi-structured interviews and an online survey were completed by adults ($N = 34$) who self-identified as mental health consumers. Reflexive thematic analysis was performed on transcribed data. The social identity model of the working alliance informed data analysis and theme development. Participant attitudes were generally positive, with practitioner lived experience being considered a therapeutic resource. Analysis led to the development of three primary themes, where attitudes to lived experience reflected considerations about (a) changes to the working alliance, (b) practitioner recovery, and (c) perceived practitioner professionalism. While a one-size-fits-all approach to mental health service delivery should be avoided, this exploration provides some guidance for mental health policymakers, organisations, and practitioners. Given the positive attitudes of consumers towards practitioner lived experience, future research should explore the role of this cohort as a potential novel avenue beyond peer worker models for integrating consumer perspectives in mental health settings.

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Mental Health Consumer Attitudes Towards Practitioner Lived Experience

Consumer engagement is associated with extensive benefits for the mental health sector, including improved outcomes for service users, practitioners, and institutions (Gordon, 2005; Scholz et al., 2018; Scholz et al., 2020). However, meaningful consumer engagement beyond tokenistic representation that simply meets government standards is rare (Scholz, 2022), and increasingly prevalent peer worker approaches face several challenges with medical model integration (Vandewalle et al., 2016). Despite this, there has been insufficient investigation of mental health practitioners with personal experiences of mental illness who already work in these contexts and may provide a unique avenue for consumer representation. The limited research that does exist on this cohort finds positive outcomes associated with their use of lived experience in mental health practice (Adame et al., 2017; Oates et al., 2017; Viado, 2015), but also highlights that pervasive self-stigmatisation of mental illness constrains the choice to share these experiences (King, Brophy, et al., 2023; Knaak et al., 2017). As such, there is a considerable need for investigation of consumer perspectives towards lived experience practitioners in mental health settings (King, Roennfeldt, et al., 2023).

Defining Key Terms

Mental health consumers (hereafter, *consumers*) refers to individuals with current or previous lived experience of a mental illness or disorder. Arising from the consumer movement in the 1960s, the term 'consumer' was chosen in response to the passivity and paternalistic nature of the 'patient' label (McAllister & Walsh, 2004). Despite varying terminology preferences and a need for further investigation (Hensley, 2006), 'consumer' is used throughout the present paper to describe this cohort given it is the term most widely adopted or endorsed by such individuals in the current Australian context (Our Consumer Place, 2010).

Peer workers are individuals employed in designated lived experience roles that are expected to use their personal experience with mental illness to support current consumers (Byrne et al., 2019; Conchar & Repper, 2014).

Lived experience practitioners (or *consumer-practitioners*) refers to mental health professionals (here, psychologists and psychiatrists) who have personal experience with a mental illness but do not work in a designated lived experience role (Byrne et al., 2016). Such practitioners often feel unclear how lived experience may influence their practice (Dunlop et al., 2022; King, Brophy, et al., 2023).

Stigma is a complex social process involving labelling, othering, and discrimination that is often driven by negative beliefs about a group of people (Knaak et al., 2017). Mental illness is highly stigmatised in Australia (Reavley & Jorm, 2011), including amongst mental health practitioners (Horsfall et al., 2010; Knaak et al., 2017), and even those practitioners with lived experience (King et al., 2020). Stigma diminishes consumer experiences with mental health systems, where they often report feeling dismissed by practitioners (Knaak et al., 2017). Reducing the stigmatisation of mental illness in Australia is a core target of domestic mental health policy (Morgan et al., 2021).

The Benefits of Consumer Engagement

A range of positive outcome are associated with consumer engagement in the mental health sector, including the reduction of stigma (Byrne et al., 2019). Consumer engagement varies across organisations and initiatives, but can involve contributions to service planning, implementation, delivery, and impact evaluation (Scholz et al., 2017). The Australian government has recommended that mental health services adopt a more collaborative approach, where consumers are empowered to contribute to the policies and decisions that impact their lives (Productivity Commission, 2020). The achievement of the National Safety and Quality Health Service accreditation – which conveys a nationally standardised assurance of the level of care consumers can expect from the service – depends on fulfilling consumer involvement at all health service levels (Shih et al., 2022).

Consumer engagement reduces stigmatisation of mental illnesses through enabling an increased understanding of, and collaboration with, individuals with mental illness (Ibrahim et al., 2020; Morgan et al., 2021). For example, hearing testimonies of experiences with mental illness, recovery, and the healthcare system is a crucial approach for professional educational approaches to reducing stigma in healthcare (Knaak et al., 2017).

The contributions of consumers in the mental health sector are also found to shift power relations tied to the medical model, which places focus on the biological determinants of mental illness rather than the individual, which is standard practice across Australian mental health-care delivery (Bennetts et al., 2011). Consumer engagement also challenges organisational resistance to change (Bennetts et al., 2011; Lloyd & King, 2003), bringing new ideas into the sector that lead to improved health outcomes (McAllister & Walsh, 2004), which is supported by the findings of several randomised control trials (Felton et al., 1995; Price et al., 2022; Rivera et al., 2007). Consumer experiences of system use and recovery improves professional knowledge (Lambert et al., 2021), enhancing the community credibility of the mental health organisation (Scholz et al., 2018). As the literature depicts, consumer engagement in mental health services is associated with a range of positive outcomes.

A Role for Mental Health Practitioners with Lived Experience

Despite the proven advantages of incorporating consumers into the mental health sector and continuing governmental pressure to include consumers in related policy and research (Butler, 2023), investigation of practitioners’ use of lived experience has been limited, where many organisations largely overlook the existence of this cohort in their workplace (King, 2023).

To date, efforts to represent consumers in mental health settings have centred on peer support models, where individuals with experience of mental illness often external to the institution are recruited to bolster current consumers (Conchar & Repper, 2014). A recent literature review finds that peer support models are highly advantageous in several mental health contexts, including severe mental illness, addiction, amongst older adults, and adolescents (Shalaby & Agyapong, 2020). Furthermore, the provision of peer support was found to be associated with decreased admission and rehospitalisation rates, reduced lengths of stay, and reduced absenteeism in mental health workforces (Shalaby & Agyapong, 2020).

Regardless of the advantages associated with peer worker models, peer workers face several barriers upon integrating into organisation and medical structures, including challenges with establishing credibility, cultural hurdles, negative attitudes from mental health practitioners, inadequate organisational arrangements, tensions with consumers, and insufficient social and mental health policies to support their role (Vandewalle et al., 2016). External consumer representatives are also often restricted to trivial matters, with authority preserved for those in traditional medical positions (Gordon, 2005; Meagher, 2011). In spite of the challenges facing peer worker integration into organisational and medical structures (Vandewalle et al., 2016), the many existing internal mental health practitioners with both lived experience and institutional knowledge appear unacknowledged.

Achieving meaningful consumer engagement that goes beyond merely satiating policy requirements continues to pose a challenge (Scholz, 2022). Given the barriers associated with integrating peer workers, lived experience practitioners may provide an additional and unique avenue for consumer representation. Some research has begun to explore this, where one study interviewing lived experience mental health nurses found that personal experiences of mental illness were used as a tool to better understand and develop relationships with consumers (Oates et al., 2017). Further, lived experience practitioners explain leveraging reflections on their own engagements with mental health services to define their practice and shape their unique value as practitioners (Cleary & Armour, 2022). Nevertheless, it should be noted that the limited research on lived experience practitioners has largely been restricted to those in social work (Fox, 2016; Moran et al., 2022) and nursing (Happell et al., 2021), and has focused on the practitioner's perspective (Cleary & Armour, 2022). Shortcomings in peer worker models and the attempted integration of consumers into medicalised mental health settings may be enhanced through better incorporating lived experience practitioners, such as psychologists and psychiatrists.

Practitioner Disclosure of Lived Experience

Despite the push to better incorporate lived experiences in mental health settings, open discussion of such personal experiences amongst mental health practitioners at work is still widely regarded a taboo (King, 2023). This may be due to the prevalence of mental health stigmatisation in mental health professions, even towards peers facing their own mental health struggles (Cleary & Armour, 2022; Fox, 2021). For example, practitioners were more resistant than consumers and carers to the employment of lived experience practitioners at an eating disorder clinic, despite a third of the practitioner participants disclosing history of an eating disorder (Johnston et al., 2005). The choice to share personal experience is also intrinsically limited as self-stigmatisation and shame amongst mental health practitioners with mental illness is rife (Henderson et al., 2012; Marino et al., 2016). Ironically, sharing these experiences combats stigmatising views of mental health, leading to greater inclusivity for mental health practitioners and improved outcomes for consumers (Knaak et al., 2017).

