

Who am I?

The identity crisis of mental health professionals living with mental illness

Abstract

There are growing numbers of mental health professionals with their own lived experience of mental illness. This is both in part due to increased visibility and openness, and students embarking on professional courses motivated by their own personal mental health history. The somewhat limited research in this area highlights the difficulty practitioners have in navigating this distinct identity. There are limited options, including a wounded healer, impaired professional and professional survivor. All have their limitations. We need to revise the conceptualisation of mental health professionals with personal lived experience of mental illness. Our identity needs to be celebrated and valued, as are the roles of peer support worker and expert by experience. Through personal reflection, I describe my own challenges in negotiating my identity as a mental health nurse, lecturer, and service user. My solution is to embrace authenticity, and to have courage to stand in in vulnerability and strength, embracing all aspects of myself. I call for others to do the same.

Relevance statement

Mental health professionals can have their own lived experience of mental illness. Research shows that navigating this unique and distinct identity can be challenging, both for students and professionals on the front line. When our different identities, or roles are seismically different, it poses a huge challenge to fully integrate all aspects ourselves. Professionals with personal lived experience of mental illness need to be valued within the mental health workforce and provided with the supervision and support to be their authentic true selves. I draw from my own experience of being simultaneously a mental health nurse and service user in attempts to forge a new identity for myself and others.

Accessible summary

What is known on the subject?

- Large numbers of mental health professionals live with their own mental health challenges.
- Despite working in mental health care, they can experience stigma in the workplace.
- Mental health professionals with lived experience of mental illness can find it a challenge to integrate their identities as both a mental health professional and mental health service user.

- There are currently limited options available to them.

What the paper adds to existing knowledge?

- This is a personal reflection from a mental health nurse and lecturer, who lives with a severe and enduring mental illness.
- It offers a lived experience account of the identity struggles of a mental health professional living with a mental illness.
- This article attempts to redefine the identity of professionals with personal lived experience in a more positive manner. They can be valued and celebrated for their unique perspective on mental illness and mental health care.

What are the implications for practice?

- There remains a stigma attached to people living with mental health conditions. This article challenges some of this stigma.
- It will empower and encourage other health professionals with lived experience to embrace all aspects of their identity with authenticity and courage.

Introduction

My life dramatically collided with mental illness seven years ago. I was a mental health nurse on maternity leave and virtually overnight became a mental health patient. I experienced a radical role reversal, going from privileged access to the staff office, to anxiously pacing the patients waiting room. This was the beginning of my life with mental illness, and the start of an uncomfortable identity crisis.

I am simultaneously a mental health nurse, lecturer, and service user. This brings unique challenges. Navigating and transitioning between these roles has, for a long time, caused internal conflict and tension. My identities as nurse, lecturer, and service user, often seem separate, distinct, and conflicting. They have been difficult to fully integrate, leading to feelings of duplicity, deception, and isolation. This prompts the emotive question I have asked myself frequently over the last seven years. Who am I, and where do I belong? The staff office or the patient's waiting room?

Nurse versus Patient

The archetypal concepts of 'nurse' and 'patient' have thankfully evolved over time. This traditional concept of a subordinate patient and all-knowing powerful nurse has advanced, however there remains a fundamental difference between the two. Often, they are

conceptualised as binary opposites, with little commonality. This is especially apparent within the medical model of psychiatry. The medical model empathises mental illness as a disease, and as such, something to recover *from*. Professionals are viewed as the 'expert' and beyond distress or illness. Therefore, a transition from a mental health professional to service user, or nurse to patient, is a radical role reversal (Richards et al., 2016).

According to Zamir et al., (2022) psychiatrists were less likely than psychologists to disclose lived experience of mental health problems in the workplace. This may be due to different training and contradictory conceptualisations of mental illness within the two professions. Psychiatry remains under the shadow of the medical model, desperately searching for biomarkers of disease. Psychology, however, has a variety of ways to conceptualise mental distress.

I have reflected on my own experiences of constructing and negotiating my identity both as a nurse and patient. My thoughts, feelings, and behaviours are markedly different depending on whether I am accessing or delivering mental health care. I subconsciously adopt conflicting roles of either power and knowledge (nurse), or submission and fear (patient).

As a mental health professional (before my own mental illness) I thought I was an approachable, friendly nurse. I valued service user

empowerment and considered myself an advocate for my patients. I had elements of these qualities, however upon reflection I was in fact deluded. I was almost completely oblivious to the massive power difference between myself and my service users. Seven years as a mental health patient has shown me how powerless and helpless it feels to be a service user. This is despite my 'dual identity' of nurse and patient.

