Exploring the Workplace Experiences of Mental Health Staff Diagnosed with Borderline or Emotionally Unstable Personality Disorder: An Interpretative Phenomenological Analysis

Word Count: 32283

(Excluding: Title page, acknowledgements, contents pages, abstract, tables, figures, references and appendices)

Eleanor Louise Idowu

August 2026

Portfolio Volume 1: Major Research Project

Submitted to the University of Hertfordshire in partial fulfilment of the degree of Doctorate in Clinical Psychology

Acknowledgements

To my participants,

I would like to extend my sincere thanks to the nine participants who took part in this study. Thank you for trusting me with your unique stories and experiences. It was a privilege to hear and learn from your accounts and I am grateful to have met each of you during this process. Your openness, enthusiasm and support for this research have been invaluable. This project simply would not have been possible without you.

To my supervisory and consulting team,

Natalie, Gen and Georgie – Thank you for supporting the development of this project through your guidance, expertise, feedback and encouragement. Each of your contributions has helped to shape this research in countless ways and has been essential in helping me navigate the challenges encountered throughout the process. I am greatly appreciative of your investment in both this work and my development as a researcher, as well as the solidarity and support you have shown throughout.

To Jen,

Thank you for seeing the best in me from the very start to the end of my DClinPsy journey - from my interview to now. I feel incredibly fortunate to have had your support throughout this chapter. I will always be thankful for the patience, kindness, warmth and guidance you have shown me over the last 3 years. Thank you for believing in me.

To my family and friends,

I doubt I could have reached this point without you. For those of you who have been there in the years before and during DClinPsy, you have been there through it all and I am so grateful. Thank you all for the love, encouragement, fun and distraction that has helped to prop me up throughout. It has meant so much to have had you be so invested in my journey and cheer me on over the years. To the new friends I have met on the course, I am so glad our paths have crossed, who knows what this experience would have been like without you. Thank you all for being there through the highs and lows of training.

And finally,

Thank you to each version of myself that has led me to this point.

Table of Contents

Abstract **15**

1.0. Introduction **17**

1.1. Overview 17

1.2. Language and Terminology 17

1.3. Situating the Researcher 21

1.3.1. Insider Research Position *21*

1.3.2. Ontological Position *23*

1.3.3. Epistemological Position *23*

1.4. Previous Literature on the Lived Experience of Mental Health Difficulties Amongst Mental Health Staff 24

1.5. Policies and Initiatives Towards Embracing Lived Experience of Mental Health Difficulties in the Mental Health Workforce 26

1.6. The Value of Lived Experience within the Mental Health Workforce 28

1.7. Previous Literature on Mental Health Staff Experiences of Sharing Mental Health Difficulties with Colleagues in the Workplace 29

2.0. A Systematic Literature Review of the Experiences of Mental Health Staff in Relation to Sharing Mental Health Difficulties with Colleagues in the Workplace **32**

2.1. Overview 32

2.2. Rationale and Objective of the Current Review 32

2.3. Research Question and Aims....33

2.3. Methodology 34

2.3.1. Protocol Registration and Quality Assurance 34

2.3.2. Eligibility Criteria....34

2.3.3. Search Strategy 39

2.3.4. Information Sources and final search terms 40

Information sources used to access published papers. 40

Information sources for grey literature retrieval. 40

2.3.5. Data exportation, screening and study selection 42

2.3.6. Data Extraction....47

2.3.7. Study Characteristics 47

2.3.8. Critical Evaluation of Papers 55

2.3.9. Stages of Thematic Synthesis 55

2.4. Review Findings....57

Analytical Theme 1: Sharing as a Complex Decision-Making Process Characterised by Weighing Potential Benefits and Risks 59

Analytical Theme 2: Shame, stigma and acceptability of distress in the mental health profession 62

Analytical Theme 3 - Navigating dual identity – the interaction of the 'personal' and 'professional' self....67

Analytical Theme 4 - The quality of sharing experiences....71

Analytical Theme 5 - Workplace culture and opportunity for change 77

2.5. SLR Discussion 80

2.5.1. Overview *80*

2.5.2. Summary of Main Findings *80*

2.5.3. Positioning the Findings Within the Broader Literature *82*

2.5.4. Strengths and Limitations *84*

2.5.5. Future Implications and Suggestions for Further Research *86*

2.5.6. Review Findings Informing the Present Study *87*

3.0. Empirical Study - Exploring the Workplace Experiences of Mental Health Staff Diagnosed with Borderline or Emotionally Unstable Personality Disorder: An Interpretative Phenomenological Analysis 89

3.1. Overview 89

3.2. Emotionally Unstable Personality Disorder (also known as Borderline Personality Disorder) 89

3.3. Differing perspectives towards the EUPD diagnosis 91

3.4. Pre-existing Literature on Mental Health Staff Who Have Been Diagnosed with EUPD 92

3.5. Rationale, Aims and Research Question of The Present Study 93

Research Aim *94*

Research Question *94*

4.0. Methodology 95

4.1. Overview 95

4.2. Methodological Approach 95

4.2.1. Rationale for Qualitative Method of Study *95*

4.2.2. An Introduction to Interpretive Phenomenological Analysis (IPA) *95*

4.2.3. The Suitability of IPA Compared with Alternative Approaches *96*

4.2.4. Decolonising values within IPA *97*

4.2.5. Study design *98*

4.2.6. Ethics *98*

4.2.7. Expert by Experience Consultant (EBE) *99*

4.2.8. Recruitment *100*

4.2.9. Participant Inclusion/Exclusion Criteria *100*

4.2.10. Data Collection *103*

4.3. Analysis 111

4.3.1. Stages of IPA *111*

4.4. Reflexivity 114

4.5. Quality Assurance 114

5.0. Findings 117

5.1. Overview 117

5.2. Table of Group Experiential Themes (GETs) and Subthemes 117

5.3. GET 1: Early Encounters with the Diagnosis Experienced as a 'Double-Edged Sword' 119

5.3.1. Subordinate Theme: The Diagnosis Opening Some Doors whilst Closing Others *119*

5.3.2. Subordinate Theme: Remaining Curious to Alternative Explanations of Distress and Questioning the Diagnosis as a Construct.....121

5.4. GET 2: The Value and Tension of Integrating Lived Experience and Professional Identities 123

5.4.1. Subordinate Theme: Lived Experience as a Source of Connection and Hope for Others, Despite its Weight 123

5.4.2. Subordinate Theme: Navigating Shifts Between Identity Parts and Contexts.....126

When reflecting on navigating shifts between identity parts and contexts, Sammy also described the experience of shifting in another context, from service user spaces to professional spaces. 126

5.4.3. Subordinate Theme: Expectations of Reduced Vulnerability to Distress when Working in Mental Health 128

5.4.4. Subordinate Theme: Boundary Violations When Repositioned as a Patient by the Workplace.....130

5.5. GET 3: Managing the Emotional Impact of Stigma and Discrimination in the Workplace Towards 'People Like Me' 132

5.5.1. Subordinate Theme: Hypervigilance Whilst Feeling a Need to Be Undercover.....132

5.5.2. Subordinate Theme: Heightened Stigma and Distancing from those Diagnosed with EUPD Compared to Other More 'Socially Acceptable' Difficulties.....133

5.5.3. Subordinate Theme: Inner Dialogue of 'What I Wish I Could Say' 135

5.5.4. Subordinate Theme: Balancing Hurt with Understanding Towards Those Who Lack Awareness *138*

5.5.5. Subordinate Theme: Systemic Influences on Stigma and Discrimination *139*

5.6. GET 4: Navigating Authenticity, Sharing and Relational Safety in the Workplace 142

5.6.1. Subordinate Theme: Safe Workplace Relationships as a Foundation for Belonging *142*

5.6.2. Subordinate Theme: Weighing Up the Risks and Benefits of Sharing . *144*

5.6.3. Subordinate Theme: Testing the Waters *148*

5.6.4. Subordinate Theme: The Mixed Aftermath of Sharing *151*

5.6.5. Subordinate Theme: The Emotional Cost when Authenticity is Suppressed *153*

5.7. GET 5: Moving Beyond Reductionist Narratives Associated with EUPD 155

5.7.1. Subordinate Theme: The Reward of Contributing to Positive Shifts in Workplace Culture *155*

5.7.2. Subordinate Theme: Adaptive Compartmentalisation Versus 'EUPD Splitting' *157*

5.7.3. Subordinate Theme: 'Turning Lemons into Lemonade' - Healing Alongside 'Giving Back' to Others *158*

6.0. Discussion..... 161

6.1. Overview 161

6.2. Summary of Findings 161

6.3. Positioning the Findings Within the Broader Literature 162

6.4. GET 1 - Early Encounters with the Diagnosis Experienced as a Double-Edged Sword..... 162

6.5. GET 2 - The Value and Tension of Integrating Lived Experience with Professional Identities 164

6.6. GET 3 – Managing the Emotional Impact of Stigma and Discrimination Towards 'People Like Me' 167

6.7. GET 4 – Navigating Authenticity, Sharing and Relational Safety in the Workplace 173

6.8. GET 5 - Moving Beyond Reductionist Narratives Associated with EUPD 177

6.9. Critical Review..... 180

6.10. Implications of the Empirical Study 181

6.11. Suggestions for Future Research 184

6.12. Conclusion 185

References 186

List of Appendices

Appendix A – Example Pilot Searches for SLR

Appendix B – Final Grey Literature Search Terms

Appendix C – SLR Data Extraction Table

Appendix D – Quality Appraisal Tool for SLR

Appendix E – Example of the Coding Process During the SLR Thematic Synthesis

Appendix F – Example of Coding Clusters in SLR Thematic Synthesis

Appendix G – Initial Descriptive Subthemes for SLR

Appendix H – Notification of Ethical Approval

Appendix I – Participant Information Sheet

Appendix J – Participant Consent Form

Appendix K – Participant Debrief Sheet

Appendix L – Participant Recruitment Poster

Appendix M – Interview Schedule

Appendix N – Participant Demographic Form

Appendix O – Example Process of Exploratory Notes (EN) to Experiential Statements

Appendix P – Example Clustering of Experiential Statements (ES)

Appendix Q – Participant PETs (with Example of Moving from ES to PETs)

Appendix R – Tentative Participant GETs (with Examples of Moving from PETs to GETs)

Appendix S – IPA Recurrence of Theme Table

Appendix T – Example of the PR's Reflective Journalling

List of Tables and Figures

Table 1 - Definitions of key terminology used throughout the thesis within the context of the present study

Table 2 - SPIDER Framework for the inclusion and exclusion criteria

Table 3 - Finalised search terms for the first Scopus database search

Table 4 - Stages of Screening and study selection

Table 5 - Key study characteristics of the 11 reviewed papers

Table 6 - Stages of Thomas, & Harden's (2008)'s thematic synthesis

Table 7 - Final analytical themes and subthemes

Table 8 - Participant inclusion criteria

Table 9 - A summary of participant demographic information. A full list of demographic categories included in the questionnaire is presented in Appendix N

Table 10 - Other self-reported mental health conditions, disabilities, neurodevelopmental presentations, long-term physical health conditions reported alongside participants' EUPD diagnosis

Table 11 – Neurodiversity

Table 12 - Physical disability/long term health condition

Table 13 - Overview of both current and previous clinical job role experience amongst participants within mental health settings

Table 14 - Overview of both current and previous clinical mental health settings participants have worked in

Table 15 - Length of experience working in mental health settings

Table 16 - IPA stages of analysis taken by the PR (Smith et al., 2022)

Table 17 - CASP (2018) Qualitative Checklist for the present study

Table 18 - Table of Group Experiential Themes and Subthemes

Figure 1 - PRISMA flowchart

Figure 2 - Chaudoir & Fisher's (2010) Disclosure Processes Model (DPM)

Abstract

Background: Previous research has highlighted the value of lived experience within the mental health workforce. Alongside this, the challenges staff with personal experiences of mental health difficulties may face when navigating the workplace in relation to stigma have also been explored. These experiences have particularly been documented in relation to more commonly reported difficulties. However, little is known about the workplace experiences of staff who have been diagnosed with EUPD.

Aim: Given previous research highlighting increased stigma towards service users diagnosed with EUPD, this study aimed to explore how mental health staff with a diagnosis of EUPD experience the workplace in the context of their lived experience and to gain insight into the meanings attached to these experiences.

Method: Interpretative Phenomenological Analysis (IPA) was used to analyse nine semi-structured interview transcripts and identify group experiential themes.

Results: Five group experiential themes were identified: Early encounters with the diagnosis experienced as a 'double-edged sword'; The value and tension of integrating lived experience with professional identities; Managing the emotional impact of stigma and discrimination towards 'people like me'; Navigating authenticity, sharing and relational safety in the workplace; and Moving beyond reductionist narratives associated with EUPD.

Implications: The findings highlight the ongoing impact of stigma towards individuals diagnosed with EUPD within mental health services and the need for psychologically safe and inclusive workplace cultures. Greater acceptance of lived experience and person-centred understandings of distress may support staff wellbeing, facilitate help-seeking and improve care for service users.

Keywords: mental health, mental health staff, Interpretative Phenomenological Analysis, IPA, lived experience, living experience, stigma, discrimination, qualitative, Emotionally Unstable Personality Disorder, EUPD, Borderline Personality Disorder, BPD, dual experience.

1.0. Introduction

1.1. Overview

This chapter provides a contextual foundation for this thesis. The chapter begins by presenting key language and terminology used throughout the thesis. The primary researcher PR's position within the study is then situated, including a description of the epistemological and ontological stance adopted throughout. Current literature on the lived experience of mental health difficulties among mental health staff is then introduced, alongside policy developments and organisational initiatives that reflect increasing recognition of lived experience within the workforce. The value of lived experience is highlighted, before considering staff experiences of sharing mental health difficulties with colleagues in the workplace. Taken together, this chapter provides the basis for the rationale for the systematic literature review presented in Chapter 2.