In addition to stigmatisation, identity management presents a barrier to lived experience disclosure (Cleary & Armour, 2022). Whether lived experience practitioners identify with the ‘wounded healer’ or ‘impaired professional’ archetype plays an important role in their choice to share or conceal experiences of mental illness (King et al., 2020). The wounded healer concept refers to the value of lived experience in clinical practice (Jung, 1951, 1966), where it has been said, “it is [a practitioner’s] own hurt that gives the measure of his power to heal” (Henderson, 2019, p. 118). Where lived experience practitioners identified with this perspective, and lived experience is more widely regarded an asset, practitioner disclosure is more likely (King et al., 2020). In contrast, practitioners who identified more as an impaired professional, who is bound by allowed ways of being a practitioner that exclude emotional expression, believed they were regarded a liability in the workplace by peers and supervisors (King et al., 2020).

Beyond these archetypes, lived experience practitioners also balance the identities of both therapist and consumer. Navigating the divide between these identities, typically considered mutually exclusive, while attempting to establish a sense of identity congruence as a lived experience practitioner is highlighted as a challenge (Cleary & Armour, 2022). Lived experience practitioners acknowledge distress associated with negotiating hybrid identities and bridging an us vs. them divide, making it difficult to hold both identities simultaneously (King et al., 2020). Identity management remains a persistent challenge for lived-experience practitioners and impacts the ways in which practitioners relate to consumers (Cleary & Armour, 2022).

Theoretical Framework: Social Identity Theory

Recognising the complex identity divide between lived experience practitioners and consumers calls into question the relevance of the social identity perspective, which proposes that an individual’s sense of self is founded upon group memberships (Tajfel & Turner, 2004). According to social identity theory, the self-concept is established and enhanced via a process of in-group identification and favouritism (Turner et al., 1979). The role of group association in defining one’s identity, perspectives, and behaviours was elaborated upon by self-categorisation theory (Turner, 1987, 1994), which recognises that individuals hold membership in several groups (e.g., gender, race, profession, sports team) and that the salience of a particular group is contextually determined. To achieve group acceptance, an individual may perform several identity switches throughout the day, in a highly automated manner (Zinn et al., 2022). Therefore, identity can be understood as an unstable, dynamic construct, that is founded upon the groups one considers oneself a member of. For example, lived experience practitioners hold membership in both ‘patient’ and ‘therapist’ social groups, creating complexities in their relationship with consumers (Cleary & Armour, 2022).

The Working Alliance

Some research has begun exploring the consumer and practitioner working alliance using social identity perspectives (Cruwys et al., 2023; Lee et al., 2021; Lee et al., 2023). Working alliance refers to the dynamic relationship, and often affective bond, between consumers and practitioners in therapeutic contexts (Castonguay, 2006). A strong working alliance is associated with beneficial consumer outcomes (Castonguay et al., 2006), including reduced suicidal ideation (Barzilay et al., 2020), enhanced mental health recovery, psychological wellbeing, and quality of life (Browne et al., 2019). According to Haslam et al. (2020) therapists can be considered group leaders in the therapeutic relationship, assuming roles of social influence (Pentony, 1981) and teaching (Butler, 2023). Extensive evidence indicates that leaders, such as practitioners, are more likely to gain engaged followership and be viewed favourably when they embody group prototypes (Lee et al., 2021; Van Knippenberg, 2011; Van Knippenberg et al., 2008). For example, prior research has encouraged practitioners to emphasise psychological similarities between themselves and consumers (Lee et al., 2021).

An important distinction exists between psychological and sociological groups. Sociological groups are defined by externally observable characteristics such as roles, norms, sex, race, and ethnicity, while psychological groups are subjective, self-defined groups in which an individual believes they hold membership (Haslam et al., 2020, pp. 105-124). Investigation of sociological group memberships in explaining the working alliance have so far not been fruitful; for example, demographic congruence between practitioners and consumers was found to explain no more than 3% of the variance in working alliance (Cruwys et al., 2023). Thus, simply possessing similar characteristics or roles as others will not garner leaders' followership; instead, leaders should focus on developing psychological ingroup credentials (Haslam et al., 2020).

Evidence finds that therapists who foster a stronger sense of shared identity achieve a deeper therapeutic alliance and better client outcomes (Cruwys et al., 2023). Social identity leadership literature proposes four key elements for successful leadership that practitioners can leverage to enhance the working alliance: identity prototypicality (i.e., being one of us), identity advancement (i.e., doing it for us), identity entrepreneurship (i.e., creating a sense of us), identity impresarioship (i.e., making us matter; Haslam et al., 2020; Lee et al., 2021; Steffens et al., 2014). Despite the recognised importance of the working alliance in therapeutic success, tools developed for its assessment are criticised for their inconsistency and lack of specificity (Elvins & Green, 2008), and little is known about the impact of practitioner behaviours on the relationship (Lee et al., 2021). Given the literature's emphasis on therapist prototypicality and identification, there is a need to explore consumer attitudes towards practitioner lived experience, which may provide a means to enhance identification, working alliance, and therapeutic outcomes.

Aims and Objectives

The stigmatisation of mental illness persists amongst mental health practitioners, including towards their own colleagues (Cleary & Armour, 2022; Knaak et al., 2017). While emerging literature has investigated the perspectives of lived experience practitioners, to the researcher's knowledge, there has been no exploration of consumer perspectives towards mental health practitioners with lived experience. It is important to explore the preferences of mental health consumers to ensure provision of the best possible services (Happell et al., 2018), as well as support the existing mental health practitioners working in these spaces who continue to feel stigmatised for their experiences (King, Roennfeldt, et al., 2023). Thus, the aim of this study is to better understand mental health consumer attitudes towards lived experience practitioners. To achieve this aim, the specific objectives are to:

1. Conduct interviews and surveys to gain an in-depth understanding of mental health consumer attitudes towards practitioner lived experience through identifying patterns of meaning (i.e., themes) shared amongst participants.
2. Determine whether practitioner lived experience is viewed as a strength or limitation and if so, in what ways.
3. Explore whether consumers have a preference in seeing a lived experience or non-lived experience practitioner.

Hypotheses were not included in this study given the goal of exploratory qualitative investigation is the generation, not the testing of hypotheses (Pope & Mays, 1995).

Method

Design

This research adopted an exploratory, qualitative design where data were collected through surveys and semi-structured interviews. A qualitative approach was chosen to facilitate expansive and in-depth responses, given this research aimed to gain a rich appreciation of diverse consumer attitudes (Braun & Clarke, 2013; Dearnley, 2005). Analysis adopted a reflexive thematic analysis approach (Braun & Clarke, 2006, 2021a). The assumptions that informed the design of this study are aligned with a phenomenological and constructionist epistemology that acknowledges the relevance of one's own experiences and subjectivity in interpreting the world around them (Tuffour, 2017). Subjectivity was recognised at three levels: perspectives of the individual consumer participant, the lived experience practitioners whom participants reflected upon, and my own subjectivity as the researcher interpreting participant responses.

Ethical approval for this study was granted by the Australian National University (ANU) Human Research Ethics Committee (Protocol 2023/174).

Participants

Adults (*N* = 34) who had previously or were currently accessing mental health support from a psychologist or psychiatrist for any mental illness were invited to participate in the study through either through an online survey, online interview, or in-person interview, according to preference. Individuals who had accessed support specifically from a psychologist or psychiatrist were selected given lacking clarity regarding public perceptions of and expectations for these practitioner roles (Patel et al., 2018) and the predominant investigation of lived experience in other mental health disciplines to date (Ibrahim et al., 2020; King, 2023; Oates et al., 2017). Given the time and potential commute, all interview participants were given a $20 supermarket voucher.

Eligibility was founded upon an individual's capacity to self-identify as either previously or currently experiencing mental illness (Schomerus et al., 2019); no information about diagnoses, the recency, or frequency of support-seeking was sought from participants. In line with the literature, the term 'mental illness' encompasses a broad spectrum of the human psychological experience, where support is sought for various reasons and the delineation between normal and abnormal emotions is complex (Horwitz, 2015). Further, the explicit communication of diagnoses is often avoided to prevent stigmatisation (Ben-Zeev et al., 2010). Diagnosis information was however occasionally volunteered by participants in their responses. Demographic information was collected from participants (see Appendix A) but was determined irrelevant to the themes developed and thus not included in the analysis.

A mixed recruitment approach was adopted, with participants recruited via social media advertisements, community, and professional groups (e.g., Facebook and LinkedIn), and by contacting psychological and psychiatric practices to request study advertisement (see flyer at Appendix B). A total of 24 practices were emailed and called, in addition to one non-profit mental health services organisation that approached the researcher and requested to share the research (the Australian Primary Mental Health Alliance). A website was developed to host study information and provide participants with a means to select their participation method of choice (a QR code on the flyer linked to this website). Participants could directly access the Qualtrics survey through the website platform or contact the researcher to schedule a time to be interviewed.