This experience is sadly shared by other mental health professionals with lived experience. Richards et al., (2016) identified the 'patient' identity as powerless, having little rights or choices, and complying with the treatment directed by those in control – the 'professionals.' When I am accessing mental health care as a patient, I feel worthless and undeserving of care and compassion. All too frequently I am caught between the rhetoric of 'too complex' and 'not ill enough.' I adhere to medication plans, whilst enduring distressing side effects, through fear of being labelled as 'non-compliant.' I sit for hours in emotional turmoil, waiting for decisions on gatekeeping assessment. This is a dehumanising experience.

When I present to services needing support, I have also the internal dilemma of whether to admit my job role. Richards et al (2016) found professionals with lived experience spoke about hiding certain aspects of themselves in different contexts. They also revealed being pushed, or expected, to behave in certain ways in certain

environments. Often, I have found my identity as a nurse and lecturer, a hindrance when accessing care. Concealing my full identity leads to shame and internal conflict.

There are various reasons this could be. This first is based on internal shame. Self-stigma is evident across many studies of mental health professionals with lived experience. Participants report shame, embarrassment and seeing mental health problems as weakness (Zamir et al., 2022). Yet the title of registered mental health nurse does not make anyone immune to experiencing mental health challenges. I spent fifteen years as a nurse tackling stigma and shame, telling others that mental illness was nothing to be ashamed of and more common than we realise. Why did I find this so difficult to accept for myself?

I also debate revealing my job role, based on some of the responses I have received from services. Sadly, I am not alone in this experience. Current research demonstrates that stigma and discrimination are common in UK healthcare workplaces, and this impacts on decisions to disclose mental illness (Waugh et al., 2017). More recently, Zamir et al., (2022) found evidence of structural stigma within workplaces. The 'them and us' mentality sadly lingers on.

Identity is fluid and we continually reconstruct our identity based on the social context. When the identities, or conceptualisation, of

nurse and patient are so seismically different, it poses a huge challenge for someone to embrace both identities at the same time. Therefore, it is likely they will be forced to change their identity based on the context.

Wounded healer vs Impaired Professional

'only the wounded physician heals'

If the medical model does not allow us to conceptualise and navigate our identity, then maybe ancient Greek and psychotherapy can offer an alternative. The concept of a wounded healer dates to Greek mythology. It has a place in religion, philosophy and more recently in psychology and medicine. The wounded healer is an archetype, where healing power emerges from woundedness, struggles and pain. The wounded healer can transform their own pain and use it to heal others. A benefit of this ideology is that 'wounded' and 'healer' can both co-exist (Zerubavel & Wright, 2012). They do not have to be dichotomous. This has the potential to remove the conflict between the roles of 'nurse' and 'patient' that the medical model makes so difficult.

Unfortunately, the application of a wounded healer to mental health nursing is limited. Even the field of psychotherapy struggles with the concept of a wounded healer in practice. There is a judgement to be

made around when someone has healed themselves sufficiently enough to be able to practice effectively. Psychotherapists have similar concerns to other mental health professionals surrounding stigma, judgement, and competency to practice (Zerubavel & Wright, 2012). As with other health professionals this can lead to secrecy, shame, and self-stigma. A romanticised and idyllic image of pain turned into healing power is somewhat attractive. However, potentially elusive to a registered mental health nurse in charge of a busy acute ward.

A rather less attractive image of a mental health professional with lived experience is the 'impaired professional.' The impaired professional is seen as a liability and potential risk to service users and clinicians. As opposed to the wounded healer who draws positively on their experiences, the impaired professional draws negatively on their lived experiences and this has an adverse effect on therapeutic relationships and clinical practice.

Dunlop et al., (2022) report that the ethical guidelines around disclosure are ambiguous, and little training is offered on the use of sharing lived experience in clinical practice. Lovell et al., (2020) found that practitioners fear disclosure could even lead to disciplinary action from their employer or registering body. It is disappointing that evidence also suggests that healthcare

professionals view those with lived experience as a liability (Zamir et al., 2022).

Survivor versus Professional Survivor

I have an uncomfortable internal debate when contemplating deciding to 'admit' to service users that I am also a nurse. Stigma is not limited to the staff office. I have also had experiences when I have been ostracised and stigmatised by mental health service users. When I have admitted (after much reluctance and soul-searching) allegiance to the 'other camp,' I become somewhat of an impostor. Not a true service user. How can I be accepted by psychiatric survivor movements when I have spent twenty years being part of the 'problem?' Can I become a 'survivor' of the system I currently work in, and the workforce I educate?