1.2. Language and Terminology

The language used throughout this study in Table 1 has been consulted on by the Expert by Experience (EBE), supervisory team and by participants who contributed to the empirical study.

Table 1

Definitions of key terminology used throughout the thesis within the context of the present study

Terminology	Meaning in relation to the current study
'Mental health difficulties'	Experiences of psychological distress that interfere with daily functioning, wellbeing, or an individual's ability to cope with everyday life. This is consistent with NHS England descriptions as experiences that "cause marked emotional distress and interfere with daily function" (NHS England Digital, 2025). The PR writes with the acknowledgment that mental health difficulties arise in response to a variety of biopsychosocial factors that may include an interaction of social and cultural contexts, interpersonal dynamics, developmental experiences, genetic vulnerability and neurobiology as some examples (Mahapatra, & Sharma, 2024).
'Lived Experience'	Within this thesis and other literature (King et al., 2020) alike, the term 'lived experience' refers to mental health staff who have experienced mental health difficulties, with the acknowledgement that this experience is not always limited to past tense and that staff may continue to have current ('living experience') of mental health difficulties.

'Dual-identity'	The experience of being someone who is both a mental health worker and someone who has lived or living experience of mental health difficulties (Byrne et al., 2015)
'Mental health staff'	Throughout this thesis, mental health staff may refer to (but may not necessarily limited to the following titles: clinical psychologists, mental health nurses, psychiatrists, social workers, occupational therapists, counsellors, psychological therapists, healthcare assistants, support workers and peer support specialists).
'Stigma'	The overarching negative associations attached to a person or group at a social level, involving the process of devaluation and stereotyping (Link, & Phelan, 2001)
'Prejudice'	The negative emotional reactions, attitudes, or evaluations held within an individual, towards a person or group, often arising from stereotypes (Corrigan & Watson, 2002).
'Discrimination'	Behavioural actions towards members of a stigmatised group, often including exclusion, avoidance, or unfair treatment (Corrigan & Watson, 2002)

'Sharing' (in the context of self-disclosure)	For the purposes of this study, the term sharing is used where possible to encompass disclosure, to indicate the sharing of personal information, such as mental health difficulties with others. This terminology was chosen because it more closely reflects the varied and selective ways participants described communicating personal experiences within professional contexts. It also avoids some of the connotations associated with the term self-disclosure, which may be interpreted as emphasising the revelation of private or sensitive information and in some contexts, can evoke formal or investigative processes (Byrne et al., 2015; Corrigan & Rao, 2012). However, as disclosure remains the predominant term within the contemporary literature, it is retained when referring to existing research and theoretical frameworks where the term has been used.
'Emotionally Unstable Personality Disorder' (EUPD) and 'Borderline Personality Disorder' (BPD)	In order to be inclusive of participants who do not identify with the EUPD or BPD diagnosis they have received, the PR makes references throughout this study to people "diagnosed with" rather than "people with" EUPD or BPD. Both the terms BPD and EUPD are used within UK clinical practice and literature, reflecting variation in diagnostic systems and terminology. Although the diagnosis remains contested in relation to its conceptualisation and validity (Campbell et al., 2020), the terms are frequently used to refer to the same clinical

	construct (NHS England, 2024). Therefore, both terms are used throughout this thesis where appropriate, with EUPD being used preferentially in keeping in line with terminology commonly used within UK mental health services. Further discussion of the diagnosis and associated terminology is provided in chapter 3 when introducing the empirical project.
The primary researcher (PR)	The main investigator of this study.

1.3. Situating the Researcher

1.3.1. Insider Research Position

An 'Insider researcher' refers to an individual who conducts research on a population or community that themselves, are also a member of (Greene, 2014). This thesis is classed as 'insider research' as the researcher and supervisory/consulting team also hold the position of being mental health staff with lived experience of mental health difficulties. An advantage of insider research is that the researcher may hold a wider understanding and familiarity of the topic and increased knowledge of the social and political factors that may be relevant to the study (Saidin, 2016). It is helpful to consider insider research frameworks (Mercer 2007) to consider how the research process is influenced by the researcher's own personal beliefs and experiences (Alvesson, & Sköldberg, 2017). Within such frameworks, it is suggested to consider and address the following aspects: reflexivity, the researcher's position, double reflexivity, contextualization, a critical approach to the research and transparency of the process. In this study, the PR engaged in bracketing interviews and reflective journalling as

ways to mitigate the impact of their own beliefs and prior assumptions throughout the research process.

Within this thesis, the researcher adopted a third-person writing style. This was a deliberate decision intended to maintain a consistent academic voice and to encourage reflexive distance from the researcher's dual insider position. Although this approach does not remove the influence of researcher subjectivity, it supported continual awareness of the distinction between the researcher's personal and professional experiences and the interpretations presented within the research. This writing style complemented the reflexive processes undertaken throughout the study, reinforcing the need for interpretations to remain grounded in participants' accounts rather than the researcher's own perspectives.

The researcher's insider position was multifaceted, drawing on experiences as both a mental health professional and an individual with lived experience of mental health difficulties. Throughout the research process, it was recognised that prior experience of working within and personally navigating mental health services may have influenced the researcher’s perspectives. Supervision provided opportunities to reflect on this experience, including an awareness of the complexities of mental health care, organisational cultures, stigma and the potential impact of diagnostic labels. In particular, the researcher’s previous experience of working within teams where people diagnosed with EUPD were sometimes understood through a pathologising lens may have heightened sensitivity to accounts of stigma and diagnostic assumptions. In these settings, developmental trauma sometimes received less attention within formulations, which may have further shaped the researcher’s awareness of how diagnostic labels can influence understandings of distress.

During analysis, particular attention was therefore given to distinguishing participants' meanings from the researcher's pre-existing understandings and expectations. Reflexive discussions within supervision provided opportunities to consider alternative interpretations and remain attentive to assumptions that may have shaped the analytic process. At the same time, the advantages of this dual insider position were also recognised. Shared professional knowledge and an understanding of mental health services facilitated rapport with participants, supported a nuanced appreciation of their accounts and enabled the researcher to recognise contextual factors that may have been less apparent to an outsider researcher.

1.3.2. Ontological Position

This study is situated within a critical realist ontological position, which assumes that experiences and social phenomena exist independently of the researcher, whilst recognising that access to these realities is inevitably mediated through individual interpretation and social context (Bhaskar, 1975). From this perspective, workplace experiences such as stigma, prejudice, discrimination, sharing and professional relationships are understood as having real consequences for mental health staff with lived experience. However, the critical realist position considers the meanings attached to these experiences to being shaped by broader social, cultural and organisational influences. This stance, therefore, acknowledges both the reality of participants' experiences and the contextual processes through which those experiences are understood.

1.3.3. Epistemological Position

This thesis adopts an interpretivist epistemological stance (Schwartz-Shea, & Yanow 2012) which assumes that knowledge is generated through an individuals' subjective interpretations of their experiences rather than discovered as objective fact (Smith et al., 2022). This position recognises that individuals actively construct meaning from their experiences and that

understanding of these experiences is shaped through the interactions between the participant and the researcher. This stance therefore aligns with the Interpretative Phenomenological Analysis (IPA), approach adopted for the empirical study to explore the 'meaning-making' individuals attach to significant life experiences. The methodological underpinnings of this approach are discussed in further detail in chapter 3.

1.4. Previous Literature on the Lived Experience of Mental Health Difficulties Amongst Mental Health Staff

Mental health staff who experience mental health difficulties are not a homogenous group and the relationship between lived experience and professional identity may emerge through a range of pathways. For some, experiences of psychological distress, or witnessing mental health difficulties in someone else close to them, may contribute to an interest in working within mental health services. Some research has conceptualised this through the notion of the "wounded healer", where personal experiences of distress are understood to inform empathy, compassion and therapeutic understanding (Taylor, 2025). However, other mental health staff may develop difficulties later in life, including in response to personal circumstances (Deutsch, 1985), stress, burnout, vicarious trauma, or the emotional demands associated with the workplace (Morse et al., 2012). Furthermore, this reflects the reality that mental health staff are no less immune to psychological distress and lived experience should be understood as diverse, dynamic and multifaceted.

Existing literature suggests that mental health staff experience a wide range of mental health difficulties across a continuum of severity ranging from short-term, situational distress to more persistent and layered presentations. In an anonymous survey by Tay (2016), exploring lived experience of mental health difficulties among 678 UK-qualified clinical psychologists, approximately two-thirds of respondents reported having experienced a significant mental

health difficulty at some point in their lives. In a more recent survey completed by 1700 trainee psychologists and psychology university faculty members, over 80% of participants reported experiencing mental health difficulties and 48% shared they have previously been diagnosed with a mental illness (Victor et al., 2022). Within this study, depression, generalised anxiety disorder and suicidal thinking/behaviours were the most commonly reported categories of distress. In addition, post-traumatic stress symptoms in the context of vicarious trauma have been highlighted amongst counsellors, mental health nurses, social workers, psychiatrists and clinical psychologists, who are routinely exposed to high levels of distressing material in their work (Sutton et al, 2022). Internationally, medical professional bodies such as the Royal Australian and New Zealand College of Psychiatrists have similarly emphasised the prevalence of mental health difficulties among doctors, the role of stigma and fear of professional consequences, as delaying help-seeking. Additionally, there has been an increased development of peer support specialist roles within mental health services, acknowledging the value that can be drawn from lived experience of mental health difficulties as part of the workforce (Cooper, et al., 2025). Collectively, this literature demonstrates that mental health professionals experience mental health difficulties in ways that can influence both their professional and personal identities. While these studies highlight important challenges, they also raise questions about how wider organisational and policy contexts shape these experiences. The following section therefore considers contemporary policy initiatives aimed at increasing recognition and inclusion of lived experience within the mental health workforce.

1.5. Policies and Initiatives Towards Embracing Lived Experience of Mental Health Difficulties in the Mental Health Workforce

In 2020, The Division of Clinical Psychology, under the British Psychological Society (BPS), released a position statement regarding lived experience of mental health difficulties amongst mental health staff, including the challenges they may face in the workplace (British Psychological Society, 2020). This statement addressed the stigma (from others and towards one's self) and concerns surrounding discrimination. The report highlighted that the types of mental health difficulties staff face are common, diverse and a beneficial asset to the profession. It was suggested that, as a collective, the workforce should work towards developing systems that actively reduce stigma at all levels of the profession, thereby supporting more open and psychologically safe sharing practices. The NHS England Health and Wellbeing Framework (2022) similarly highlights the importance of psychologically safe workplace cultures, supportive leadership and accessible support for staff, with the aim of increasing feelings of safety when sharing mental health experiences without fear of negative judgement or professional consequences. Although the policies outlined above promote the value of lived experience within the mental health workforce, there remains limited understanding of how these policy aspirations are experienced in practice. To explore this further, theoretical perspectives are considered below to examine how stigma and identity may shape the experiences of staff with lived experience of mental health difficulties.

Theoretical Perspectives on the Lived Experiences of Mental Health Difficulties Amongst Mental Health Staff

Goffman's (1963) theory of stigma, describes a socially constructed process through which certain attributes related to an individual or group become discredited, resulting in a process of social devaluation. Building on this, Corrigan et al. (2005), propose a model of 'mental illness stigma', highlighting how stigma operates through a sequence of cognitive, emotional

and behavioural processes, beginning with stereotypes, which give rise to prejudice and may ultimately result in discriminatory behaviour. Within this framework, a distinction is made between public stigma and self-stigma. Public stigma refers to societal attitudes and stereotypes directed towards a stigmatised group, whereas self-stigma describes the internalisation of these beliefs, which can adversely affect self-concept, self-esteem and help-seeking (Corrigan & Watson, 2002).

Within mental health workplace contexts, stigma may be reinforced by perceptions that mental health staff are less vulnerable to psychological distress than service users, contributing to a sense of psychological and social distancing between staff and service users, sometimes described as an “us and them” dynamic (Helmus et al., 2019).

Previous research suggests that stigma within healthcare settings may discourage staff from seeking timely psychological support, with potential consequences including worsening mental health, burnout, sickness absence and increased staff turnover (Corrigan et al., 2014). These workplace cultures may contribute to presenteeism, where staff continue working despite significant distress, with potential implications for wellbeing and quality of care (Brooks et al., 2011).

Tajefel & Turner’s (1979) Social Identity provides a useful lens through which to understand the negotiation of multiple and potentially competing identities. This theory proposes that people derive part of their self-concept from membership within social ‘in-groups’, shaped through processes of categorisation, identification and social comparison. Within the mental health workforce, professional identity may therefore be strongly associated with membership of the ‘mental health staff’ in-group, which is often constructed around expectations of competence, emotional resilience and the capacity to support others (Richards et al., 2016). In contrast, lived experience of mental health difficulties may introduce an

additional identity, which may or may not be legitimised within professional contexts and depending on workplace culture and attitudes towards mental health, may feel conflicting to 'professional identity'. In more supportive environments, however, lived experiences may comfortably align with professional identities as an integrated 'dual identity' that is recognised as a positive asset in professional spaces, as a source of insight and empathy (Moran et al., 2013).

The Division of Clinical Psychology (British Psychological Society, 2015) emphasises that competence should be understood as "in-action", recognising that staff may appropriately reduce or suspend aspects of their work during periods of psychological distress whilst simultaneously maintaining overall professional capability. In this context, it is important to distinguish between capacity and competence, as reduced capacity during these periods, does not necessarily equate to a lack of professional competence. This challenges assumptions that mental health difficulties are inherently incompatible with clinical roles and instead highlights the importance of organisational support and reasonable adjustments in enabling staff to continue working effectively. Taken together, these perspectives suggest that lived experience should not be considered solely in terms of its potential challenges to clinical practice but also in terms of what it may contribute to the workplace.