Sample size for this study was determined by the quality of the data and what was pragmatic for the scope of the research (Braun & Clarke, 2021b). The a priori determination of sample size in qualitative research has been criticised for frequent lack of sufficient justification (Braun & Clarke, 2021b). Further, despite the popularisation of saturation – the cessation of data collection when the researcher deems it to be rich enough for meaningful analysis – has also faced criticism (Braun & Clarke, 2021b). Some guidance is provided by Braun and Clarke (2021b), who advise that theme (i.e., pattern) identification may be challenging with less than six participants, but when data sets become too large, participants' nuanced perspectives may be missed. Ultimately, cohort size decisions were made in line with the reflexive thematic analysis approach (Braun & Clarke, 2021a) and were consistent with other similar, high quality qualitative research (King & Simmons, 2023; Scholz et al., 2018).

Data collection

Surveys and interviews were both piloted prior to commencing recruitment. Surveys were anticipated to take approximately 20 minutes, and interviews took an average of 39 minutes. After excluding incomplete responses – i.e., one participant who completed only two out of the three pages of the survey – 24 survey participants were included in the analysis. Ten individuals opted to contribute via interview, either in-person or virtually, making the total of 34 participants. Survey and interview questions were identical (see Table 1), but interviews used a semi-structured approach to enable flexibility (Dearnley, 2005) and to empower participants to lead the conversation.

Table 1

Interview and Survey Questions

No.	Question
1	Have you ever considered that your mental health practitioner may have their own personal experience/s of mental illness? If yes, what were your thoughts on this?
2	What kinds of concerns might you have regarding mental health practitioners with lived experience in their roles?
3	Can you think of any advantages that a mental health practitioner with lived experience might have in providing support to consumers?
4	How would you feel if a mental health practitioner referred to their own experience of mental illness in working with you?
5	Do you feel as though practitioner lived experience is better considered a resource or a barrier in effectively supporting mental health consumers?
6	What are some of the ways you think a mental health practitioner might utilise their lived experience in their role?

No.	Question
7	Do you think that there can be “appropriate” disclosure/sharing of practitioner lived experience in consumer settings without compromising “professionalism”? What might this look like?
8	Do you have a preference in seeing a practitioner with or without lived experience? Why/why not?
9	Is there anything else you would like to add?

Note. Interviews were guided by but not constrained to these questions. When relevant, alternative follow-up questions were asked.

Interviews were recorded using a digital voice recorder or Zoom’s built-in recording function. Recordings were roughly transcribed using Microsoft 365s Word transcription service, and then checked and corrected in full to ensure accuracy. Participants were given the opportunity to select how they would like to be identified in the research, where consent forms included three tick-box options: ‘de-identified/pseudonym’, ‘full name attribution’, ‘no attribution’. To ensure deidentification for the majority of participants that selected this attribution, quotes are not reported with a correlating participant number. Once transcribed, data were stored, managed, and analysed using NVivo (Version 13).

Data analysis

Responses were recorded, transcribed, coded, and analysed utilising the principles of Braun & Clarke’s (2006) reflexive thematic analysis. The data collected were rich, with an average of 6808 words for each transcribed interview and 342 words per survey participant. Analysis was conducted in accordance with Braun & Clarke’s (2006) six stages of reflexive thematic analysis (see Appendix C). To support the standardised evaluation of reflexive thematic analysis quality, Braun and Clarke (2006) developed a 15-point checklist for reviewers. An outline of this study’s fulfilment of the criteria can be seen at Appendix E. Per Byrne (2022), data were predominantly coded inductively in that they were not interpreted according to a predetermined codebook and were instead categorised based on the raw content of the data. However, noting both the subjectivity of the researcher and the essentially theory-driven nature of observation – including the influence of social identity perspectives in the researcher’s analysis – an inevitable degree of deductive analysis enabled coding to be both relevant and meaningful to the research question (Braun & Clarke, 2006). Data included in this thesis were grammatically corrected to enhance readability.

Reflexivity

Reflexive thematic analysis does not aim to determine objective truths, but instead encourages deep engagement with the data and recognises the researcher’s subjectivity in ascribing meaning (Braun & Clarke, 2019). Thus, the personal experiences, training, and values of the researcher are considered as a resource rather than a limitation (Braun & Clarke, 2019). Reflexive thematic analysis encourages researchers to transparently examine their own assumptions, judgements, and practices throughout the research process and explore the possible influence of these elements in their data interpretation (Braun & Clarke, 2021a). Reflexivity is an important aspect of Reflexive Thematic Analysis in establishing rigour.

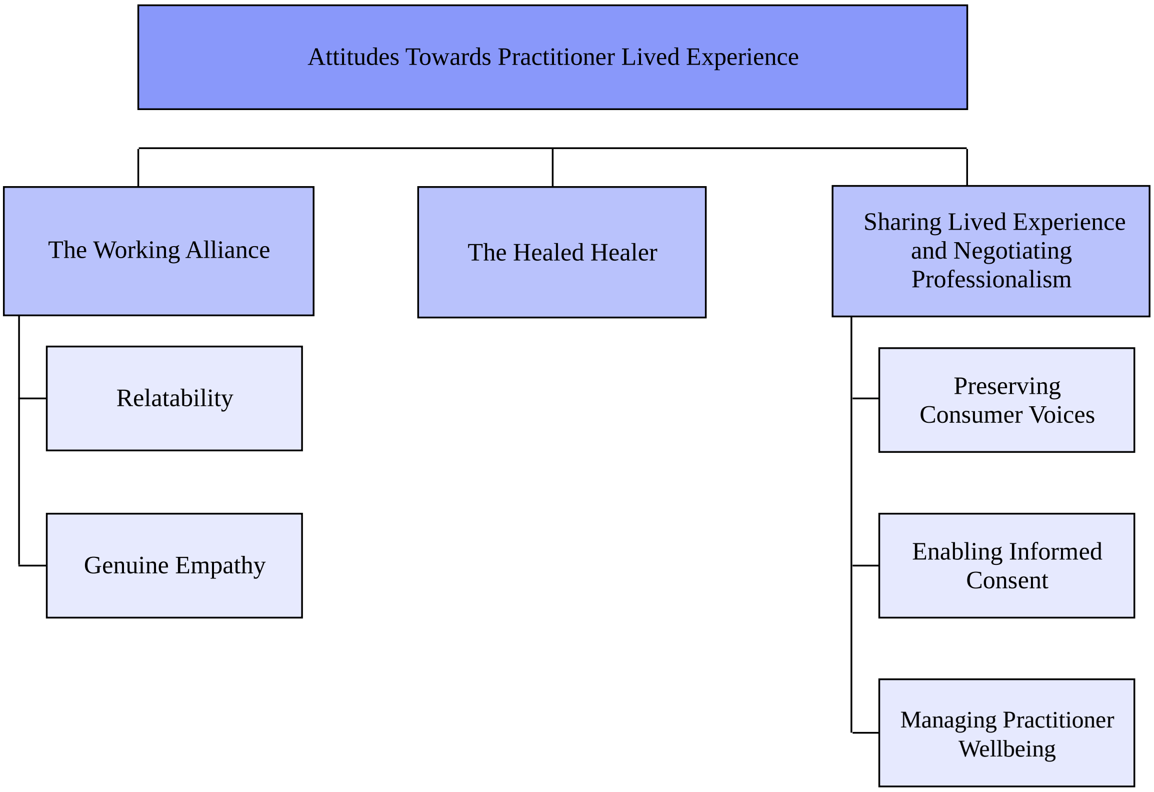
Throughout the research process and after each interview, I reflected on both the content of the responses and on my technique as an interviewer and researcher (Dearnley, 2005). My own experiences and values shaped the way this study was conducted and produced in many ways. In line with the constructivist epistemological approach, the motivation and interest for the present research were undoubtedly influenced by my experiences as both a mental health consumer and aspiring psychologist. To engage with my own positionality, I kept a reflexive journal (i.e., intellectual audit trail) throughout the process of this study, in which I would write my thoughts following each interview and at decision points in this study’s conduct (Carcary, 2009). An audit trail (see Appendix D) provides insights into the researchers decision-making process, enhancing credibility (Wolf, 2003). Interview spacing and regular meetings with my supervisor to discuss challenges and successes supported my capacity to engage in reflexivity.

Results

The aim of this study was to explore consumer perspectives towards mental health practitioners with personal experience of mental illness. While data were coded inductively and without the use of a pre-existing codebook, social identity approaches to explaining the working alliance (Haslam, 2014; Lee et al., 2021) provided a frame for interpretation given an emphasis on the therapeutic relationship in participant responses. The relevance of these models to each theme is briefly mentioned but will be further explored in the Discussion. Data analysis resulted in the development of three primary themes (see Figure 1).

Figure 1

Themes and Sub-Themes Identified Through Analysis



Note. Three themes encapsulated participant attitudes towards practitioner lived experience: The working Alliance, The Healed Healer, and Sharing Lived Experience and Negotiating Professionalism. The Healed Healer theme had no subthemes.

Before detailing these themes, overarching consumer attitudes towards practitioner lived experience will be explained.