This is sadly backed up by Adame (2011), who found mental health professionals experienced stigma and isolation when disclosing their 'professional' identity to psychiatric survivors. They were not seen as 'real' service users or survivors. 'Professional survivors,' can feel rejected by both professionals, *and* survivors. This is again evidence for the roles being in complete opposition with each other. This reinforces and perpetuates the 'them and us' dynamic and mentality. For me, this was perhaps the most difficult rejection to endure. After years of struggling with mental illness I wanted to belong. I wanted a

peer group who understood the relentless battle of illness. I wanted to be accepted. Yet I felt rejection, because when I 'admitted' to also being a nurse, I felt a subtle shift in compassion and empathy.

Paradoxically this was the same subtle shift I felt when I discussed my mental health challenges with fellow professionals in the staff office.

I can be either nurse, or patient. Survivor, or part of the problem. Not both. Consequently, I don't entirely belong anywhere because I am unable to be fully authentic. My identities seem to be at odds with each other. When you are both mental health nurse and patient you risk isolating yourself with either group when you admit to belonging to both. This makes it a very difficult task negotiating your own mental health care and career. The two sadly do not easily coexist. These experiences lead me to believe that I do not belong anywhere.

Expert by Experience versus Expert by Training

With the emergence of peer support roles, lived experience is finally being recognised as valuable within NHS mental health services.

Peer support workers are employed based on having personal lived experience of mental illness. They are provided with training, support, and supervision to fulfil their role of sharing their lived experience. They are given explicit permission to disclose their own

mental health experiences, and this is formalised as a core competency of the role (Health Education England, 2020).

Unlike peer support workers who are employed to discuss their own experiences, professionals with lived experience can harbour a fear of being 'unprofessional' if they discuss their lived experience with service users. Self-disclosure can even be seen as a violation of professional values and codes of conduct (Lovell et al., 2020).

However, after reviewing 20 main codes of practice, including the NMC Code (2018), Lovell et al (2020) confirmed that self-disclosure was not forbidden in any guidelines. However, unlike peer support workers, professionals with lived experience do not receive training on how to use their lived experience in clinical practice. Lovell et al (2020) argues that this discourages self-disclosure from an organisational standpoint.

Alongside the development of the peer support role has been the 'expert by experience' input in service development. Again, this demonstrates the value of lived experience. Alongside the peer support roles, this involvement in the creation of policy and services is much welcomed and long overdue.

Experts by experience, and peer support workers are however, often distinctly separate from the role of health professionals. This subtly empathises the differing roles. None the less I have personally found

peer support workers as definite allies to professionals with lived experience. We share a narrative of lives impacted by mental illness. There is power in uniting as people living with mental illness and working in mental health care. It is amongst peer support workers that I have felt a moving sense of belonging and acceptance.

Systemic change

More people motivated by their own mental health lived experience, are aspiring to become mental health professionals. In my role as mental health nurse lecturer, I will always be a staunch advocate of recruiting and nurturing students with their own lived experience of mental illness. More research is needed on the specific support that these students require on a pre-registration programme.

There is a crucial role for mental health services and academic institutions. When we work and access care in a system with limited ability to acknowledge and recognise our unique skills and perspective, we will always struggle. Living with a mental illness and working as a mental health nurse requires different support and supervision which should be offered by academic institutions and mental health employers. At the core of this should be an acceptance and value placed on someone's lived experience, whether they talk directly about this in practice or not.

Dunlop et al., (2022) provides a framework for professionals when considering the self-disclosure of lived experience. This is something that should be incorporated into training for professionals and student nurses with lived experience. It has been beyond the scope of this paper to discuss the nuances and emotional intelligence involved in boundaries and self-disclosure. Oates et al., (2017) found negotiating boundaries came with years of mental health nursing experience. This demonstrates the complexities we are faced with.

The future and a positive identity

A reconstruction of the identity and value of mental health professionals with lived experience of mental illness is desperately needed. We have value. We have something different to offer. Research around mental health professionals with lived experience often focuses on the negative aspects. Zamir et al., (2022) identified that researchers generally did not specifically look for positive experiences of sharing lived experience. Therefore, there is a risk that stigma in the literature may be perpetuated due to researcher bias.

There are benefits to being a nurse with lived experience of mental illness. This needs to be celebrated in front line nursing practice and academic writing. My personal experiences of accessing mental health care changed me as a nurse. It did not make me a 'better'

nurse than someone without lived experiences, but it did profoundly impact my nursing practice.

I won't undervalue the importance of hope, compassion and human connection. Littered between my trauma of accessing care, are moments of hope, care and compassion. I will never underestimate the impact of living with and loving someone with a mental illness. Families and loved ones need far more credit and understanding than they are often given.