1.6. The Value of Lived Experience within the Mental Health Workforce

Literature has highlighted that lived experience of mental health difficulties can contribute to increased empathy, compassion and understanding of the challenges faced by service users, helping to develop successful therapeutic relationships and provide care with an authentic and person-centred approach (Elliott & Ragsdale, 2020; Zerubavel & Wright, 2012). Lived experience amongst staff, has also been suggested to foster hope towards clients, as staff can draw upon their own experiences of healing to maintain optimism towards the potential of

their clients in their own journeys (Burke et al., 2018). Furthermore, lived experience can provide staff with a deeper understanding of mental health difficulties and stigma, often informed by their own perspective as a service user. It is increasingly recognised as a valuable source of knowledge that can enhance clinical practice, support service improvement and promote diversity in the workforce (British Psychological Society, 2020; Richards et al., 2016). However, recognising the potential value of lived experience does not necessarily mean that staff feel able, or choose, to share these experiences within the workplace. Understanding how staff navigate the decision to share their mental health difficulties therefore provides an important next step in considering how the value of lived experience can be realised in practice.

1.7. Previous Literature on Mental Health Staff Experiences of Sharing Mental Health Difficulties with Colleagues in the Workplace

Decisions about whether to share aspects of lived experience with colleagues - particularly supervisors, managers and occupational health staff, are an important feature of workplace culture. These decisions reflect broader issues relating to stigma, psychological safety, professional identity and access to organisational support. For instance, where staff feel unable to share experiences of such difficulties, this may limit opportunities for support and contribute to the continued perception that such experiences are uncommon or incompatible with professional roles (Corrigan & Watson, 2002; King et al., 2020). Therefore, understanding how staff navigate decisions around sharing lived experience is important for understanding how workplace cultures may either reinforce or challenge stigma.

Previous literature has found sharing decisions to represent a complex and context-dependent process. Reflecting this, initiatives such as the UCL Unit for Stigma Research's Honest, Open, Proud programme (Scior, et al., 2020), recognise that sharing decisions are highly

personal and involve weighing potential risks and benefits. Rather than promoting sharing itself, the programme aims to support staff in navigating self-stigma and making informed decisions about whether, how and with whom to share with (Scior et al., 2020).

Previous literature suggests that mental health staff decisions to share lived experiences in the workplace, are shaped by a balance of perceived risks and benefits (King et al., 2020). Key barriers include concerns about negative judgement on their professional credibility, fitness to practise investigations and risks of confidentiality being broken (Elliott & Ragsdale, 2020; King et al., 2020; Tay, 2016). Conversely, sharing appears more likely when staff perceive their work environment as psychologically safe, supportive and characterised by trust (Elliott & Ragsdale, 2020; Zamir et al., 2022).

Previous literature reviews in this area were conducted prior to the COVID-19 pandemic (King et al., 2020; Zamir et al., 2022). This is an important consideration given the substantial impact of the pandemic on the wellbeing of healthcare staff, with increased reports of occupational stress and psychological distress across the workforce (GOV.UK, 2020; Nightingale et al., 2026). Greater attention was directed towards staff wellbeing during the pandemic, including the rapid development and expansion of support structures such as staff mental health hubs, reflective spaces and organisational wellbeing initiatives (NHS England, 2023).

It is important to recognise that mental health difficulties among mental health staff are not unique to the pandemic context, nor solely a consequence of it. Rather, evidence suggests that vulnerability to mental health difficulties amongst staff were already present prior to COVID-19, with the pandemic serving to intensify, exacerbate and bring increased visibility to existing experiences of distress, burnout and emotional strain within the workforce (Nightingale et al., 2026). This changing context highlights a need for more contemporary

research examining how mental health staff navigate decisions about sharing mental health difficulties within the workplace. Furthermore, an up-to-date synthesis of the literature in this area may build upon research conducted prior to COVID-19, whilst helping to establish whether increased attention to staff wellbeing following the pandemic, has influenced experiences of sharing, stigma and workplace support. This provides the basis of the rationale for the systematic literature review presented in the following chapter.

2.0. A Systematic Literature Review of the Experiences of Mental Health Staff in Relation to Sharing Mental Health Difficulties with Colleagues in the Workplace

2.1.Overview

A Systematic Literature Review (SLR) is an approach used to identify, evaluate and synthesise literature conducted within a particular topic area. Within this, the primary researcher (PR) of an SLR is required to document the process transparently to increase the replicability of the study (Lame, 2019, July).

This chapter begins by outlining the rationale and objective of the review, followed by a description of the methodology employed and a thematic synthesis of the findings. At the end of the chapter, a discussion of the results is presented, including a critical evaluation of the project and implications for future research and clinical practice.

2.2.Rationale and Objective of the Current Review

As part of the rationale for this SLR, it is suggested that an updated review is warranted given the significant changes towards mental health both within healthcare systems and wider society during this period. For example, The COVID-19 pandemic brought increased attention to the wellbeing of healthcare staff, resulting in initiatives such as an increased development of staff wellbeing hubs (Snider & Flaherty, 2020). However, despite these developments, research exploring the experiences of mental health staff working specifically within UK mental health services remains limited, meaning it is unclear whether increased awareness of staff wellbeing has translated into changes in workplace experiences of disclosure. Previous literature reviews in this area by King et al. (2020) and Zamir et al. (2022) primarily included studies published prior to 2019, with only one included study from the published in 2020 and not specifically focused on mental health workplaces within the

UK. In contrast, the present review aims to synthesise research from 2020 onwards, to include studies conducted during and after the COVID-19 pandemic.

Whilst Zamir et al. (2022)'s review listed grey literature as an inclusion criteria for their review, they did not report a systematic search strategy for grey literature sources and the final included studies appear to consist solely of peer-reviewed publications. The present review sought to build on this by adopting a structured and transparent approach to searching grey literature by including doctoral theses as eligible studies for inclusion. Given the sensitive nature of mental health staff experiences of lived experience, including issues of stigma, discrimination and attention drawn to negative workplace experiences, there is a potential for publication bias, with studies being less prevalent in peer-reviewed journals (Hopewell et al., 2006). Therefore, including grey literature within this review aims to broaden the evidence base and provide a more comprehensive and up to date understanding of the barriers, facilitators and lived experiences shaping disclosure and wellbeing in mental health settings.

2.3. Research Question and Aims

The primary research question for this SLR is: '*What are the experiences of mental health staff in relation to sharing mental health difficulties with colleagues in the workplace?'*

Given the exploratory nature of the research question and its focus on understanding lived experiences and perspectives, this review will prioritise qualitative studies as a means of exploring the subjective and nuanced factors that shape these experiences.

Alongside the primary research question, the main aim of this review is to identify factors that facilitate or hinder an individual's willingness to share mental health difficulties in the

workplace. Further exploration of these factors may help inform the development of workplace wellbeing policies, contribute to stigma reduction initiatives and support the creation of more inclusive working environments for mental health staff.

2.3. Methodology

2.3.1. Protocol Registration and Quality Assurance

Prior to developing the research protocol, the PR conducted preliminary searches of PROSPERO and Google Scholar to determine whether the proposed review would offer a novel contribution to the existing literature.

Following this, the proposed SLR was registered on PROSPERO (protocol: CRD420251170571) with registration made publicly available to prevent duplication amongst other researchers who may have been considering conducting a similar SLR.

The Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) checklist (Page et al., 2021) was utilised by the PR throughout the protocol to enhance the quality and rigor of the methodological procedure.

2.3.2. Eligibility Criteria

The Sample, Phenomenon of Interest, Design, Evaluation and Research type (SPIDER) framework (Cooke, et al., 2012). was utilised to inform the inclusion and exclusion criteria of the papers eligible for review, as displayed below in Table 2.

Table 2

SPIDER Framework for the inclusion and exclusion criteria

SPIDER FRAMEWORK	Inclusion Criteria	Exclusion Criteria
S: Sample	Studies exploring the experience of mental health staff with lived and/or living experience of mental health difficulties.	Research discussing the lived experience of clients/service users/patients who are not or have not been mental health staff.
	The population sample can include staff/students who are trainees within a mental health professional training programme working on placements and/or awaiting accreditation. Eligible roles may include (but may not necessarily limited to), psychotherapists, support workers, assistant psychologists, counsellors, psychiatrists, clinical and counselling psychologists,	Research focused on the lived experienced of peer support workers (due to their job role explicitly highlighting the presence of lived/living experience of mental health difficulties, with the knowledge that information has been implicitly shared).

	occupational therapists and nurses working within mental health settings.	
PI: Phenomenon of Interest	The workplace experiences of mental health staff who have experiences of disclosure and/or non-disclosure of their own mental health difficulties with colleagues in the workplace, namely studies that explore the considerations taken around these decisions. Studies that have explored the lived experience of healthcare professionals in general where the data regarding lived experience of mental health staff is able to be extracted	Studies that centre mental health staff experiences of sharing mental health difficulties with people in non-workplace contexts (e.g. in their personal life) Studies focusing on disclosure to service users or patients, as this occurs within a distinct therapeutic context shaped by ethical, boundary and clinical considerations that differ from colleague-to-colleague disclosure (Barnett, 2011). Studies focusing primarily on physical health staff or non-clinical mental health service roles (e.g., administrative staff) were excluded. Studies that primarily focus on the experiences of physical health staff

		or staff working in non-clinical roles within mental health services (e.g., administrative staff)
D: Design	Qualitative Studies Mixed method studies exploring the phenomena interest above where relevant qualitative data is able to be extracted and synthesised separately.	Studies that have not undertaken a robust qualitative methodology
E: Evaluation	Author, participant sample size, year of publication, methodology, main results containing a documented account of personal experiences from participants, limitations of studies and geographical location.	

R: Research Type	Peer reviewed empirical qualitative studies Unpublished doctoral theses (grey literature) on the basis that, although unpublished, such work has typically undergone frequent supervision and rigorous viva examination at doctoral level, often with amendments required to meet the standards expected of doctoral research. Studies that have full text available in English Studies published/listed between the years 2020-2025	Opinion pieces or self-reported accounts/personal stories Studies that are not available in English Studies that do not have an accompanying full text/report accompanying the abstract that can be accessed through the university's databases after reasonable attempts to access this were not considered.

2.3.3. Search Strategy

Prior to finalising the search strategy, the PR conducted a range of preliminary scoping searches using Google Scholar with broad keywords relating to the main concepts of the research question. These searches aimed to assess the scope and nature of existing research in the field, refine the focus of the review to minimise the potential duplication of previous research and to inform the development of the search terms. Key terms from the inclusion vs exclusion criteria within the SPIDER framework presented above was also utilised in the construction of search terms. From this, the primary researcher deconstructed the area of study into four key concept blocks, as presented in Table 3. In preparation for the final search string.

The refinement of the search terms was an iterative process. Initial pilot searches were conducted across databases to evaluate the sensitivity and specificity of the developing search strings (see Appendix A). Insights from these preliminary searches informed multiple revisions, including the removal of terms that consistently returned irrelevant results.

The early search strategy incorporated broad descriptors of mental health difficulties. However, as the pilot searches progressed, it became evident that a wider range of more specific diagnostic terms needed to be added to ensure comprehensive coverage. This iterative expansion of terminology aimed to minimise the risk of missing relevant studies that employed varied diagnostic labels or symptom descriptions within their titles or abstracts. Final searches were carried out on databases in December 2025.

2.3.4. Information Sources and final search terms

Information sources used to access published papers.

To ensure a wide coverage of data for published literature, four databases were utilised for data collection (Scopus, Medline, CINAHL and PsychInfo). Collectively, these databases cover a range of research throughout the social sciences, particularly within the areas of psychology, psychiatry, nursing and other allied health professions.

Information sources for grey literature retrieval.

Google Scholar was included as a supplementary source due to its broad coverage of peer-reviewed and grey literature. However, because it does not support structured systematic searching or direct export functions compatible with Covidence (see section on screening and study selection). Therefore, searches were conducted using Publish or Perish (Harzing, 2007), a software tool that enables systematic and reproducible retrieval of Google Scholar records and facilitates export in CSV or RIS formats for screening within Covidence. To ensure consistency across sources, searches were limited to the first 200 retrievable records.

Search terms were adapted from the main database strategies for the grey literature search by simplifying syntax and using broader keyword combinations (see Appendix B). This was necessary because Google Scholar as a standalone platform has limited support for advanced Boolean operators and controlled vocabulary. Broader search strings were therefore employed to maximise sensitivity and capture relevant doctoral theses, while remaining aligned with the core concepts of the research question.

Alternative grey literature sources were considered but not utilised for this review. For example, the Electronic Theses Online Service (EThOS), despite its focus on UK doctoral theses, was not used due to reduced accessibility and incomplete coverage following a

cyberattack. Preliminary searches in ProQuest Dissertations & Theses and CORE also indicated inconsistent indexing of UK doctoral theses, yielding relatively few relevant records and a high proportion of unrelated publications so were therefore not utilised.

Final search terms.

The final search terms used for searches are presented below in Table 3.

Table 3

Finalised search terms for the first Scopus database search (example terms used within the Scopus database with minor modifications later applied for compatibility with the remaining databases

Search Term Concept Blocks	Final Search Terms
Block 1: Mental Health Staff	"mental health professional*" OR "mental health worker*" OR psycholog* OR therapist OR psychotherapist OR counsellor* OR "psychiatric nurse*" OR "mental health nurse*" OR psychiatrist* OR "support worker*" OR "mental health assistant*" OR "mental healthcare assistant*" OR "mental health workforce" OR "wellbeing practitioner*" OR "dual experience*" OR "prosumer"
Block 2: Mental health Difficulties	"mental health" OR "mental illness*" OR distress* OR wellbeing OR "liv* experience" OR "mental health problems" OR "mental health difficulties" OR

	"psychiatric disorder*" OR depress* OR bipolar OR anxiet* OR "panic disorder" OR phobi* OR PTSD OR "post-traumatic stress" OR trauma* OR psychosis OR "hearing voice*" OR "obsessive compulsive" OR OCD OR "eating disorder*" OR anorex* OR bulimi* OR "binge eating disorder" OR "perinatal mental health" OR "personality disorder*" OR EUPD OR "Emotionally Unstable personality" OR BPD OR "borderline personality" OR addiction OR suicid* OR "self-harm" OR "self-injury*"
Block 3: Action of Sharing/Disclosure/Non Disclosure of Mental Health Difficulties in the Workplace	disclos* OR conceal* OR nondisclos* OR "non disclosure*" OR stigma OR "share*"
Block 4: The Context of the Workplace Environment	workplace OR supervision OR colleagues OR work OR "occupational health" OR "fitness to practice"

2.3.5. *Data exportation, screening and study selection*

The process of data exportation, screening and study selection are outlined below in Table 4.