Attitudes Towards Lived Experience Practitioners

Previous research has found that practitioners continue to be self-stigmatising of their personal experiences of mental illness (King et al., 2020). However, consumer attitudes in this study run counter to the devaluation of practitioner these experiences. Many participants indicated a clear preference for seeing a lived experience practitioner, particularly one who has experience with the same mental illness. Practitioner lived experience was predominantly regarded an additional resource or “bonus” in a practitioner’s therapeutic toolkit. Several participants reflected on their previous experiences with mental health practitioners, where an absence of lived experience was adversely regarded. For example, one participant shared, “I actually feel that if my practitioner had some personal experience with mental illness, they may have done their job more effectively.” Another commented, “I wish [disclosure of practitioner lived experience] existed. I always feel so alienated from my psychs.” Practitioner lived experience was often considered a means to improve consumer experiences of seeking support. Participant responses also reflected the importance of having access to mental health practitioners who are representative of the consumers they treat, where one participant noted that while they do not have a preference, they “do believe that more practitioners with lived experience in specific settings (such as Indigenous communities, refugees) are needed.” Consumer attitudes reflected a positive perception of practitioner lived experience, where it was viewed as a resource in therapeutic settings, not a barrier.

While most participants spoke favourably of practitioners possessing lived experience, perspectives regarding the sharing of these experiences were more mixed. Several participants said they would prefer a practitioner with lived experience, “as long as they’re not going to talk to me about it!”. While it was considered a valuable mechanism through which practitioners could empathise with consumers, some preferred not to know about practitioner lived experiences. In this way, lived experience was regarded as a useful behind-the-scenes capability, comparable to other psychological techniques that are leveraged in a therapeutic setting (e.g., Cognitive Behavioural Therapy, Acceptance and Commitment Therapy). Participant attitudes towards disclosures of practitioner lived experience were highly nuanced.

Participants demonstrated significant awareness of practitioners in mental health settings who have personal experiences with mental illness. In responding to the first attitude question (see Table 1, Question 1), most participants indicated that they had previously considered practitioner lived experience. Some had even experienced disclosure, such as one who said, "my therapist disclosed her experience to show there was hope for me."

Participant awareness of practitioner lived experience could be explained by cohort-wide communication the high prevalence of mental illness in Australia, where one response stated, "99% of people are probably going to be having challenges with something." Indeed, many participants felt the pervasiveness of mental illness speaks to what it is to be human. For example, in sharing their awareness of practitioner lived experience, another participant shared, "obviously they're human… they're going to have, yeah, gone through stuff." Mental illness was often conceptualised as a normative experience, as opposed to definitions more aligned to medical model "disorders". For example, one participant believed that "one problem we see today is that the stats around 1 in 4 people experiencing [mental illness] is that normal human experiences are pathologised." Consumers demonstrated a clear awareness of the prevalence and normality of mental illness, to which practitioners were not considered immune.

Theme A: The Working Alliance

The aspect of therapy most frequently perceived to be impacted by practitioner lived experience was the relationship between practitioners and consumer, commonly called the working alliance or therapeutic relationship. Per the social identity working alliance literature, stronger identification with the practitioner is associated with improved therapeutic relationships and therapeutic outcomes (Cruwys et al., 2023). Practitioners who establish a shared sense of "us" or are considered prototypical of the in-group, and emphasise group-based similarities between the practitioner and consumer, are more positively regarded (Lee et al., 2021, p. 271). In this study, two primary aspects of the working alliance were perceived by consumers to be affected by practitioner lived experience: relatability and genuine practitioner empathy.

Relatability

Practitioner lived experience was described to enhance the working alliance, where consumers anticipated feeling a greater sense of relatability with lived experience practitioners, as shown below.

> “It's not to say that psychs, without mental health issues themselves can't create [a relationship]. I just feel like it's going to take longer and… it will be a bit weaker”.

Participants felt they could identify with their mental health practitioner more rapidly, robustly, and effortlessly if they shared lived experience of mental illness. Furthermore, participants indicated that despite knowledge of mental illness’ high prevalence in Australia, feeling “alone” was a common occurrence. One participant noted that “knowing [practitioners have] experienced some of the same challenges… makes me feel less alone and alienated”. Practitioners’ personal experience of mental illness facilitated relatability and connection, encouraging consumers’ willingness to divulge information wholly and quickly, where participants felt they “wouldn’t want to talk to someone who doesn’t understand”.

Genuine Empathy

Consumers anticipated practitioners with lived experience would demonstrate greater empathy than those without. Participants believed that practitioner’s lived experience would reduce consumers’ fear of judgement or criticism. For example, one participant expressed that lived experience “opens up that judgment-free zone.”

Concerns about feeling vulnerable when sharing experiences of their mental illness were also expressed by participants, who felt that “other people might hear those stories and think that it makes you a bad person or whatever, but someone who's been through it knows that it's just part of the illness”. Consumers felt that lived experience practitioners would display authentic empathy due to their ability to grasp “just how debilitating [mental illness] is”, and that it is not a “personal force”.

Participants expected lived experience practitioners would access a deeper sense of understanding, which was likened to an added credential, as shown in the extract below:

> “When you read about someone's PhD specialization or thesis topic, they've obviously got a lot of experience in that area. If they've also got lived experience in that area, I'd see that as another avenue of their expertise.”

Lived experience was regarded an additional area of expertise beyond academic or medical training. This sentiment was echoed by other participants, who felt that practitioner’s lived experiences would enhance their ability to empathetically communicate with consumers. For example, many participants felt that comprehending medicalised information would be more likely when communicated by lived experience practitioners, given they could contextualise such information with their own personal experiences, enhancing accessibility for consumers. Because of this, participants described that they would feel a greater sense of trust in guidance and advice from practitioners with lived experience, where one participant noted, “they’re not just saying, ‘well, this is what I’ve read, and this apparently works.’ It’s like, no, I know this works, I’ve implemented it.”

Perhaps the most meaningful and consistent pattern in participant responses was the emphasis on the importance of lived experience in fostering the working alliance, both through improved relatability and enhanced ability to empathise with consumers.

Theme B: The Healed Healer

Aligning to the ‘Wounded Healer’ construct (Jung, 1951, 1966), participants believed that practitioners experiences of mental illnesses would aid their ability to support consumers. However, participants highlighted the importance of practitioner recovery in determining the value of lived experience. For participants, lived experience practitioners were considered more favourably when conceptualised as a ‘Healed Healer’ than a ‘Wounded Healer’; that is, “how recovered” the practitioner was perceived to be impacted participants’ attitudes towards seeing a practitioner with lived experience. This finding can again be framed by the working alliance literature, where research suggests that leaders (i.e., practitioners) who are more prototypical of a group’s aspired identity (i.e., consumers’ desires to be recovered from mental illness), as opposed to its current identity (i.e., mental illness sufferer), are more successful in facilitating group change (Robertson et al., 2023a). Practitioner recovery influenced participant attitudes towards lived experience.

Notably, practitioner lived experience was regarded a more meaningful resource when the practitioner was perceived to be recovered. For example, one participant shared an experience with practitioner disclosure, where “having a perfect example of a functional person with my mental health issues was a big help in [my] recovery.” The participant’s positive regard for lived experience appeared contingent on how “functional” the practitioner was. Another participant stated, “I think I’d want someone who’d come out the other side of it, because that would make me feel more like they can help me get to the other side”. Further, some participants believed that lived experience practitioners still in recovery posed “a greater risk to themselves and everybody else” because of their mental illness. Many participants stipulated a preference for lived experience practitioners only when the practitioner was considered “recovered”.

Participant attitudes about recovery initiated some interesting discourse regarding the nature of psychological recovery. While some participants stated they would prefer not to see practitioners currently struggling with a mental illness, others attested, “I'm not 100% at work every day and I don't think I would expect my psych to be 100% at work every day.” Some participants argued that lived experience could be used to educate consumers about psychological recovery, where one said, “there is no time limit to healing. It's a long-term, lifelong thing." That is, some participants questioned the assumption that mental illness recovery is at all possible, where it is instead better considered "like a scribble instead of the whole linear approach". Participants communicated varying expectations regarding lived experience practitioner recovery.

Recovery discourses often emphasised the importance of practitioners being able to facilitate optimism and hope, where their own recovery successes could be leveraged. For example, one participant shared, "when you are really in the thick of it, you don't see yourself as coming out of the hole you're in. But then when you see someone else who's already done it, you're like, oh, OK. They can do it; I can do it too." Hope and recovery were important elements in participant responses, where "recovered" practitioners were considered preferable to those still struggling with mental health issues.

Theme C: Sharing Lived Experience and Negotiating Professionalism

Finally, participant attitudes reflected an exploration of "appropriate" ways of sharing lived experience. The sharing approach chosen by practitioners influenced consumer perspectives towards lived experience, where its perception as a resource was "greatly dependent on how it's delivered". Critically, participants highlighted that practitioner lived experience should not threaten consumer voices. This resonates with the working alliance literature, which emphasises the importance of practitioners elevating the consumer voice; that is, empowering consumers to "have a say" in clinical settings (Lee et al., 2023, p. 3).