My perspectives on recovery have dramatically altered. Recovery is not an idyllic destination where mental illness is banished. Recovery is not glamorous or exciting. It is chaotic and complicated and filled with tears and frustration as I try and work out the best way to live my life with mental illness.

Personally, I have found many benefits in sharing my personal experiences of mental illness. However, I am aware these currently take place within the somewhat protected world of academia. Disclosures on the 'front line' of mental health services carry higher risk. I have nothing but admiration and respect for my colleagues who navigate their lived experience whilst working in secondary mental health services.

A new identity, a call for authenticity

If we believe we cannot effectively be both mental health professional and patient, at the same time, it removes our authenticity. When authenticity is removed it creates shame and fear. When there are two distinctly separate identities, it removes everything in between. It hides the real us. Our authentic self. My authentic self is a mental health nurse and lecturer, who lives with ongoing mental health challenges.

When we look for evidence that we don't belong we will always find it. When we attach belonging to an external group, whether that be nurse, service user, wounded healer, survivor, professional survivor, or lecturer, we will always fall short. Belonging begins with ourselves. Who I am is built upon a firm foundation and belief that I am enough. I am a whole person.

This is authenticity. This is personal acceptance. We must be prepared to stand alone, in vulnerability and strength. In what feels to be an enormous chasm between where nurse ends, and patient begins. With the self-acceptance and emotional integrity to embrace all aspects of ourselves as one complete person.

In my attempts to navigate the juxtaposition of nurse and service user it will always return to authenticity. We are all just people, trying muddle our way through life. We all navigate stress and vulnerability daily, despite any job role or diagnosis. We will all

struggle with our mental and emotional health at some point in our lives.

There is no archetypal nurse or patient. Patient is not an anthesis to nurse. I can use my wounds to help others without becoming a liability. The psychiatric survivor and professional survivor can both be celebrated for their rich and diverse experiences. There is no them and us. There are just people.

When we are forced into a role or identity, whether that be by ourselves, society, or mental health services, we will always be disingenuous. I am prepared to stand alone with vulnerability and strength and invite others to as well. I call for other professionals with lived experience of mental illness to also embrace authenticity.

Who am I? That is found within me, not by any role or label. I am more than a nurse. I am more than a mental health patient. I am more than a psychiatric survivor.

I am. And that is enough.

References

- Dunlop, B. J., Woods, B., Lovell, J., O'Connell, A., Rawcliffe-Foo, S., & Hinsby, K. (2022). Sharing lived experiences framework (SLEF): A framework for mental health practitioners when making disclosure decisions. *Journal of Social Work Practice, 36*(1), 25-39. <https://doi.org/10.1080/02650533.2021.1922367>
- Elliott, M., & Ragsdale, J. M. (2020). Mental health professionals with mental illnesses: A qualitative interview study. *American Journal of Orthopsychiatry; Am J Orthopsychiatry, 90*(6), 677-686. <https://doi.org/10.1037/ort0000499>
- Holttum, S. (2017). Research watch: Is social inclusion for service users increased when mental health professionals “come out” as service users? *Mental Health and Social Inclusion, 21*(2), 73-79. <https://doi.org/10.1108/MHSI-02-2017-0006>
- Oates, J., Drey, N., & Jones, J. (2017). ‘Your experiences were your tools’. how personal experience of mental health problems informs mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing; J Psychiatr Ment Health Nurs, 24*(7), 471-479. <https://doi.org/10.1111/jpm.12376>
- Richards, J., Holttum, S., & Springham, N. (2016). How do “Mental health professionals” who are also or have been “Mental health service users” construct their identities? *SAGE Open, 6*(1), 215824401562134. <https://doi.org/10.1177/2158244015621348>
- Waugh, W., Lethem, C., Sherring, S., & Henderson, C. (2017). Exploring experiences of and attitudes towards mental illness and disclosure amongst health care professionals: A qualitative study. *Journal of Mental Health (Abingdon, England); J Ment Health, 26*(5), 457-463. <https://doi.org/10.1080/09638237.2017.1322184>
- Zamir, A., Tickle, A., & Sabin-Farrell, R. (2022). A systematic review of the evidence relating to disclosure of psychological distress by mental health professionals within the

workplace. *Journal of Clinical Psychology; J Clin Psychol*, 78(9), 1712-1738. <https://doi.org/10.1002/jclp.23339>

Zerubavel, N., & Wright, M. O. (2012). The dilemma of the wounded healer. *Psychotherapy (Chicago, Ill.); Psychotherapy (Chic)*, 49(4), 482-491. <https://doi.org/10.1037/a0027824>