Table 4

Stages of Screening and study selection

Stage of Process	Action Taken
Exportation from Databases	Search results were exported from all databases in RIS format and imported into the Covidence (n.d.) which is a platform that helps researchers in the management and development of literature reviews, particularly during the screening process.
Importing of Search Results into Covidence and Duplicate Removal	A total of 3568 studies were imported from the databases. Duplicates were removed both automatically by the Covidence platform and manually by the PR and the stages of screening were captured in a PRISMA flowchart (see image 1).
Title and Abstract Screening	The PR initially screened the titles and abstracts of all imported studies. To enhance the reliability and validity of the study selection process, a second reviewer independently screened 15.6% of titles and

abstracts, reducing the risk of bias and promoting consistent application of the inclusion and exclusion criteria. (Stoll, et al., 2019). Titles and abstracts were reviewed against the inclusion criteria and assigned a screening decision of ‘yes’, ‘no’, or ‘maybe’.

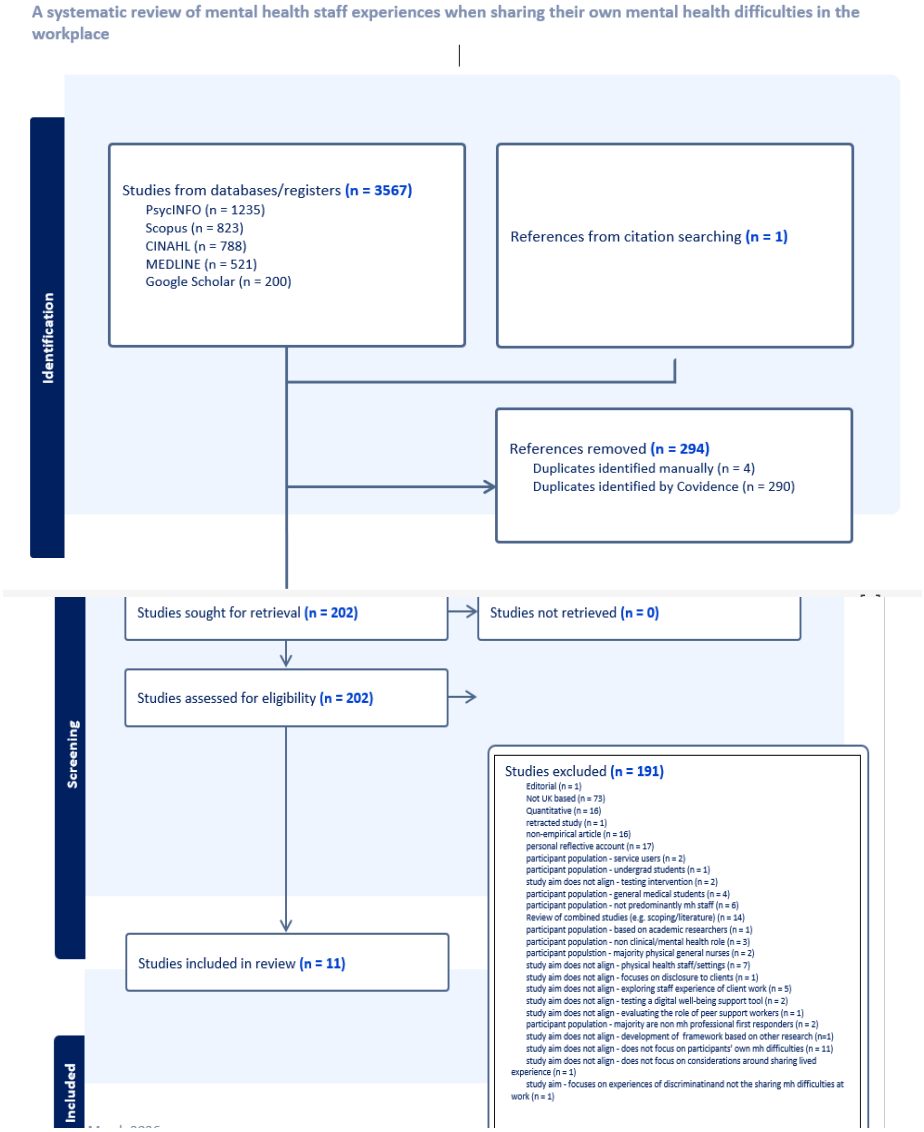
Initial screening and pilot searches indicated that the pool of studies likely to meet the review's inclusion criteria was relatively small. Therefore, a cautious approach was taken during the title and abstract screening stage, to minimise the risk of prematurely excluding potentially relevant literature.

For example, some studies conducted outside the UK appeared from their title or abstract not to meet the geographical inclusion criteria. Rather than excluding these studies at this stage, they were categorised as “maybe” as a precaution, allowing full-text review and examination of introductions and reference lists for any potentially relevant UK-based studies,

	including those potentially identified through cross-comparisons. This ensured that potentially relevant literature was not prematurely excluded, with any studies identified through this process subsequently screened against the predefined eligibility criteria. Similarly, studies referring to healthcare workers in general were not automatically excluded at this stage, so that the researchers could review the population sample more closely during a full-text review.
Full Text Screening	Following title and abstract screening, 202 studies progressed to full-text review. The second reviewer screened 20% of the full-text articles and the reviewers resolved any conflicts in decision at both stages of screening through discussion.

Figure 1

PRISMA flowchart



[1]Dual screening produced a Cohen's kappa coefficient, which reflects the level of agreement between reviewers. Following title and abstract screening, the kappa was 0.43, indicating moderate agreement between the two reviewers (Landis & Koch, 1977). This relatively lower coefficient may reflect the PR's cautious application of exclusion criteria, where studies were

[1] Common reasons for exclusion during the title and abstract screening stage included detection of obvious exclusion criteria such as population sample as service user/clients or undergrad students, case study/opinion pieces, quantitative studies, studies exploring self-disclosure to clients as opposed to colleagues, studies where the topic was obviously irrelevant to the research question and aims, e.g. mental health staff experiences of workplace not related to self-disclosure

not prematurely excluded in order to capture potentially relevant studies for full-text review. The coefficient produced following full text screening was 1 which indicates a perfect agreement. Furthermore, this suggests that the screening process, particularly at full text stage was applied consistently and that reviewer decisions were reliable.

2.3.6. Data Extraction

A data extraction table was developed by the researcher and informed by recommendations for systematic review reporting (Page et al., 2021), capturing study characteristics including publication details, aims, methodology, sample characteristics, limitations and key findings (see Appendix C.)

2.3.7. Study Characteristics

The researcher condensed key aspects from the data extraction detail to present key study characteristics as presented in Table 5.

Table 5

Key study characteristics of the 11 reviewed papers

Author and Year	Title	Location & Publication Status	Population Sample	Research Design and Method	Key Relevant Findings
Bailey et al. (2024)	Isn't it mad that we're all psychologists and we can't talk about our feelings?': A mixed-methods study exploring trainee clinical psychologists' experience of (non) disclosure of psychological distress during training	UK - published	13 trainee clinical psychologists on UK doctoral programmes. depression, low mood, generalised and social anxiety, panic, trauma, eating disorders, bipolar, self-harm and dissociation	Semi-structured interviews and a Reflective Thematic Analysis) analysed for this SLR.	Participants described how diagnostic and psychological understandings shaped disclosure, alongside worries about judgement that complicated sharing decisions. Disclosure was strongly influenced by the quality of relationships and shaped by expectations of emotional versus practical responses. Findings also highlighted desired changes to improve disclosure experiences and the lasting impact of previous disclosure experiences.

Bamber et al., (2025)	"I am a clinician, but I'm also a service user..." Navigating doctoral training as a trainee clinical psychologist (TCP) with lived mental health experience (LMHE)"	UK - published	12 Trainee Clinical Psychologists on UK Doctoral Programmes. Depression (including postnatal depression) and anxiety disorders, or trauma related presentations.	Data Collection carried out via semi-structured interviews and analysed via Constructivist Grounded Theory approach	Trainees described systemic pressures affecting mental health, tensions between personal and professional identity, decisions to share or conceal lived experience, the importance of safe and supportive relationships and the challenges and benefits of integrating lived experience into clinical practice. They also reflected on evolving professional narratives and ongoing stigma.
Bowman, (2023)	SECTION B ONLY (Empirical Paper): "The importance of perceptions of "NHS Culture" for clinical psychologists considering a	UK – Grey Literature (doctoral thesis)	9 clinical psychologists with experience working in the NHS specifically. Anxiety disorders, depression/mood disorders (including bipolar). Trauma related experiences, eating disorders, self-harm, dissociation.	Data collection was carried out via semi-structured interviews and Grounded Theory was used for analysis.	Participants' decision to disclose was shaped by NHS culture, motivations for sharing (e.g., accessing support or adjustments), perceptions of safety (e.g., confidentiality, stigma and fear of consequences) and aspects of professional identity, including dual identity, perfectionism, imposter syndrome and seniority.

	workplace self-disclosure of their lived experience of mental health difficulties"				
Cleary & Armour, (2022)	Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy	UK - published	3 psychotherapists/counsellors. Third sector and private organisations Low mood, anxiety, post-traumatic stress	Data collection was carried out via semi-structed interviews. The methodology and analysis undertook IPA	Participants explored professional identity, the role of self-disclosure in enhancing therapeutic relationships, the importance of supervision and processes of healing and recovery.
Davies et al (2023)	"Being human": A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide	UK - Published	9 qualified clinical psychologists working as trainers on Clinical Psychology Doctorate Programmes in the UK. Experiences of anxiety, depressions, life stressors (within	Data collection was carried out via semi-structured interviews and analysis undertook a constructivist	Participants described disclosure decisions as a dynamic process shaped by weighing usefulness and risk, prioritising safety and containment of stigma and shame and considering relevance, intent and purposefulness.

	whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees		workplace, relationships, parenting), experiences of childhood trauma	grounded theory approach	
Farley et al., (2025)	'It would probably do more harm than good': mental health nurses' experiences of nondisclosure within individual clinical supervision	UK - published	10 mental health nurses working in the NHS. Participants were all permanent staff (at band 5 or 6 level) and had previous experience working on inpatient units within the last 3 years. Difficulties stemming from burnout and stress related work pressures	Data collection was carried out via semi-structured interviews, data was analysed using thematic analysis	Participants described pressures to appear resilient and "superhuman", the influence of team dynamics and organisational culture, uncertainty around appropriate spaces for discussing difficulties, experiences of relational unsafety and strategies used to protect themselves. Findings highlighted the importance of regular, structured and psychologically safe supervision where sharing could take place.
Groves et al., (2026)	'Not Angels but Humans' An Exploratory Qualitative	UK - published	8 qualified nurses within the NHS who had experience of self-harming whilst training or during a period of	Data collection was carried out via semi-structured interviews,	Themes explored contributors to self-harm, nursing culture and barriers to sharing and support-seeking, tensions associated with holding both professional

	Study of Female Nurses With Lived Experience of Self-Harm and Suicidal Behaviours		their practice. Of the 8 participants, 5 were trained as mental health nurses. Self-harming and suicidal ideation and behaviours.	data analysis carried out via reflexive thematic analysis	and lived experience identities. Findings generated recommendations for workplace support and suicide prevention.
Hannah, (2023)	Experiences of trainee clinical psychologists and workplace supervisors when mental health difficulties are shared.	UK – Grey Literature (doctoral thesis)	12 qualified clinical psychologists. Participants had qualified within 5 years prior to the interview. Depression, low mood, anxiety disorders, stress and burnout.	Data collection was carried out via narrative informed interviews. Data was analysed via a reflexive thematic analysis.	Trainees described a complex process of deciding whether to share mental health difficulties, influenced by fears, selectivity and contextual factors. Psychological safety, supportive supervision and normalisation facilitated sharing, while power imbalances and concerns about judgement created barriers. Lived experience also shaped professional identity and clinical practice.
Ryan, (2020)	The Wounded Healer: Personal experiences of mental health	Uk – grey literature	17 qualified clinical psychologists Anxiety and depression most frequently reported, some eating	Data collection was carried out via semi-structured interviews.	Lived experience was described as both a clinical asset and a source of challenges requiring monitoring and management. Participants reflected on the

	difficulties and trauma and their influence on the professional practice of Clinical Psychologists and other therapy professionals	(doctoral thesis)	disorder and self-harm, 1 report of previous difficulties with EUPD	Data analysis was carried out via thematic analysis	interaction between personal and professional identities, including its influence on career choices and sense of self. Secrecy was often used as a form of self-preservation, preventing sharing, shaped by professional expectations and evolving over time..
Turner et al. (2022)	I think it does just opens it up and you're not hiding it anymore': Trainee clinical psychologists' experiences of self-disclosing mental health difficulties	UK - published	12 trainee clinical psychologists UK doctoral training programmes. Anxiety, low mood/depression, emotion regulation difficulties, PTSD/CPTSD, self-harm, suicidal behaviour and bipolar.	Data collection was carried out via semi-structured interviews. Data analysis was carried out via a constructivist grounded theory approach.	Themes explored motivations, enablers and barriers to self-disclosure, the ways in which disclosure was communicated, responses from recipients and the individual, relational and social impacts of sharing. Disclosure was described as a dynamic process, with previous responses influencing future disclosure decisions.