Discourse regarding the sharing of lived experience was intertwined with conceptualisations of "professionalism"; many participants questioned the intersection between practitioners with lived experience and traditional medical model depictions of mental health professionals. For example, some participants felt that practitioner disclosure of lived experience would unavoidably compromise professionalism. In contrast, others argued that lived experience can be shared in such a way that perceived professionalism is upheld.

Although, some participants entirely challenged the researcher’s suggestion that practitioner lived experience is associated with medical model professionalism (see Table 1, Question 7):

> “The whole idea of professionalism is the problem. I think that the various disciplines need to rethink what it means to be professional in a system that is supposed to be caring for people in distress.”

As the extract reveals, participants challenged conventional conceptualisations of mental health practitioners and expected behaviour attached to these roles. One participant attested, practitioners “can’t keep it 100% professional because that won’t allow you to bond [with the consumer]”. In this sense, the professional expectations prescribed to mental health practitioners were believed to be the problem, not the practitioner’s lived experience, where the suggestion of lived experience compromising professionalism was perceived to reflect the coldness of the medicalised experience.

However, to circumvent these expectations or avoid compromising perceived professionalism, participants detailed approaches that could be used when sharing lived experience, where a failure to share “appropriately” may undermine the working alliance and drive negative attitudes towards lived experience practitioners. These approaches were organised according to the primary concern relating to disclosure: preserving consumer voices, enabling informed consent, and managing practitioner wellbeing. Approaches are summarised in Table 2, and further described in the section following.

Table 2

Themes and Preferred Approaches for Practitioner Sharing of Lived Experience

Theme	Approach	Participant Recommendations	Representative Quote
Preserving Consumer Voices	Recognising Individual Uniqueness	Learn what consumers want from the therapeutic session and from the practitioner. Recognise the individuality of mental illness.	“You have to kind of judge like how [the consumer’s] going to react based on like your knowledge of them.” “They've got their very own unique situation that is actually quite different to mine, even if on the surface level it seems similar.”
	Sharing Briefly	Keep references to experiences of mental illness brief and not too personal.	“Like a sentence or two to keep it really short, sweet so then they kind of get the idea that you have gone through it, but it’s not you talking about yourself.”
	Ensuring Relevance	Any references to lived experience should be directly relevant, both temporally and contextually, to what the consumer is disclosing.	“If it's relevant, I feel like it would be really good. But I wouldn't want them to just like make it about them or to bring up things that aren't helpful to me just because they’ve experienced it before.”
Enabling Informed Consent	Waiting for an Invitation to Share	Before disclosing lived experience, ask consumers whether they would like you to.	“Simple questions such as: ‘in our sessions, would you mind if I talked about my experience’, or ‘I have a similar experience, would you like me to share?’; would allow the consumer to engage in the practitioners lived experience at their own decision.”
	Including Lived Experience in Biography	Practitioners may include some reference to lived experience in their bio, empowering consumers to make an informed choice in practitioner.	“In your bio you could say that ‘practitioner X’ has lived experience with depression and approaches her work with an empathetic, and I don't know, holistic way, like something along those lines.”
Managing Practitioner Wellbeing	Preventing Burnout & Setting Boundaries	Practitioners should set clear boundaries around how much of their lived experience they are willing to share to prevent both burnout and burdening consumers.	“Using your own lived experience can actually be quite exhausting… you might end up getting like bit burnt out of compassion.” “If it's like more details… I'd almost feel like it was a burden to me to have to deal with that.”

	Seeking Support	Lived experience practitioners and non-lived experience practitioners are encouraged to work in a collaborative and supportive manner.	“Unfortunately, I think the system is so discriminatory that clinicians with lived experience often feel like they need to prove themselves.”

Note. Three overarching concerns were identified in participant responses regarding the sharing of lived experience: preserving consumer voices, enabling informed consent, and managing practitioner wellbeing, which formed subthemes of Theme C: Practitioner Sharing of Lived Experience and Negotiating Professionalism. Recommended approaches to practitioner disclosure of lived experiences expressed by participants were then organised under these sub-themes.

Preserving Consumer Voices

To avoid consumers feeling a shift in the session's subject, participants recommended that practitioners keep self-disclosure "short and sweet" and ensure that personal experiences are "relevant" to the consumer. Participants conveyed the importance of practitioners ensuring that the therapeutic focus remains on the consumer, who should always be the subject of the session. In this way, practitioner lived experience should only be employed to amplify or validate the voice of the consumer. Suggested approaches to ensuring this included: recognising the unique experiences and preferences of each consumer and keeping disclosure of lived experience brief and relevant.

Recognising Individual Uniqueness. Participants viewed practitioner lived experience as a double-edged sword, where its usefulness hinges upon offering connection without hindering objectivity. Concerns included the risk of overapplication, potential bias, and comparison against the practitioner's experience. For lived experience to be considered a resource, participants stressed the importance of tailored sharing based on individual preferences, considering factors like generational differences and consumers' specific mental health condition. In this sense, the adoption of a one-size-fits-all approach to treatment was advised against. Expectations were set for practitioners to dynamically explore consumer preferences and determine the appropriateness of sharing lived experience in sessions.

Sharing Briefly. Participants expressed concerns about session focus shifting to the practitioner if lived experience practitioners shared extensively. The risk of practitioner "oversharing" was perceived to be greatest when specific details such as diagnosis were disclosed or if the practitioner spoke for too long or too frequently about their experiences. For example, participants attested that mentions "in passing" would enable practitioners to keep references to lived experience "short, sweet", to give "the idea that you have gone through it, but it's not you talking about yourself". Brevity of practitioner sharing was a significant concern for participants.

Ensuring Relevance. Perceived changes in the subject of the session were also anticipated to occur in instances where practitioners referred to lived experiences not directly relevant to the consumer. When a practitioner is seen to be doing this, participants anticipated feeling as though the practitioner is "not really listening to them." Furthermore, several participants indicated an increased appreciation for lived experience disclosures regarding the mental illness "that's specifically relevant" to them. Participants felt that irrelevant or unnatural disclosure of lived experience, "would cross the bounds of professionalism'. Participants communicated the need for any sharing of lived experience to have clear value for the consumer.

Enabling Informed Consent

A pivotal aspect of professionalism in the therapeutic context is informed consent. Participants expressed two primary approaches that practitioners could adopt to enable informed consent when sharing lived experience: waiting for an invitation to share and including lived experience in the practitioner's biography (bio).

Waiting for an Invitation to Share. Participants suggested that practitioners mention that they have lived experience on a particular matter and offer to share this further, "inviting" the consumer to either accept or decline this offer. In doing so, consumers are empowered to determine the session's direction and what they are comfortable discussing with their therapist. For example, one participant expressed "it's important for the mental health practitioner to ask permission before disclosing". This was also suggested to decrease the likelihood of accidentally "triggering" the consumer.

Including Lived Experience in Biography. Participants suggested that lived experience practitioners could use their bio to communicate their background, including lived experience, avoiding potentially risky and uncomfortable in-session disclosure. While including a particular diagnosis was advised against, many participants indicated that disclosure of practitioner lived experience or “interests” in a bio (e.g., as is common practice for general practitioners) would empower consumers in choosing a psychologist or psychiatrist.

Managing Practitioner Wellbeing

The wellbeing of practitioners was also considered an important aspect of practitioner disclosure of lived experience. Participants felt that disclosure would only be valuable for the consumer if it was manageable for the practitioner. Recommended approaches to ensure practitioner wellbeing included setting boundaries to prevent burnout and seeking support.

Preventing Burnout and Setting Boundaries. Participants flagged the importance of practitioners setting boundaries around self-disclosure. Frequently conveyed was the assertion that utilising lived experience can be “quite exhausting”. Participants believed that when lived experience practitioners reached such a point of burnout, their illness may be exacerbated, thus negatively impacting consumers because “mental illness tends to limit our emotional availability for others when not looking out for ourselves.” Participants encouraged practitioners in this position to consider how they can share to the benefit of the consumer without putting themselves in a vulnerable position and urged practitioners to set boundaries consistent with this.

Seeking Support. Participants acknowledged potential challenges for lived experience practitioners, including discrimination from non-lived experience colleagues. However, instead of causing tension, participants believed that these disparities would provide a valuable peer-to-peer learning experience. Just as other medical practitioners work collaboratively with illness diagnosis and treatment, one participant recommended that “if you come across a scenario that you think ‘oh I’m out of my depth here – I don't have any experience', you've got a network of people that you can go to that can help". In this sense, practitioner lived experience can become a shared resource.

Discussion

The aim of this study was to qualitatively explore consumer attitudes towards mental health practitioners (i.e., psychologists and psychiatrists) with lived experience. There is growing pressure to improve consumer collaboration in the Australian mental health context (Butler, 2023). However, little investigation of consumer perspectives regarding the use and disclosure of practitioner lived experience has occurred. Thirty-four participants shared their perspectives either through a semi-structured interview or an online survey, leading to the development of three themes that embodied their considerations: The Working Alliance, The Healed Healer, and Sharing Lived Experience and Negotiating Professionalism. The latter was further divided into approaches for preserving consumer voices, enabling informed consent, and managing practitioner wellbeing. Consequently, this study identified several key findings, including consumers' positive regard for practitioner lived experience, lived experience as a means of strengthening the working alliance, and the delineation of instances in which lived experience disclosure is favourable.

Lived Experience as a Resource

Participants generally regarded practitioner lived experience as a resource which could be leveraged in practice. Practitioner lived experience was considered to improve relatability, consumers' willingness to open-up, and normalised their experiences. Albeit novel, this study's discovery of positive consumer attitudes towards psychologist and psychiatrist lived experience is somewhat unsurprising given consumers' high regard for peer workers (Francia et al., 2023) and the beneficial outcomes experienced by consumers who engage with them (Shalaby & Agyapong, 2020). Contrary to the positive consumer attitudes identified in this study, lived experience practitioners indicate a high prevalence of self-stigmatisation and reluctance to disclose experiences (King, Roennfeldt, et al., 2023). While a small minority of lived experience practitioners speak to the positive impact of their experience in their practice, many express fear of being judged by both colleagues and consumers as unstable, incompetent, or dangerous (King, Roennfeldt, et al., 2023). Therefore, a primary finding of this study is that lived experience practitioners' negative self-perceptions are largely unsupported by consumer attitudes towards lived experience; instead, many participants indicated a *preference* for seeing a practitioner with lived experience.

Lived Experience, Social Identification, and the Working Alliance

Participants predominantly valued lived experience due to its anticipated positive impact on the working alliance (see Theme A: The Working Alliance). The association between lived experience and the working alliance has only recently been explored (King, Brophy, et al., 2023; Wasil et al., 2019), and largely in the peer worker context (Francia et al., 2023). However, an understanding of the means through which lived experience impacts the working alliance is yet to be established, where the findings of this study provide novel theoretical implications for the use of social identity theory to understand the consumer and practitioner relationship.

Participants emphasised that knowledge of practitioner lived experience would enhance relatability to the practitioner and provide a sense of mutual understanding, given they have been or currently are a mental health consumer themself. In this sense, the shared experience of mental illness facilitated perceived collective group membership and identification with practitioners as also 'mental health consumers'. Some prior investigation of group memberships in explaining the working alliance has focused on shared sociological characteristics, such as demographics, which explained no more than 3% of working alliance variance (Cruwys et al., 2023). However, the shared identity of mental health consumers may be better conceptualised and researched as a psychological group than a sociological group

(Rüsch et al., 2009), which aligns with prior definitions (Haslam et al., 2020; Platow et al., 2015). Furthermore, research has found that the value of lived experience disclosure increases when the consumer and practitioner share an identity aspect, or psychological group membership, such as religious or sexual orientation (Dunlop et al., 2022). Perhaps participants' positive view of practitioner lived experience's impact on the working alliance can at least in part be attributed to identification with their practitioner through shared membership in the psychological group of 'mental health consumer'.

Prior literature has compelled practitioners to emphasise shared psychological ingroup credentials to foster social identification and hence strengthen the working alliance (Haslam et al., 2020; Lee et al., 2021). Thus, when the shared psychological group membership of mental health consumer is made salient in the clinical context – e.g., through practitioners' disclosure of lived experience – consumers may experience identification with the practitioner, thus strengthening the working alliance, and improving therapeutic outcomes. This anticipated experience of ingroup identification provides one possible explanation for participants' emphasis on the role of lived experience in enhancing the working alliance. This study uniquely leveraged the social identity framework to explore consumers' identification of lived experience as a resource in strengthening the working alliance, presenting novel theoretical implications for social identity conceptualisations of this relationship.

Approaches to Disclosing Lived Experience that Support the Working Alliance

Participants expressed nuanced views regarding the circumstances under which the disclosure of lived experience would be most valuable. These included when the practitioner was considered to be recovered (see Theme B: 'The Healed Healer) and perceived to adopt a suitable approach to sharing (see Theme C: Sharing Lived Experience and Negotiating Professionalism). A key contribution of this study was the delineation of instances in which practitioner disclosure of lived experience may either undermine or enhance the working alliance. Indeed findings are reflected in the consumer literature, where, for example, peer workers' lived experience strengthens the therapeutic alliance through building trust, credibility and hope (Francia et al., 2023). However, these positive outcomes would be undermined if consumers do not feel heard (Lee et al., 2023), or perceive practitioners to still be in the throes of mental illness.

Understandably, participants wanted to feel heard by their practitioner, where the approach to lived experience disclosure would determine its impact on the working alliance. Perhaps this can at least in part be explained by the social identity literature, which expresses the importance of consumers being afforded voice, which predicts both social identification and identity leadership, accounting for over half of working alliance variance (Lee et al., 2023). Thus, where the provision of voice is undermined by practitioner disclosure, one can foresee negative impacts on the practitioner's ability to facilitate social identification and identity leadership.

Practitioner recovery also influenced participant attitudes towards lived experience, where recovered practitioners were viewed more favourably, considered more inspiring, and seen to be more capable at generating hope in consumers. This finding resonates with evidence supporting the effectiveness of connecting with others in therapy and speaks to the success of consumer-led mental health interventions (Robertson et al., 2023b). Further, meta-analysis finds leaders who embody "who we want to be" (i.e., recovered) as opposed to "who we are" (i.e., mental illness sufferer) can be particularly effective in gaining followership (i.e., aspirational prototypicality; Steffens et al., 2018). In the clinical context, research finds that group facilitators for a body acceptance intervention who were perceived by attendees to be more aspirational on mental illness-related behaviours, such as less frequent dieting, achieved a greater reduction in group member approval of dieting (Robertson et al., 2023a). This study's findings suggest that practitioners who embody consumers' aspired identity as a recovered or “high functioning” person with experience of a mental illness may see particularly beneficial outcomes following lived experience disclosure.

Limitations

The present study has limitations that should be considered alongside its findings. Specifically, areas for improvement have been identified concerning the transferability of findings, exclusive practitioner cohort, and standardisation of mental illness.

Firstly, in qualitative research the term transferability describes the extent to which a study’s findings are relevant in other contexts (Kisely & Kendall, 2011; Smith, 2018). While this study identified a wide range of attitudes towards practitioner lived experience, findings may not be applicable to all consumer populations in Australia or abroad. Further, while qualitative research discourages actively seeking individuals to create a false distribution of participant characteristics (Braun & Clarke, 2006; Carl, 1999), the present study’s participants were largely aged between 18 and 35 and identified as female. While this may broadly reflect Australian consumer demographics (Australian Bureau of Statistics, 2023), this study did not include a wide range of ages or varied gender identifications. Thus, the perspectives of consumers in this study are not assumed to represent all consumers; these expectations can be disempowering and limit consumer engagement (Scholz et al., 2019).

Secondly, this study sought to explore consumer attitudes towards lived experience psychologists and psychiatrists. In Australia, there are several barriers to accessing mental health support from these professions, including limited practitioners and therefore appointments, obstacles to obtaining a referral from a general practitioner, and high financial expenses not met by government subsidies (Davey, 2021) – hurdles that were often mentioned by participants. As a result, consumer perspectives in this study only reflect those of individuals able to access the services of a psychologist or psychiatrist. Furthermore, all participants voluntarily sought mental health support from a practitioner, so therefore may have less stigmatised attitudes towards practitioner lived experience than individuals from the general population who have chosen not to seek support or those consumers who have not freely chosen to access care; for example, have been compelled by a parent or guardian, or are required to access psychological services to attain government assistance (Services Australia, 2023).

Finally, mental illness is not homogenous. Notably, one participant in the present study that disclosed prior experience with an eating disorder demonstrated unique attitudes towards practitioner lived experience, including fears that comparison may undermine the therapeutic alliance and limit their willingness to be honest and vulnerable. Furthermore, some mental illnesses are more stigmatised than others (e.g., schizophrenia; Hengartner et al., 2013), and may therefore illicit different attitudes from consumers upon disclosure. This study aimed to include a variety of perspectives that are often underrepresented through reducing barriers to participation; for example, broad inclusion criteria that did not require the formal diagnosis of a mental illness and multiple options for participation (i.e., anonymous online survey, in-person interview, or online interview). However, in determining the value of this study, one should note that this approach minimises the ability to determine the perspectives towards lived experience that are unique to particular mental illnesses and the individuals that experience them.

Implications for Policy and Practice

At the policy level, where consumer involvement in decision-making is obligated across the mental health system (Scholz et al., 2019), this study suggests that policymakers consider the potential role of lived experience practitioners. Lived experience practitioners are familiar with the medical model and organisational structures, and so may not face the same barriers to integration experienced by peer workers (Vandewalle et al., 2016). Given the positive attitudes of this study’s participants towards practitioner lived experience, policymakers should explore the inclusion of lived experience practitioners as an additional avenue for amplifying consumer voices in mental health service research, design, delivery, and evaluation.