Weatherston & Lorna, (2022)	Experiencing Mental Health when Treating Others. Experiences of Mental Health Workers in Relation to Mental Health Problems: Stigma, Perception and Employment	UK – published	4 mental health professionals. Wellbeing difficulties/stress, sometimes reported to be to be intensified by the workplace	Data collection was carried out via semi-structured focus group interviews, data analysis was carried out using thematic analysis.	Mental health professionals reported workplace pressures, limited support, fears of judgement and career consequences and concerns about gossip. Decisions to disclose were often influenced by crisis severity or impact on clinical work, while increased knowledge, supportive colleagues and lived experience were seen as reducing stigma.)

2.3.8. Critical Evaluation of Papers

The researcher evaluated the quality of the studies within this review by applying the Critical Appraisal Skills (CASP) checklist (CASP, 2018). This checklist is a structured tool used to evaluate the quality, validity and relevance of research studies. In particular, the checklist considers how robust a qualitative methodology within a study is. Within the context of a systematic literature review, the CASP checklist is commonly used to support transparent and consistent quality appraisal of included studies in the final review. The quality appraisal of studies included in this review found that the studies were of good quality (see Appendix D), with appropriate methodology in line with the study aim and key findings clearly presented. Therefore, all 11 studies were retained for the synthesis.

2.3.9. Stages of Thematic Synthesis

Coding was undertaken on the findings and/or results sections of included studies rather than the discussion sections. This ensured that the synthesis remained focused on reported findings, including participant quotations and authors' presentation of their analyses, while avoiding additional interpretations or theoretical explanations developed in the discussion. Discussion sections were reviewed where necessary to support understanding of study context and methodology but were not included as coded data.

Data within the studies was analysed using thematic synthesis following Thomas, & Harden's (2008) three iterative stages as described in Table 6.

Table 6

Stages of Thomas, & Harden's (2008)'s thematic synthesis

Stage of synthesis	Action Taken
Stage 1 - Free line-by-line coding	The PR began by carrying out line by line coding to identify and label meaningful portions of the text within the findings and results section of each study. Each code was labelled to indicate whether segments from the text were derived from an author quote or interpretation (AQ) or a participant quotation (PQ) within the study (see Appendix E) Whilst pre-established themes from the author of each study were noted, these were not included as final codes, to help ensure that coding remained grounded in the primary data of each study.
Stage 2: Development of descriptive subthemes	Codes were organised into initial clusters based on similarity in meaning which helped the researcher form a framework for the coding (see Appendix F). Within this clustering phase, duplicate or overlapping codes were removed and the researcher iteratively compared and reallocated codes across clusters where necessary. Overtime,

	these clusters were separated into initial descriptive subthemes (see Appendix G)
Stage 3: Development of analytical themes	The final stage of analysis involved interpreting the descriptive subthemes to develop overarching analytical themes (see Table 7) .This process moved beyond the original themes generated from the individual studies to consider new insights from the literature as a collective. Final analytical and subthemes were checked through within the supervisory team.

2.4. Review Findings

Following the thematic synthesis, five analytical themes (with subthemes) were developed, as presented in Table 7.

Table 7

Final analytical themes and subthemes

Analytical themes	Subthemes
1 - Sharing as a Complex Decision-Making Process Characterised by Weighing Potential Benefits and Risks	The significance of the evaluative nature in work and training environments
	Sharing as a possible route to accessing support
2 - Shame, Stigma and Acceptability of Distress in the Mental Health Profession	Societal expectations of healthcare workers to be resilient and self-sacrificing
	Wider stigma internalised amongst mental health staff
	A perceived hierarchy of acceptable mental health difficulties
	The workplace as a contributor to distress
3 - Navigating Dual Identity – the Interaction of the 'Personal' and 'Professional' self	Making sense of personal distress through the professional lens
	Personal vs professional identity
	Sharing aligning with professional values
4 - The Quality of Sharing Experiences	Previous experiences informing sharing decisions
	Management and control of the sharing process
	Quality and safety of relationships with the recipient
5 - Workplace Culture and Opportunity for Change	Sharing as a way to support others in the profession
	The impact of organisational culture on feeling able to share

Analytical Theme 1: Sharing as a Complex Decision-Making Process Characterised by Weighing Potential Benefits and Risks

All of the reviewed studies highlighted that participants considered both the potential benefits and risks associated with sharing mental health difficulties with colleagues in the workplace and/or their training programme. Self-disclosure was commonly described as a complex, deliberate and context-dependent process, where staff weighed potential risks against anticipated benefits beforehand. While concerns regarding the evaluative nature of workplace and training environments often shaped these decisions, disclosure was also recognised as a potential route to accessing support. Participants also suggested that drawing on lived experience and reflecting on personal distress could enhance empathy, insight and clinical understanding.

Subtheme - The significance of evaluative nature in workplace and training environments.

Across all of the reviewed studies, participants expressed concerns that sharing mental health difficulties contributed to a sense of professional vulnerability which may potentially influence how their competence, professionalism and suitability to practise were judged by colleagues, supervisors and institutions. These fears were often linked to potential professional consequences, including impacts on career progression, reputation and increased scrutiny during fitness to practise processes. It was highlighted that fears in this area were sometimes intensified by lack of knowledge on what formal fitness to practice procedures would entail.

"I remember saying to my wife I can't tell them on the course, they won't say I'm fit to practice." (Hannah, 2023)

Fear of professional consequences sometimes led participants to fully conceal their difficulties, with the degree of concealment varying across contexts (e.g. within university and clinical placement) with some of the literature highlighting that these fears were intensified in circumstances where participants had observed institutional consequences in others.

In studies where participants reflected from the perspective of being a trainee clinician, frequent assessment and ongoing evaluation within the training environment, combined with power imbalances such as within supervisory or course tutor relationships (Bailey et al., 2024; Hannah, 2023; Turner et al., 2022), contributed to heightened concerns about the risks associated with disclosure. These concerns were further shaped by pressure to successfully complete and pass clinical placements, with some concerns on financial impact reported if course completion was delayed (Hannah, 2023). Participants also highlighted apprehension about the potential permanence of disclosure, acknowledging that once lived experience was shared, it could be difficult to retract (Bowman, 2023).

"Once you've uncorked that conversation, you can't put the genie back in the bottle. It's like, 'God, I'm forever gonna be, you know, seen as being not capable'... I'd kind of be, you know, marked." (Bowman, 2023)

Subtheme - Disclosure as a possible route to accessing support.

Multiple studies identified self-disclosure as a potential pathway to accessing support, including sick leave and other workplace accommodations, which helped individuals continue working and/or advance within their training programmes (Bowman, 2023; Hannah, 2023; Bamber et al., 2025; Turner et al., 2022, Bailey et al., 2024, Weatherstone & Dodd, 2022; Groves et al., 2026). Formal support pathways included occupational health services, therapy and structured support plans. Informal support such as peer networks and safe spaces for discussing mental health experiences, were also highlighted as valuable and accessible. Many of the studies found that individual safe spaces for staff to talk about their difficulties were beneficial. The literature highlighted mixed viewpoints towards group support with some suggesting that group support takes away from individual needs whilst other participants drew benefit from a sense of connection in a group setting.

"I personally don't want to sit with a group of people because I end up focusing on their needs and I put my needs secondary. I personally would need a one- to- one. Others who like that camaraderie and that peer that peer support would probably like that. Yeah, I think it needs to be bespoke to the individual." (Groves et al., 2026)

Participants also described engaging in self-monitoring to recognise when support might be needed, with encouragement from colleagues or supervisors sometimes acting as a catalyst for seeking help.

"They need to know how much I'm struggling because I need the adaptations (…) I didn't know what was possible, I didn't know how flexible the course could be, I didn't know that I

could go back part-time… so I needed them to guide me and give me the options." (Hannah, 2023)

Although self-disclosure was often framed positively in facilitating access to support, participants also described a sense that disclosure was effectively mandatory in order to receive such support. This reflects an underlying tension between the need to access support to maintain the ability to practise safely and the fear of potential professional consequences following disclosure.

"I guess sometimes there are gonna be times when we don't have a choice about disclosure. If we need to have time off or we need specific adaptations. Umm, you know, you're then faced with the choice of either you quit or you disclose." (Bowman, 2023)

Analytical Theme 2: Shame, stigma and acceptability of distress in the mental health profession

All studies identified shame, stigma and the perceived acceptability of distress within the mental health profession as key influences on disclosure decisions. This theme encompassed societal expectations of resilience and self-sacrifice, internalised stigma, a hierarchy of 'acceptable' difficulties and the workplace itself as a source of distress.

Subtheme - Societal expectations of healthcare workers to be resilient and self-sacrificing.

Several studies specifically highlighted societal expectations for mental health staff to be resilient and self-sacrificing which conversely made sharing decisions or asking for help,

difficult (Bailey et al., 2024; Bowman, 2023; Cleary & Armour. 2022; Groves et al., 2026; Weatherstone & Dodd, 2022). Some participants shared that they felt portrayed as 'superhuman' which reinforced expectations that they should endure high levels of stress whilst putting the vulnerabilities they were experiencing to the side (Ryan, 2020). Distress was normalised within these contexts, particularly during times of public crisis such as during the COVID-19 pandemic with some findings highlighting the 'clap for heroes' to further perpetuate the assumption and need for healthcare workers to be highly resilient (Farley et al., 2025).

"I'm a public servant or, you know, I work for the NHS. I need to remain solid… And there's an overall value the NHS puts on, 'Come on, we can do this. We're a team, we're helping other people', which I think can sometimes undermine people's sense of being able to disclose sort of mental health difficulties themselves." (Bowman, 2023)

An increased pressure for participants to prioritise the needs of others over their own was found. Furthermore, studies highlighted the association between these expectations and a reluctance to seek support due to concerns around being perceived as weak. Wider societal expectations towards healthcare staff appeared to filter down at a more local level within mental health services, with some staff in psychology-based roles sharing a sense of pressure from colleagues assumed them to be problem solvers responsible for figuring out difficulties within the team when they are unsure themselves (Bowman, 2023; Ryan, 2020).

"It's like something awful happens and it's 'oh we'll go to psychology team they'll sort it out for us' (…) there is this perception that we can somehow tolerate things in a superhuman way." (Ryan, 2020)

Subtheme - Wider stigma internalised amongst mental health staff.

Across the literature, public expectations appeared to contribute to internalised stigma amongst mental health staff. Feelings of shame, embarrassment and anxiety shaped decisions around disclosure, with many professionals reluctant to reveal their difficulties due to internalised negative beliefs (Bailey et al., 2024; Bowman, 2023; Davies et al., 2023; Farley et al., 2025; Turner et al., 2022, Ryan, 2020).

"I think especially being a psychologist, there's almost this duality of 'I'm supposed to be able to manage this better,' so sometimes there's a fear or a sense of shame coming from if I am having a really difficult time". (Davies et al., 2023)

Synthesised findings indicated that this reluctance was linked to pressure to appear "perfect," and the internalised belief that mental health practitioners should be able to manage their own psychological difficulties independently because of their training and expertise. Whilst studies highlighted the tendency for perfectionists to be drawn to working in the mental health field, concerns in this area were often not considered to be irrational, as they were grounded in professional expectations reinforced in training and the workplace.

"I think if you have all of these strategies, tools and knowledge, yet you still need help and support yourself, then does that make you a really bad psychologist?" (Bailey et al., 2024)

These experiences further intensified self-scrutiny and contributed to the concealment of difficulties as staff sought to maintain an image consistent with perceived professional norms.

Collectively, these findings illustrate how internalised stigma may operate to reinforce shame and limit openness around distress within the profession.

Subtheme - A perceived hierarchy of acceptable mental health difficulties.

The synthesis also identified a perceived hierarchy of 'acceptable' difficulties amongst mental health staff (Bailey et al., 2024; Bowman, 2023; Clearly & Armour, 2022; Davies et al., 2023; Groves et al., 2026; Hannah, 2023; Weatherstone & Dodd, 2022). This sometimes shaped attitudes toward distress and influenced disclosure amongst participants. For example, common workplace related challenges, such as stress, burnout and workload pressures, were described to be more normalised and therefore more acceptable when considering self-disclosure as they were viewed to carry less stigma.

"I think a lot about the wider, the wider culture of labels and understanding for different difficulties, I think and the potential shame around some of them… I think it almost feels like there's a sliding scale of acceptance for me and that affects what people talk about."

(Bowman, 2023)

In particular, some findings highlighted distress related to less commonly reported mental health diagnoses such as personality disorders or psychosis were noted to be less acceptable and more stigmatised than other mental health presentations.

"I think it's like that with anxiety and personality disorder because you can get someone who, likes, says, "I'm really anxious about that", but when you look at them, I think 'well, you're

not giving out any anxiety-like, indicators to me' (...) I know it's quite big on like personality disorders, just again, 'it's just bad behavior (...) kicking off for no reason what so ever'. So, I think there's still a lot of - even though there's more information and more stuff out there, there is still deep down there is still a lot of stigma about a lot of mental health conditions."

(Weatherstone & Dodd, 2022)

Bailey et al., (2024) referred to this as the 'Goldilocks zone' where staff felt that they were able to experience or show a 'little bit' of distress but that much beyond this is less accepted within the profession. This hierarchy of 'acceptable' difficulties was further perpetuated in scenarios where participants had witnessed judgemental attitudes from colleagues towards service users who presented with similar difficulties to themselves;

"I remember this comment that a psychiatrist made that 'oh I hate working with anorexic girls because they just turn out to be personality disordered adults'... and I felt like 'y'know how could I possibly talk about my experience... if that's what you think." (Groves et al., 2026)

Subtheme - The workplace as a contributor to distress.

The workplace itself was identified as a significant contributor to distress among mental health professionals (Bailey et al., 2024; Bamber et al., 2025; Bowman, 2023; Farley et al., 2025; Groves et al., 2026; Weatherstone & Dodd, 2022). Training and assessment demands, high caseloads, staffing shortages and limited time, were reported as key sources of pressure.