At the organisational level, positive attitudes towards practitioner lived experience identified in this study urge an increased recognition of lived experience across the mental health workforce. Strategies to demonstrate organisational support for practitioner lived experience include establishing human resources policies that reflect the existence of lived experience practitioners, providing opportunities for staff to share these experiences, and consultatively reviewing and updating guidelines regarding self-disclosure (King, Brophy, et al., 2023). Supervisors should be encouraged to support lived experience practitioners, where the choice to disclose (or not disclose) is respected. Mental health organisations could consider undertaking whole-of-workforce training that addresses the unique role and expertise of lived experience workforces (King, Brophy, et al., 2023). Opportunities for team reflection, discourse, and mutual engagement between lived and non-lived experience practitioners should be taken where possible and appropriate (King, Brophy, et al., 2023), particularly given evidence of practitioner-self stigmatisation and lived experience-related taboo (King, 2023). Furthermore, organisations may use these opportunities to explore how lived experience practitioners may already be utilising or disclosing experiences in the organisation, as well as discuss the challenges with and approaches to integrating the identities of both consumer and practitioner (Cleary & Armour, 2022). Ultimately, given the positive consumer attitudes towards practitioner lived experience identified in this study, there must be a greater effort at the organisational level to *at minimum* acknowledge the presence of practitioner lived experience and recognise its value.

For practitioners, this study challenges the self-stigmatisation of mental illnesses common amongst lived experience practitioners (King, Brophy, et al., 2023), finding that consumers often prefer practitioners with lived experience. Practitioners should consider their positionality towards the role of lived experience in the workplace, be it their own experiences or their colleagues'. Further, practitioners are reminded of the importance of dynamic and reactive psychological practice that is conscious of consumer cues (Hill et al., 1988; Marie-Thérèse & Claude, 2009); a one-size-fits-all approach to treating mental illness is unlikely to produce desirable outcomes, particularly given varying consumer preferences regarding the disclosure of lived experience found in this study. The choice to disclose lived experience should be founded upon the practitioners' comfort in doing so, alongside an educated assessment of how valuable disclosure may be for that consumer. The findings of this study offer some initial guidance for practitioners when disclosing lived experience, as conveyed by consumers themselves (see Table 2).

Future Research Directions

As the use of practitioner lived experience in mental health settings is still an understudied phenomenon, there are several directions for future research.

Firstly, additional qualitative analysis of consumer attitudes towards lived experience is necessary. Potential areas of focus could include whether attitudes vary between mental illness diagnoses, which each present unique symptoms and harbour differing levels of stigmatisation (Hengartner et al., 2013). Attitudes regarding lived experience may differ amongst consumers, but could also vary in relation to the illness of the practitioner; that is, do consumers regard practitioners with experience of any type of mental illness favourably, or are experiences with certain mental illnesses more polarising? Further research should seek to clarify differences in consumer attitudes. Also warranting further qualitative investigation is the complex identity negotiation experienced by consumer-practitioners (Cleary & Armour, 2022). If practitioner lived experience is to be meaningfully harnessed in clinical contexts, further understanding as to how these dual identities can be navigated in practice is required.

Secondly, quantitative investigation of the influence of lived experience on social identification and working alliance would substantiate findings of the present paper. To the researcher’s knowledge, this study was the first to recognise practitioner lived experience as a means to engender social identification and thus strengthen the working alliance. While prior approaches to understanding the working alliance have emphasised the importance of the duration and course of therapy (Ardito & Rabellino, 2011) and practitioner characteristics such as warmth (Castonguay et al., 2006) in determining working alliance, further research is needed to determine the contributions of identity aspects. In the social identity literature, there has been a call to further explore practitioner strategies perceived by consumers to successfully foster the working alliance (Cruwys et al., 2023), where this study recommends that future investigation of this relationship via social identity frameworks consider practitioner lived experience. Additionally, while some participants in the present study had previous exposure to the disclosure of lived experience, most were considering this in hypothetical terms. Future research may seek to test responses to the sharing of lived experience in a “real life”, clinical context.

Finally, as some participants in this small study did indicate previous experience with practitioner disclosure, there are likely many lived experience practitioners already sharing their experiences with consumers here in Australia. Prior literature suggests that as much as 90% of practitioners have disclosed some form of lived experience to consumers (Henretty & Levitt, 2009; Pope et al., 1987). However, there is currently very little guidance for such practitioners as to how experiences can be shared in a safe and valuable way. Many practitioners consider the ethical principles regarding self-disclosure to be ambiguous and receive little direction on how lived experience can be used in practice (Dunlop et al., 2022). Clarification regarding disclosure expectations and related supports is particularly pertinent given participants’ concerns regarding lived experience practitioner burnout and lacking support from peers (see Theme C: Sharing Lived Experience and Negotiating Professionalism, approach ‘Managing Practitioner Wellbeing). Future research should investigate the disclosure approaches currently being employed by lived experience practitioners and the impact of such strategies on the consumer. Social identity and identity leadership literature on the working alliance has recommended some practitioner approaches to strengthening the working alliance, such as emphasising shared goals and values, framing goal achievement as a mutual effort, focusing on collaboration with consumers, and adopting inclusive language in clinical sessions (Cruwys et al., 2023; Lee et al., 2023). However, practitioner lived experience has not yet been considered. Given participants emphasised that the disclosure approach adopted by the practitioner would largely determine attitudes towards lived experience, it seems likely that certain disclosure strategies may be more favourable than others. For example, this study found that voice preservation and speaking from a place of recovery were preferred when disclosing lived experience. Per Robertson et al. (2023b), future research should seek to clarify the conditions under which the disclosure of lived experience hinders or supports the working alliance.

Conclusion

This study found that consumers positively regard practitioner lived experience, particularly for its anticipated adaptive impact on the working alliance. Several approaches to sharing of lived experience were outlined by consumers, with practitioner recovery and the preservation of consumer voices largely determining the value of disclosure. Participant attitudes are consistent with findings in the consumer and social identity literature of the working alliance and provide important implications for policymakers, organisations, and practitioners. While this study provides a novel application of social identity perspectives in conceptualising the impact of lived experience on the working alliance, further research is needed to establish the significance of this identity aspect on the therapeutic relationship.

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Appendix A

Demographic Information

Participant No.	Method of Inquiry	Age	Gender	Experience in Mental Health Sector
1	Interview	18-35	Female	No
2	Interview	18-35	Female	Yes – Research assistant in youth suicide prevention and General Psychologist*
3	Interview	18-35	Male	No
4	Interview	18-35	Female	Yes – Worked in a hospital nutrition department*
5	Interview	18-35	Female	Yes – Volunteer with a youth mental health charity*
6	Interview	55-70	Male	Yes – Worked in hospitals for 38 years, including being Principle Scientist of Pathology*
7	Interview	18-35	Male	No
8	Interview	35-55	Male	No
9	Interview	35-55	Female	Yes – Volunteers as aged care facilities*
10	Interview	18-35	Female	Yes – Disability support worker and psychology student*

11	Survey	18-35	Female	No
12	Survey	18-35	Male	No
13	Survey	18-35	Female	No
14	Survey	18-35	Female	Yes – intake work at mental health clinic
15	Survey	18-35	Female	Yes – worked at a non for profit AOD [alcohol and other drug] rehabilitation residence
16	Survey	18-35	Male	No response
17	Survey	18-35	Female	No
18	Survey	18-35	Female	No
19	Survey	18-35	Female	Yes – volunteer manager at a mental health charity and project officer at state government working in mental health
20	Survey	18-35	Female	Yes – registered Psychologist in a private practice
21	Survey	18-35	Female	Yes – community health peer support volunteer, volunteer psychosocial educator in schools, volunteer at suicide helpline*
22	Survey	18-35	Female	No
23	Survey	18-35	Male	No

24	Survey	18-35	Female	Yes - social worker
25	Survey	18-35	Female	No
26	Survey	18-35	Male	No response
27	Survey	55-70	Female	Yes – as a consumer consultant, manager, educator, and researcher
28	Survey	18-35	Male	No
29	Survey	18-35	Female	No
30	Survey	18-35	Female	No
31	Survey	18-35	Female	Yes – I am a psychology student at university
32	Survey	18-35	Female	No
33	Survey	18-35	Female	No
34	Survey	18-35	Female	No response

Note. Those participants (N = 3) who left their response to the work in the mental health sector blank, were marked as ‘No response’. Where practical, work experiences in the mental health sector are provided verbatim. Summarised responses are marked with an asterisk (*). Participants who did not answer beyond demographic questions were automatically excluded. Participants (N = 1) who answered beyond demographics but not past question seven were excluded as incomplete.

Appendix B

Recruitment Flyer

The ethical aspects of this research have been approved by the ANU Human Research Ethics Committee (Protocol 2023/174)

Study Participation

HOW DO YOU FEEL ABOUT SEEING PSYCHOLOGISTS/PSYCHIATRISTS WITH PERSONAL EXPERIENCE OF MENTAL ILLNESS?