"I thought that (working with patients who are suicidal) would trigger me, if I was going to be triggered. But it wasn't that way at all. It was more, how I felt at work, how disrespected I felt, how unvalued I felt, how controlled I felt, how blinded I felt and how I felt like I couldn't do anything right, there was no getting it right. How I felt like I was in danger, I was being struck off or something you know?" (Groves et al., 2026)

These pressures were perpetuated by the expectation that staff should independently manage their own wellbeing, despite working in environments characterised by high emotional demands. Furthermore, these factors contributed to experiences of overwhelm and reduced capacity to engage in self-care or reflective practice and some studies highlighted insufficient support, supervision and organisational responsiveness.

"I'm the band 5 (qualified nurse) on the ward and I'm on my own on the ward and I've got say, I don't know, three of the nurse assistants on that ward …It's not really good, me, like being an anxious melt on the floor when I'm going to be the one that they come to for help." (Weatherstone & Dodd, 2022).

Analytical Theme 3 - Navigating dual identity – the interaction of the 'personal' and 'professional' self

Previous lived experience of mental health difficulties has been frequently described as shaping professional identity, influencing both motivations to enter the field and the

development of therapeutic perspectives. This overarching theme captures how mental health professionals continually navigate and integrate their lived experience of mental health difficulties with their professional role. The subthemes reflect this dynamic by highlighting how individuals interpret their own experiences using clinical frameworks and by highlighting the ongoing negotiation, alignment and at times conflict, between the 'personal' and the 'professional' self.

Subtheme - Making sense of personal distress through the professional lens.

Review findings highlighted how mental health professionals may make sense of their own distress through a professional lens, for example, by describing their experiences using diagnostic frameworks or formulation-based approaches (Bailey et al., 2024; Cleary & Armour 2022; Groves et al., 2026). Professional knowledge of mental health difficulties and treatments was also described as facilitating disclosure, providing individuals with a language and framework through which to articulate their experiences, contributing both to greater self-understanding.

"The theoretical knowledge gave structure to my inner world and a language with which to express it and I found this to be really powerful." (Cleary & Armour, 2022)

Some accounts also suggested that working with escalating distress in patients could help staff with lived experience recognise similar patterns and triggers within themselves which helped them manage their own distress and asking for help where needed, potentially preventing similar escalation.

"One thing that I would say is that being exposed to self-harm and suicide patients during my practice, somehow protected me from going into a suicide attempt because I could recognise the escalation pattern that I was taking was something that I had seen patients done before. And I had seen the effects and the long-term effects of what a suicide attempt can bring to your life that actually protected me from going farther. That's what actually made me call for help". (Groves et al., 2026)

Subtheme - Personal vs professional identity.

Participants commonly described the challenge of navigating a dual identity, balancing the roles of practitioner and individual with lived experience (Bamber et al., 2025; Bowman, 2023; Cleary & Armour, 2022; Groves et al., 2026; Turner et al., 2022. This was particularly prominent for staff on training placements in the workplace, where the development of a professional identity was accompanied by heightened self-reflection, during development on their training into practitioners and at times, uncertainty about their sense of self. The review findings further suggested that professional identity is not fixed, but fluid and evolving over time, shaped by the dynamic interplay of personal and professional experiences.

"I am a clinician, but I'm also a service user who is accessing therapy. At the moment, I kind of have both hats and I think in teaching it felt like I kind of had to try and put that 'expert by experience hat' away and just be the expert by profession... But, that felt really uncomfortable." (Bamber et al., 2025).

Self-disclosure was identified as a key mechanism through which some individuals were able to integrate their personal and professional identities adding to a sense of relief of not feeling pressure to hide difficulties, although this process was often complex and context dependent. Additionally, previous lived experience of mental health difficulties was frequently described as shaping professional identity, often informing career choice, values and therapeutic approach.

"It's helped me to recognise my boundaries and this position that I take in terms of being a human and being a trainee and having the two together… it's helped me to own it a lot more I think and own my lived experience and how that helps me as a therapist, as a psychologist."

(Turner et al., 2022)

Professional identity was often shaped in parallel with personal experience, with individuals drawing on, but also attempting to regulate or distance themselves from, their own distress in order to align with perceived professional norms. This 'distancing' was spoken to in terms of masking or concealing personal difficulties in some, whereas for others, they were able to recognise the impact the masking was having on their wellbeing, which acted as motivation towards sharing their lived experience.

"I do think for me the biggest thing that's impacting for my mental health is this feeling like you have to be something you're not and be someone you're not and constantly having to

wear a mask. And I just think the more opportunities there are to take that mask off and be your real and authentic self, the better."

(Bamber et al., 2025)

Subtheme - Disclosure aligning with professional values.

The review findings also identified a subtheme relating to professional values and beliefs among mental health staff that support self-disclosure (Bowman, 2023; Davies et al., 2023; Turner et al., 2022). The process of sharing lived experience of mental health difficulties to access support, or when staff considered the impact it may have on their clinical work, was often in line with both personal and professional values in relation to the desire to be authentic and the importance of working through transference in clinical work, with considerations of client wellbeing in mind.

"There was only one thing, it was very clear. It was my professional duty to disclose. Because I was dealing with a case that was too close to home, I needed an outsider to help, to guide me through that case. So … that was it." (Turner et al., 2022)

Analytical Theme 4 - The quality of sharing experiences

The review findings shed light on the disclosure experience itself, namely how previous experiences helped to inform future decisions and considerations around self-disclosure. Participant management and control during the disclosure process and the quality and safety of relationship with disclosure recipient.

Subtheme - Previous experiences informing sharing decisions.

Previous experiences of disclosure and support were reported to influence future help-seeking behaviours (Bailey et al., 2024; Bowman, 2023; Hannah, 2023; Turner et al., 2022). Across the reviewed studies, positive responses to previous disclosures were described as encouraging greater openness and facilitating access to support, as participants anticipated that their difficulties would be met with understanding rather than judgement.

"It paved the way for me to be a bit more open about how I was feeling.. I didn't feel that I had to hold back" (Hannah, 2023)

On the other hand, negative or uncertain previous experiences were found to reinforce caution and at times resulted in participants minimising their difficulties or contribute to the decision to fully conceal them.

"I suppose my experience of saying that (disclosure) was, you know, when you can feel like people are having a double look at you. And I thought, I'm not saying that again… it didn't feel comfortable to me, so I did it once and I wouldn't do it again." (Bowman, 2023)

Disclosure was often described as part of an ongoing, iterative process, in which past experiences informed subsequent choices through both positive and/or negative feedback loops where confidence to disclose increased or decreased over time.

"And then I ended up… going through a fitness-to-practice hearing, which was horrific… I felt very voiceless. I felt powerless. I felt like I didn't have a say in the process. I felt… done-to and I felt like I couldn't object really, so disclosure felt like a very painful and tricky process." (Bowman 2023)

Subtheme - Management and control of the sharing process.

The review findings found that participants adopted strategies aimed at minimising potential risks that were anticipated as a result of disclosure (Bailey et al., 2024; Bamber et al., 2025; Bowman, 2023; Davies et al., 2023; Farley et al., 2025; Turner et al., 2022). These approaches to disclosure were described as a strategic decision making, often on a 'needs to know' basis and ranged from selective, 'surface level' disclosure to full concealment of mental health difficulties within the workplace across various contexts such as job interviews, academic teaching spaces, clinical supervision spaces and placements.

"*I'd probably say.. the tip of the iceberg if I want to talk about something. I'd probably make it 'PG' if that makes sense. I really sort of dampen it down sort* of." (Farley et al., 2025)

Many participants described a gradual, trust-based approach, revealing personal experiences incrementally, as confidence in the relational safety increased. For some participants, there was a sense that sharing lived experience of mental health difficulties was more acceptable to others when thought of as past experiences and less so if distress was taking place in the present.

"I always get the feeling that you have to be able to wrap your lived experience up with a bow and be very... they want a story with the beginning, middle and end... There's not that willingness for life to be messy." (Bamber et al., 2025)

On a personal level, some of the findings highlighted that participants' experiences of sharing had a different feel if the difficulties they were sharing were more current, with some reporting that they would avoid sharing until it felt like a last resort.

"I guess sometimes there are gonna be times when we don't have a choice about disclosure. If we need to have time off or we need specific adaptations.. you're then faced with the choice of either you quit or disclose." (Bowman, 2023)

The review findings found that the content and framing of disclosure were often consciously managed to make it socially and professionally palatable, with attention to minimizing perceived risk to reputation or credibility.

"I made my distress so palatable and so tolerable and still had a really difficult and unhelpful reaction." (Bailey et., 2024)

Managing the emotional impact of disclosure on themselves was also a central concern, with staff weighing potential personal vulnerability against anticipated support or validation. For

many, disclosure was therefore characterised as a deliberate, evaluative process rather than a spontaneous act with caution given to avoid ‘spilling’, particularly when usure about the degree of relational safety with the recipient. However, findings also highlighted circumstances in which participants experienced limited control, such as when distress was visible to others (i.e visible self-harm scars or heightened emotions during periods of stress).

“As soon as she asked me the questions it all just spilled out.” (Turner et al., 2022)

Subtheme - Quality and safety of relationships with recipients.

The review findings consistently highlighted the importance of the perceived quality and safety of relationships with disclosure recipients in shaping disclosure decisions (Bailey et al., 2024; Bamber et al., 2025; Bowman, 2023; Cleary & Armour 2022; Groves et al., 2026; Hannah, 2023; Farley et al., 2025; Turner et al., 2022; Weatherstone & Dodd, 2022) For example, trust, confidentiality and psychological safety were highlighted as key factors with supportive and validating responses from supervisors, tutors and colleagues increasing participants’ confidence to disclose personal mental health difficulties.

“I just spoke to my line manager about it and I half expected him to freak out but he was, he was really validating (...) he didn't freak out and he was like ‘ok it's a thought and that's ok it's a thought and you don't want to act on it and you're communicating with me about it’ and that was very very different. I don't think I wouldn't have felt like that would have been acceptable to do in any other workplace” (Groves et al., 2026)

Positive relational experiences were particularly impactful when support extended beyond the initial disclosure. For example, sustained validation and appropriate follow-up check ins contributed to an increased sense of safety and trust, enabling continued openness and engagement with support. In some cases, participants also described the value of mutual support within colleagues peer cohorts, which strengthened feelings of relational safety.

"I think having safety to have friends who are close enough to know those intricate parts of you.. they didn't made it feel like I was too much or, you know like an inconvenience to them. They totally normalised it" (Bamber et al., 2025).

In less positive accounts throughout the findings, concerns about confidentiality were frequently highlighted. These concerns were often informed by witnessing breaches of confidentiality involving other colleagues - this was reported to occur both informally through workplace gossip and formally through the recording or sharing of disclosed information within organisational systems.

"I did have a manager at the time as well, who wasn't confidential, so I like… I knew everyone else's business. I knew who was going for IVF. Who was doing this, who was doing that… there's no way I would have told her because I might as well have just stood with a microphone in the car park." (Bowman, 2023)

Power imbalances between participants and disclosure recipients were also identified as barriers to disclosure. Some also reported that disclosing difficulties led to infantilising attitudes or being treated like a service user/patient.

"I felt they treated me like a patient, I could readily identify almost to the point of techniques, reframing or different sorts of interventions in out discussion.." (Bowman, 2023)

Professional and proximity-related factors further shaped disclosure decisions. Participants varied in their preferences for disclosing to individuals of different roles or levels of seniority, with some favouring peers or those outside their immediate team. In some instances, accessing support outside one's geographical or organisational context was perceived as safer. Additionally, a lack of appropriate spaces for confidential conversations was identified as a practical barrier.

"It was like a tick box sort of thing, like they knew that they had to get it done so like they tried to squeeze it in wherever they could basically" (Farley et al., 2025*)*

Analytical Theme 5 - Workplace culture and opportunity for change

The synthesis shed light on how the workplace culture impacted disclosure decisions and offered opportunities for changed. This was particularly observed in the context of staff sharing some of their own lived experience of mental health difficulties, in an attempt to support other colleagues and how the impact of wider organisational cultures in the workplace impacted participants' disclosure decisions.

Subtheme - Sharing as a way to support others in the profession.

The review findings highlighted that disclosure was sometimes motivated by a desire to support colleagues and trainees (Bailey et al., 2024; Davies et al., 2023; Groves et al., 2026; Hannah, 2023; Turner et al., 2022). In these cases, participants described carefully tailoring what, when and how they disclosed according to the context, audience and potential impact on the recipient. Such disclosures were typically selective and primarily aimed to support others and challenge stigma by normalising emotional distress amongst mental health professionals.

"I went quite kind of targeted. I'm saying this, I'm disclosing this because I wonder if it might help this particular person right now." (Davies et al., 2023)

Finally, disclosure was positioned as a means of modelling healthy ways of coping and stress management. Through sharing their experiences, staff aimed to demonstrate adaptive responses to mental health challenges, with the intention of encouraging a more sustainable and supportive workplace culture around staff wellbeing.

"I talk about looking after yourself and I say about my own mental health (..). I wish someone had said that to me right at the start, 'it is ok to make mistakes, it's ok to struggle'." (Hannah, 2023)

Subtheme - The impact of organisational culture on feeling able to self-disclose.

The review findings highlighted an awareness that staff often share similar experiences, though these are rarely openly discussed (Bailey et al., 2024). Disclosure was strongly shaped by organisational culture, with a lack of role-modelling and silencing of lived experience reinforcing stigma and an "us vs them" dynamic between staff and service users (Bamber et al., 2025; Bowman, 2023; Cleary & Armour, 2022; Davies et al., 2023; Farley et al., 2025; Groves et al., 2026)..

> *"It felt very 'us and them' and very 'this is something that people who use services might have experience' (...) without that kind of acknowledgement that actually there might be people in the room who have gone through it."* (Bamber et al., 2025)

Hierarchical and defensive workplace structures, alongside fears of judgement, career impact and confidentiality breaches, further reduced willingness to disclose (Weatherstone & Dodd, 2022). In addition, leadership and team dynamics were pivotal, with supportive cultures facilitating openness, while poor leadership and the normalisation of stress as inevitable often discouraged it.

> *"Isn't it mad that we're all psychologists and we can't talk about our feelings?"* (Bailey et al, 2024)

Conversely, opportunities for disclosure were enhanced where there were clear "in roads" such as prior openness from others and proactive check-ins from supervisors or tutors. In particular, being asked direct and specific questions about wellbeing helped participants feel more able to share the difficulties they were experiencing.

> *"(The supervisor) had noticed a slight shift [she] would reflect on that in like a gentle way that was not too like confronting and so I think she paved the way for me…rather than me feeling like I'm raising it like totally out of the blue".* (Hannah, 2023)

2.5. SLR Discussion

2.5.1. Overview

This chapter provides an overview of the SLR findings and considers these in relation to the wider literature. The strengths and limitations of the review are discussed, followed by consideration of the implications and recommendations for future research and concluding reflections.

2.5.2. Summary of Main Findings

The synthesis of the 11 included studies suggests that mental health staff experiences of sharing their own mental health difficulties with colleagues in the workplace were complex and dynamic, with sharing rarely experienced as a single, isolated event. Instead, participants described an ongoing process of evaluating whether, when and how much to share, informed by continual consideration of potential risks, benefits, safety and necessity.

The anticipated impact of sharing was often considered in relation to the evaluative nature of workplace and training environments, where concerns about judgement or professional consequences were weighed against potential benefits such as accessing support, including reasonable adjustments or the need for sick leave.

Experiences of stigma at both societal and internalised levels played a significant role in these decisions, alongside expectations that healthcare staff should be resilient and self-sacrificing, alongside a perceived hierarchy of "acceptable" difficulties within the workplace. These factors, in interaction with individual vulnerabilities, were associated with shame and anxiety.

Workplace factors such as high workloads and limited resources also contributed to distress among mental health staff. In addition, the interaction between personal and professional identities shaped sharing decisions, with staff often interpreting their own distress through a professional lens, drawing on their knowledge of diagnosis, formulation and early warning signs of deterioration, while simultaneously negotiating expectations to remain competent and appear resilient.

Previous positive and negative responses to sharing, alongside efforts to retain control over what was shared and how, also influenced decisions. The quality of relationships with recipients and perceptions of psychological safety were consistently identified as key determinants.

Some studies reported a shift towards the normalisation of lived experience among mental health staff, particularly within local peer-support contexts such as trainee cohorts in psychological training programmes. Workplace culture at both local and organisational levels emerged as a key influence on sharing decisions and experiences. While some staff used sharing to support colleagues and challenge stigma, broader organisational cultures were

sometimes perceived as barriers to openness. Suggested areas for change included creating spaces to discuss lived experience, senior staff modelling and normalising vulnerability and introducing anti-stigma initiatives in professional training to foster more supportive environments.

2.5.3. Positioning the Findings Within the Broader Literature

These findings can be understood in relation to Tajfel and Turner's (1974) Social Identity Theory, particularly social categorisation processes that shape social norms. The review highlighted a societal expectation of healthcare workers as holding a "superhuman" identity, reflected in participants' accounts of feeling expected to "psychologise" themselves out of their own distress and experiencing shame when this was not possible. From a social identity perspective, dual identities among staff may reflect negotiation between personal and professional selves, shaped by pressures to conform to in-group norms of competence and resilience while distancing from vulnerability. This also resonates with Goffman's (1963) stigma theory, which conceptualises identity management in contexts where aspects of the self are devalued, highlighting how staff may conceal or carefully manage stigmatised identities to protect professional legitimacy.

The findings can also be situated within the post-COVID-19 context. Literature has highlighted increased pressures on the UK mental health workforce alongside greater visibility of staff wellbeing (Clarissa et al., 2021; Liberati et al., 2021). However, this review suggests that sharing mental health difficulties among staff remains constrained by enduring cultural norms of high resilience and emotional containment. Despite increased societal awareness following the pandemic, similar barriers to sharing distress persist (King et al., 2020; Zamir et al., 2022). The current findings extend this understanding by indicating that

participants sometimes drew on societal responses to the pandemic to reinforce expectations of resilience among healthcare staff.

These findings can also be understood in relation to the Disclosure Processes Model (DPM) (Earnshaw & Chaudoir, 2009), which conceptualises sharing as a goal-directed process shaped by reduced inhibition, anticipated support and changes in social information.

Figure 2

Chaudoir & Fisher's (2010) Disclosure Processes Model (DPM)

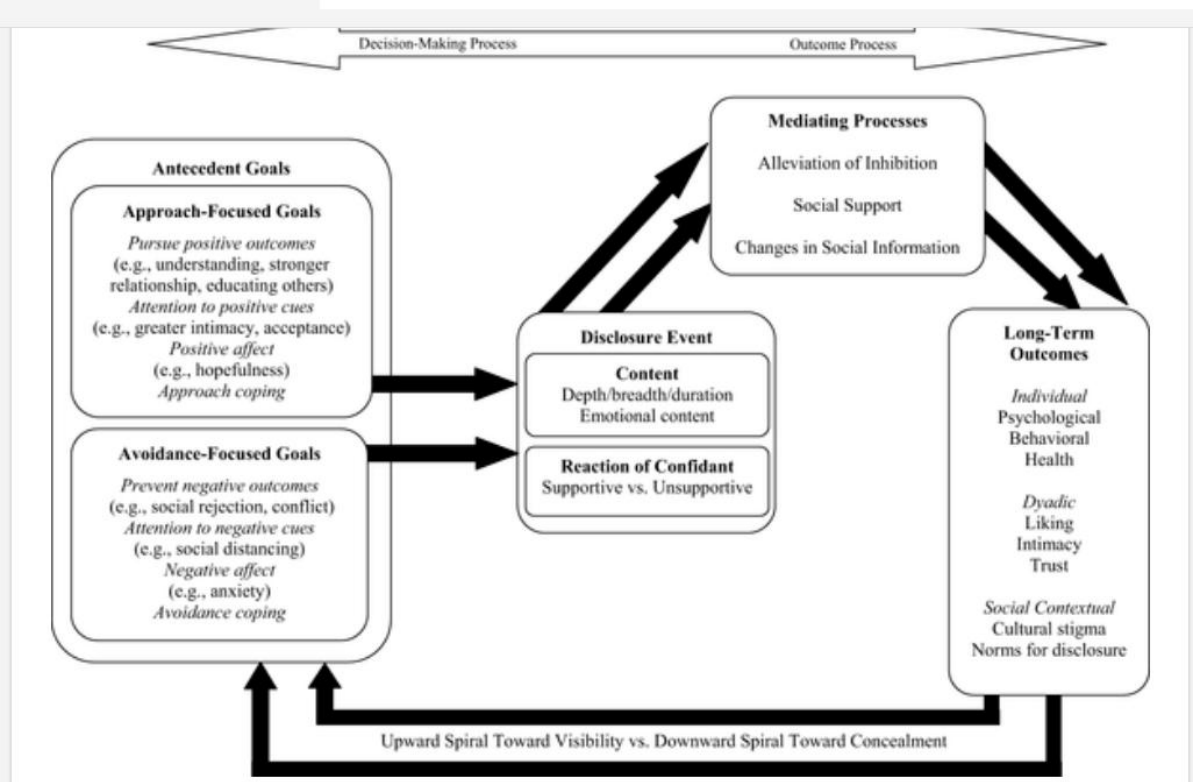


Diagram of the disclosure processes model.

Within the review findings, staff accounts reflected goal-directed approaches in line with the DPM model, such as sharing lived experience to access reasonable adjustments, support others and challenge stigma. The model also highlights that non-disclosure decisions are guided by avoidance-focused goals, reflected in participants' concerns about negative

evaluation, fears of confidentiality breaches and potential fitness to practise scrutiny. These competing motivations illustrate the tension underpinning sharing, helping to explain why sharing was often selective, strategic and context dependent.

The findings can also be considered in relation to the concept of the 'wounded healer' (Jackson, 2001), which offers a lens for understanding the dual identity of mental health staff as both clinicians and individuals with lived experience of mental health difficulties (either personally or through a loved one). Lived experience was at times positioned as a professional asset, enhancing empathy, authenticity and relational connection with clients, but was also seen as a potential burden, with concerns that sharing personal difficulties could invite scrutiny of professional competence. This tension reflects the central premise of the wounded healer concept, where personal experiences of suffering may enrich practice while also generating vulnerability and uncertainty.

The findings also align with systemic positive and negative feedback loops and behavioural reinforcement, where previous experiences shape future behaviour (Meadows, 2008; Skinner, 1953). Positive responses to sharing were described as facilitating greater openness over time, strengthening trust, psychological safety and comfort in seeking support, whereas negative experiences were associated with increased caution, withdrawal and concealment.

2.5.4. Strengths and Limitations

Most included studies recruited predominantly white participants. Therefore, the findings may not fully reflect the experiences of mental health staff from a diverse range of backgrounds important issues of intersectional identities, may contribute additional layers of

stigma that influence decisions about sharing mental health difficulties in the workplace (Alam et al., 2024).

Given the qualitative methodologies employed within the reviewed studies, participant samples were typically made up of individuals who had disclosed, or felt sufficiently safe to discuss, their experiences. As a result, a limitation of this review is that the synthesis may underrepresent the perspectives of those who felt unable to participate, as well as those whose experiences were neutral or positive and therefore less likely to motivate participation.

A key strength of this review is its focus on UK mental health workplace culture. Unlike previous reviews that synthesised evidence across countries such as the USA and Australia, the current review examines experiences within a shared healthcare, policy and regulatory context between reviewed studies. The inclusion of post-COVID-19 literature is also noteworthy, given increasing public discussion of mental health within the UK (Nightingale et al., 2026) a strength of this review is that it provides an opportunity to consider whether broader societal shifts have translated into greater openness and reduced stigma amongst the mental health workplaces while identifying both persistent and emerging barriers and facilitators to sharing mental health difficulties in the workplace.

Further strengths of this review include the methodological rigour that was enhanced through guidance from PRISMA (Page et al., 2021). In addition, literature searches across multiple databases reduced the likelihood of omitting relevant studies. The PR considers the inclusion of doctoral theses predominantly as a strength of this review due to the fact that grey literature can help to reduce publication bias. However, whilst doctoral theses undergo substantial academic scrutiny and doctoral level viva examination, it is acknowledged that

they have not been subject to the same formal peer-review processes as published journal articles. Nonetheless, to help mitigate the effects of this potential limitation, all studies within this review were critically appraised using the CASP (2018) checklist.

2.5.5. Future Implications and Suggestions for Further Research

The findings highlight the continued need to destigmatise mental health difficulties within the workplace as more open and accepting organisational cultures appear to promote psychological safety, with potential benefits for staff wellbeing, burnout, presenteeism, team functioning and quality of care for service users (Brooks et al., 2011).

At an organisational level, the findings emphasise the importance of distinguishing restorative and supportive supervision from performance management processes and ensuring that confidentiality boundaries are clearly communicated and upheld. The findings also contribute to broader critiques of wellbeing cultures within healthcare organisations, where a gap persists between formal wellbeing strategies and staff experiences. Despite national workforce and wellbeing initiatives, high workloads, understaffing and performance pressures remain prevalent, suggesting that wellbeing interventions alone may be insufficient without wider systemic change (The King's Fund, 2024).

The findings may also have implications for professional training programmes for mental health staff, as the normalisation of workplace challenges and lived experience during training, appeared to facilitate comfortability in being able to share mental health difficulties. In addition, the review highlighted a need clear organisational policies and transparency regarding fitness-to-practice procedures as uncertainty towards these amongst participants acted as a barrier towards sharing and help-seeking among staff.

Although substantial overlap was identified across professions, some role-specific differences emerged, suggesting that disclosure decisions may be shaped by profession-specific

expectations and working conditions. Further research is therefore needed to determine whether tailored approaches to supporting disclosure are warranted.

2.5.6. Review Findings Informing the Present Study

The review demonstrated that sharing experiences among mental health staff are shaped by stigma, organisational culture and perceptions of psychological safety. However, the literature focused predominantly on more commonly discussed experiences such as anxiety, stress and depression, with relatively little attention paid to diagnoses associated with greater stigma. Experiences relating to personality disorder, bipolar disorder and psychosis amongst mental health staff have very rarely been explored and on occasion where these experiences are captured within broader topics regarding disclosure and stigma in more general terms (Ryan, 2020; Weatherstone & Dodd, 2022).

These findings suggest that efforts to normalise mental health difficulties within the workplace may not be experienced equally across different forms of distress. Consequently, there remains limited understanding of how staff living with more heavily stigmatised diagnoses navigate workplace experiences and professional identity. This gap is particularly evident in relation to Emotionally Unstable Personality Disorder (EUPD), a diagnosis that remains highly stigmatised and contested within mental health services. EUPD was therefore selected as the focus of the upcoming empirical study due to its association with complex judgements regarding personality, behaviour and professional suitability (McKenzie et al., 2022), making it a useful context through which to explore the operation of stigma in the workplace.

To the researcher's knowledge, no previous research has specifically explored the workplace experiences of mental health staff diagnosed with EUPD. The present study introduced in the next chapter was therefore developed to address this gap by exploring how mental health staff diagnosed with EUPD make sense of working within mental health services.

3.0. Empirical Study - Exploring the Workplace Experiences of Mental Health Staff Diagnosed with Borderline or Emotionally Unstable Personality Disorder: An Interpretative Phenomenological Analysis

3.1. Overview

This chapter introduces the empirical study of the thesis, providing an overview of Emotionally Unstable Personality Disorder (EUPD) and Borderline Personality Disorder (BPD), including key terminology and differing perspectives on the diagnosis. The gap in the literature concerning mental health staff diagnosed with EUPD is then outlined, followed by the rationale for the study.