Hi! My name is Lillian and I am conducting research at the Australian National University about mental health consumer perspectives towards practitioners with lived experience. I would love to hear your thoughts and invite you to participate in this qualitative exploration.

Participants may choose to either complete a brief online survey or reach out to schedule an interview (online or in-person).

Scan the QR code or visit the website below to learn more!

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Appendix C

Stages of Thematic Analysis

No.	Phase	Process of the Present Study
1	Data familiarisation	All responses were read through and transcribed (where necessary) prior to the generation of codes. Initial patterns identified in responses were noted.
2	Code generation	NVivo was used to generate and record codes for interesting features or consistencies recognised in the data.
3	Exploring themes	Codes were reviewed and collated where commonalities or possible emerging themes (i.e., underlying patterns of shared meaning) were found. Themes conveyed conceptual or "top-level" meaning.
4	Reviewing themes	Themes produced via coding were then iteratively checked, modified, merged, split, and/or discarded where relevant.
5	Refining, defining, and naming themes	Themes were gradually appraised and redefined to ensure internal consistency and external heterogeneity.
6	Generating the report	A narrative was constructed for themes, as supported by the careful selection of relevant data extracts to convey the nature of the theme in the current data, as related to existing literature and the current research question.

Note. Adapted from "Using thematic analysis in psychology" by V. Braun and V. Clarke, 2006, *Qualitative Research in Psychology, 3*(2), p. 87. Copyright 2006 by Taylor and Francis.

Appendix D

Audit Trail Excerpts

Interview Number	Reflections
1	• Asking follow-up questions is tricky! I'm intently listening but also thinking about what I should ask next. Having paper next to me was helpful to jot down my thoughts so I could just focus • Difficult not to talk yourself – and trying to leave space to encourage people to say a little more o Some answers were really interesting but instead of following up with more open-ended questions I kind of just shared my own thoughts • Interview was shorter than expected and we definitely had a good conversation so I might need to advertise it as taking less time
7	• Starting to feel a little emotionally exhausted from these interviews. I always leave them feeling amazing but going into it tonight I was just not in the mood after a long day myself. Doing only one per day is good • Getting better at interviewing each time! Was more determined to keep the conversation on-topic for this one but still asked expansive questions • Found myself bringing up my own lived experience to make the participant more comfortable o Honestly not really sure this is appropriate? I will check with Brett [supervisor], but this hilariously speaks to my whole concept
10	• This was the first time I interviewed someone after having started the coding process, which was really interesting. I think I'm going to have to be careful about not almost prompting or leading people to say things that align with the themes and patterns I'm identifying in existing responses o For this reason I think it's really good that I've predominantly left coding until the end of my data collection • I identified a couple of really core patterns that have been occurring in previous interviews during the conversation: I think there are kind of two main determinants of the way people regard practitioner lived experience: 1. The way in which it is shared

  - With a preference for brief mentions, offering and waiting for invitation from the consumer, and using a bio
2. Where they are at in their recovery
  - With a preference for "recovered" but an interesting conversation around what that looks like, noting mental illness and recovery is not really a linear a→b process.

Appendix E

Checklist for Good Thematic Analysis

Process	Criterion	Present Study
Transcription	1. The data have been transcribed to an appropriate level of detail and the transcripts have been checked for accuracy	Interviews were audio-recorded and transcribed shortly after their completion to increase the likelihood of accurate transcription. Surveys were imported to NVivo verbatim.
Coding	2. Each data item has been given equal attention in the coding process.	Data were analysed and coded line-by-line at least three times in NVivo.
	3. Themes have not been generated from a few vivid examples, but instead the coding process has been thorough, inclusive and comprehensive.	All data were considered equally, where themes were formulated from patterns of information across several transcripts and survey responses. Data for each theme are from multiple participants.
	4. All relevant extracts for each theme have been collated.	NVivo hosted every interview transcript and survey response, where themes formed ‘folders’ of data. A ‘quote library’ document was also generated to support conveying themes in the present paper.
	5. Themes have been checked against each other and back to the original data set.	Themes were iteratively checked to ensure their distinctiveness and relevance to the original data.
	6. Themes are internally coherent, consistent, and distinctive.	Themes were iteratively checked to ensure their internal homogeneity and external heterogeneity.

Analysis	7. Data have been analysed – interpreted, made sense of – rather than just paraphrased or described.	Codes were dynamically formulated (i.e., merged, expanded, reduced, deleted, renamed) to ensure the essence of patterns was captured.
	8. Analysis and data match each other – the extracts illustrate the analytic claims.	Extracts included in this paper were carefully selected to clearly demonstrate and map to analytical arguments.
	9. Analysis tells a convincing and well-organised story about the data and topic.	Themes were selected in relation to the literature and organised to enhance readers' understanding of their relevance to the theory.
	10. A good balance between analytic narrative and illustrative extracts is provided	Extracts varying in length were included to balance the illustration of themes and their concise analysis.
Overall	11. Enough time has been allocated to complete all phases of the analysis adequately, without rushing a phase or giving it a once-over lightly.	The period in which this research was conducted was heavily scheduled to ensure adequate time was allocated to each stage. Analysis (coding to reporting) was completed across approximately ten weeks to enable contemplation and revision.
Written report	12. The assumptions about TA are clearly explicated.	Refer to the Method's 'Data Analysis' section.
	13. There is a good fit between what you claim to do, and what you show you have done – i.e., described method and reported analysis are consistent.	The method section was carefully considered to ensure its accuracy in capturing the process of the present study. Inclusion of an Audit Trail and reflexivity examination elucidate the researcher's process.

14. The language and concepts used in the report are consistent with the epistemological position of the analysis.	Language and concepts are in line with the phenomenological and constructionist approach that broadly informed the present study (see Method's 'Design' section for more).
15. The researcher is positioned as *active* in the research process; themes do not just 'emerge'.	The position of the researcher is discussed in the Method's 'Researcher Reflexivity' section. The researcher's thoughts and theme development are shown in Audit Trail excerpts (see Appendix D).

Note. Adapted from "Using thematic analysis in psychology" by V. Braun and V. Clarke, 2006, *Qualitative Research in Psychology, 3*(2), p. 96.

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Appendix F

Thesis Completion Form

ANU School of Medicine and Psychology
Honours Milestone Completion Form

Student's Name: Lillian Starling Student's Number: U6674497

Milestone 1. Presentation of Research Proposal

This is to be completed in Semester 1 (Semester 2, for full-time mid-year-entry students) **prior** to the commencement of data collection. Typically, presentations should be made about three months after the start of the semester (i.e., April/May; or October/November, for full-time mid-year-entry students). This should be arranged with the student's supervisor.

Supervisor's Signature: ______ Date: 21/04/2023

Milestone 2. Mid-Course Progress Report

This must include a meeting with the Honours Convenor or their delegate(s) to discuss progress. This is due in June/July (or January/February, for full-time mid-year-entry students).

Supervisor's Signature: ______ Date: 10/08/2023

Milestone 3. Major Data Collection and Analyses Completed

One month prior to the submission of the thesis, both the supervisor and the student must sign off on the scope of all data collection and data analysis required for the completion of the thesis, indicating that they think the thesis is on track. If they think the thesis is not on track, this needs to be discussed with the Honours Convenor immediately and the reasons for the problems explained. Extensions to the thesis due date will only be given for delays caused by unforeseen factors outside of the student's control.

Supervisor's Signature: ______ Date: 01/08/2023

Student's Signature: Lillian Starling Date: 01/08/2023

Milestone 4. Thesis Draft Submitted to Supervisor and Feedback Returned by Supervisor

Two weeks prior to the submission of the thesis, both the supervisor and the student must confirm that the first draft of the thesis (excluding the Discussion section) has been submitted to the supervisor and has been returned to the student by the supervisor with comments.

Supervisor's Signature: ______ Date: 10/10/2023

Student's Signature: Lillian Starling Date: 10/10/2023

Appendix G

ANU Generative AI Declaration Form

ANU School of Medicine and Psychology
Editorial Services and Generative AI Declaration Form

Student's Name: Lillian Starling

Student's University Identification Number: U6674497

1. **Have you used paid editorial services?**

Please circle 'Yes' if you have or 'No' if you have not. **Yes / [✓ No]**

If *Yes*, please specify:

Which section(s) of your thesis received editorial services:

What kind of advice was provided by the editorial services:

☐ Substance and structure	**Yes / No**
☐ Language and illustration	**Yes / No**
☐ Completeness and consistency	**Yes / No**

2. **Have you used generative AI to help you with writing your thesis.**

Please circle 'Yes' if you have or 'No' if you have not. **Yes / [✓ No]**

If *Yes*, please specify:

The specific use of generative AI to help you with writing your thesis (e.g., editing your thesis, understanding certain concepts, generating text or images, etc.):

Note. In addition to this declaration, you should also cite the generative AI tool whenever you use the tool in the main body of your thesis. Please refer to the ANU Library Guide on Generative AI for more information.

Student's Signature: Lillian Starling Date: 23/10/23