3.2. Emotionally Unstable Personality Disorder (also known as Borderline Personality Disorder)

The diagnosis of Emotionally Unstable Personality Disorder (EUPD) is described to be a mental health condition characterised by long term difficulties in regulating emotions, intensity/instability in interpersonal relationships, a strong fear of abandonment, increased suicidality/self-harming behaviours, paranoia and/or dissociation (Gunderson, et al. 2018). Typically, within clinical practice and academia, both EUPD and Borderline Personality Disorder (BPD) refer to the same diagnostic construct within different classification systems (NHS England, 2024). Historically, BPD has been the more widely used term internationally, particularly within countries utilising the Diagnostic and Statistical Manual of Mental Disorders (DSM) diagnostic system. Whereas EUPD is the term adopted in the International Classification of Diseases (ICD), predominantly used within Europe and is more commonly used in UK clinical practice (American Psychiatric Association, 2022; World Health Organization, 1992).

In 2022, the revised version of the ICD-11 modified the approach and identification towards personality disorder (PD) diagnoses with a rating scale of ‘mild’, ‘moderate’ or ‘severe’ across the domains of ‘negative affectivity’, ‘detachment’, ‘dissociation’, ‘disinhibition’, ‘anankastia’ (World Health Organization, 2019). However, the ICD-11 also includes the ‘borderline pattern specifier’ (which is in line with the DSM-5 BPD criteria) for those who may benefit from evidence-based treatment that was developed specifically for BPD previously.

The diagnosis of EUPD sits within the broader category of psychiatric diagnoses that are not defined, assessed or diagnosed in accordance to objective biological markers, such as blood tests or genetic markers but are instead constructed through the identification and clustering of behavioural, emotional and interpersonal symptom patterns identified by clinicians (Kendler, 2016). As such, diagnostic categories are not static and have evolved over time in response to shifts in clinical understanding, research evidence and wider social and political contexts (Jablensky, 2016). Historically, those diagnosed with EUPD has been associated with pessimistic clinical attitudes and assumptions regarding its treatability (Aviram, et al., 2006). However, this view appears to be shifting over time with the development and expansion of evidence-based psychological interventions for those struggling with symptoms that align with the diagnosis (Sciriha, 2024). In the UK context, policy developments such as the principle that “personality disorder is no longer a diagnosis of exclusion” have been influential in the attempt to shift towards more inclusive mental health support for those with the diagnosis (National Institute for Mental Health in England, 2003).

3.3. Differing perspectives towards the EUPD diagnosis

There have been ongoing discussions regarding the appropriateness of EUPD as a diagnostic label. Advocates argue that the label may perpetuate stigma by implying an inherently flawed personality and locating distress within the individual, rather than considering the impact of childhood trauma (Heller, 2002). However, others find that receiving a EUPD diagnosis, alongside supportive and conscientious care, can provide validation and hope for treatment (Holm-Denoma, et al., 2008).

In Elliott & Ragsdale's (2020) study, mental health staff with lived experience themselves, reported stigmatised views towards other mental health presentations, with EUPD most frequently associated with negative attitudes. Some participants expressed strong reactions, such as "I would be really hesitant about referring someone to them" (a clinician with EUPD) and that it is "a little terrifying to think that person (with EUPD) is a therapist." A systematic review of mental health staff attitudes towards people diagnosed with EUPD also found consistently more negative perspectives compared to diagnoses such as depression and anxiety, including lower optimism about treatment and reduced empathy (McKenzie et al., 2022). A related study of 706 clinicians found that half of participants preferred to avoid working with this client group (Black, et al., 2011). However, it was also found that greater experience and targeted training amongst staff was associated with higher empathy and treatment optimism, suggesting that education and exposure may reduce stigma in clinical practice.

Broader debates around EUPD reflect wider disagreements in psychiatric classification regarding categorical versus dimensional approaches to personality pathology (Hörz-

Sagstetter, et al., 2021). Concerns have also been raised about the diagnosis's reliability and validity, particularly due to overlap with trauma-related distress, autism and ADHD, leading some to question whether these experiences are best understood as distinct diagnostic entities (Ford & Courtois, 2014; Gillett et al., 2023; Matthies & Philipsen, 2014). However, while the conceptualisation of EUPD remains contested, these debates do not negate the significant emotional distress experienced by those who receive the diagnosis; rather, they reflect differing views on how such experiences should be understood, described and addressed in clinical practice.

Despite ongoing conceptual debate, EUPD remains widely used across clinical and academic contexts and has important implications for experiences of stigma, therapeutic engagement and access to care. As such, exploring staff experiences and attitudes towards this diagnosis remains both clinically and socially important

3.4.Pre-existing Literature on Mental Health Staff Who Have Been Diagnosed with EUPD

At present, it is unclear whether the limited literature in this area reflects a low prevalence of the diagnosis among mental health staff or the potential underreporting and concealment of lived experience related to EUPD within the workforce.. Given evidence that mental health staff may already have concerns about sharing their own mental health difficulties (King et al., 2020), the additional stigma attached to an EUPD diagnosis may further reduce feelings of safety in sharing their personal experience with the diagnosis. This lack of visibility may in turn reinforce assumptions that staff who identify with, or have experienced difficulties associated with EUPD are unlikely to be present within the workforce, potentially contributing to reduced research attention in this area. An example of this broader issue is

provided by Dr Marsha Linehan, a clinician who later publicly discussed her own experiences of severe psychological difficulties, that have since been widely linked to what would now be recognised as EUPD, prior to developing Dialectical Behaviour Therapy and becoming a leading figure in the field (Linehan, 2020; PsyD, 2011). As such, the limited literature may reflect not only a gap in research but also broader social and professional barriers associated with a highly stigmatised diagnosis.

3.5. Rationale, Aims and Research Question of The Present Study

Existing literature indicates that mental health staff decisions to share their lived experience are shaped by stigma, professional identity and workplace culture (King et al., 2020). However, these studies rarely distinguish between diagnostic categories, with these difficulties most commonly framed in relation to anxiety, stress, or depression (Zamir et al., 2022). Less is known about how staff navigate disclosure when living with diagnoses that may attract higher levels of stigma and more contested clinical interpretations. Where diagnoses such as personality disorder, bipolar disorder and psychosis are included in lived experience literature, they are typically addressed as secondary considerations within broader studies of clinician wellbeing, stigma, or disclosure, rather than as the primary focus (Weatherstone & Dodd, 2022).

While considerable research has examined professional attitudes towards individuals diagnosed with EUPD, there is a notable lack of research focusing on mental health staff who themselves have received the diagnosis. Consequently, the lived experiences of these staff remain largely underexplored. Exploring the experiences of mental health staff diagnosed with EUPD may therefore extend existing understandings of stigma by situating these processes within a diagnostically specific and under-researched context. In particular, it may

offer a more detailed account of how a highly stigmatised and contested diagnosis influences sharing decisions, workplace relationships, professional identity and psychological safety. More broadly, increasing understanding in this area may contribute to ongoing discussions about stigmatising assumptions associated with people diagnosed with EUPD, including both staff and service users.

Research Aim

The aim of the present study was to explore how mental health staff diagnosed with Emotionally Unstable Personality Disorder (EUPD) experience and make sense of their working lives

Research Question

The research questions of the present study are presented below:

How do mental health staff diagnosed with EUPD experience the workplace?

What meanings do mental health staff diagnosed with EUPD attach to their workplace experiences?

4.0. Methodology

4.1. Overview

This chapter outlines the methodology taken for the empirical study within this thesis, where details surrounding the study design, participant recruitment, participant demographics and the development of the interview schedule, interview process and stages of analysis are presented

4.2. Methodological Approach

4.2.1. Rationale for Qualitative Method of Study

With one of the key aims of this research being to explore the 'meaning making' participants draw from their lived experiences, a qualitative method of study was adopted to facilitate a rich insight into participant experiences, by capturing the nuanced, contextual and varying interpretations within their story (Goodwin & Goodwin, 1984). Whilst quantitative research can capture data on a wider scale, outcomes are measured numerically and are often categorised into predefined variables, which may limit its ability to capture the finer complexities and nuances of participants' experiences (Kandel, 2020).

4.2.2. An Introduction to Interpretive Phenomenological Analysis (IPA)

Interpretative Phenomenological Analysis (IPA) is a qualitative research approach that seeks to understand how individuals interpret and make sense of their lived experiences (Smith, 1996). IPA is grounded in phenomenology, which is a philosophical tradition that seeks to understand human experience as it is subjectively lived and consciously perceived (Flood, 2010). Central to phenomenology, is an interest in exploring experience as it presents itself in

consciousness, prior to extensive reflection, explanation, or theorisation (Gallagher, 2022). Drawing on these principles, IPA aims to provide a detailed exploration of how individuals perceive, interpret and attribute meaning to their lived experiences. IPA is also based on the theoretical foundation of hermeneutics, which refers to the process of how the researcher interprets a participant's experiences. Within IPA, a 'double hermeneutic' process occurs in which participants interpret and make sense of their own experiences, while the researcher seeks to interpret and make sense of the participants' accounts during analysis. (Eatough, et al 2017). In addition, IPA involves engagement with the 'hermeneutic circle', where the researcher's understanding of the data develops through an iterative process of analysis. This involves moving repeatedly between specific sections of a participant's transcript and the broader account, with each reading deepening understanding as the researcher shifts between interpreting individual elements of the text and the wider experience. A similar 'circular motion' is also experienced when the researcher shifts reflection and analysis between individual participant responses and where they are placed within broader experiences within the wider group of participants (Gyollai, 2020).

4.2.3. The Suitability of IPA Compared with Alternative Approaches

Given that the central aim of this study is to explore how mental health staff diagnosed with EUPD make sense of their workplace experiences, a methodological approach capable of capturing depth and complexity was required. IPA was considered particularly appropriate due to its idiographic and hermeneutic foundations, which facilitate in-depth exploration of individual meaning-making, particularly in relation to sensitive personal experiences. Based on a review of the literature, no previous research, to the PR's knowledge, has specifically explored the experiences of mental health staff diagnosed with EUPD. The PR therefore considered IPA a useful starting point for enquiry in this context, providing a foundation for

future research and valuing subjective experience in a way that may be less foregrounded within other approaches such as thematic analysis (Terry, et al 2017).

As previously noted, EUPD remains a contested construct, with ongoing debate among professionals and service users regarding its use in mental health services (Campbell et al., 2020). This plurality of perspectives suggests multiple and sometimes conflicting, interpretations both within and across participant accounts. While IPA does not assume uniformity of experience, it is well suited to examining patterns of convergence and divergence within a shared experiential context (Smith et al., 2009). Diversity of perspectives is therefore not viewed as problematic but as an opportunity to develop a richer understanding of how individuals interpret similar phenomena in different ways.

Other qualitative approaches were considered. Grounded Theory (Glaser & Strauss, 1968) was not selected, as the aim was not to generate a theoretical model of a social process but to explore meaning-making in participants' accounts. Narrative Analysis (Riessman, 2008) was also considered but deemed less appropriate, as the focus was not on the structure or construction of stories. In summary, IPA offered the most appropriate framework for examining how mental health staff diagnosed with EUPD make sense of their workplace experiences, while allowing for both shared and divergent accounts.

4.2.4. Decolonising values within IPA

IPA is rooted within European phenomenological and hermeneutic traditions and therefore remains situated within Western epistemological frameworks (Smith et al., 2022). However, in contrast to more positivist approaches that prioritise objectivity and measurement through hypothesis testing and control of variables (Mayrhofer et al., 2021), IPA focuses on participants' subjective meaning-making and views individual lived experiences as a legitimate source of knowledge (Smith et al., 2022). This is particularly important given that

people vary in how they relate to and discuss their mental health experiences, with comfort around disclosure often shaped by social context, workplace settings, professional roles, cultural backgrounds and religious identities (Sheikh & Furnham, 2000). IPA holds space for this variability by allowing participants to articulate their own understandings of experience, rather than these being interpreted solely through pre-existing professional or diagnostic frameworks. As such, this approach can be seen as aligning with decolonising approaches to research, which emphasise the recognition of marginalised forms of knowledge and challenge the dominance of externally imposed interpretations (Smith, 2021).

4.2.5. Study design

This study adopted a qualitative design using Interpretative Phenomenological Analysis (IPA) and semi-structured interviews. When considering whether to conduct interviews face-to-face or online, the potential limitations of online interviewing, including reduced access to non-verbal cues and challenges in rapport building, were weighed against the benefits, such as the ability to recruit participants from a wider geographical area across the UK. This led to the decision for interviews to take place online. The semi-structured nature of interviews within an IPA framework helps to balance structure and flexibility, allowing participants to respond freely, whilst also enabling follow-up questions that facilitate a deeper exploration of participants' lived experience in their own words (Smith et al., 2021).

4.2.6. Ethics

The study received ethical approval from the University of Hertfordshire Ethics Committee (reference number – 0997 STa HSET 2025) – see Appendix H. Participants were provided with a participant information sheet (see Appendix I), which outlined the purpose and rationale of the study, what participation would involve, how data would be stored and used and their rights as research participants. They were then asked to read and sign a consent

form (See Appendix J) prior to participation, confirming their voluntary agreement to take part and their understanding of the information provided.

The participant information sheet also informed participants of the possibility that recounting previous experiences during the interviews may cause distress. Participants were advised of their right to withdraw from the study without explanation. They were also informed that they could pause or move on to the next question at any time. A verbal debrief was offered following the interview once recording had stopped and a written debrief sheet (See Appendix K) was emailed to participants after the video call.

Participants were informed that, due to the nature of IPA (i.e. responses being analysed individually and then collectively), withdrawal would be possible up to four weeks after completion of the interview, as removal of data after analysis had begun may not be feasible.

All video and audio recordings, transcripts, consent forms, participant contact details and other confidential information were stored on the primary researcher's password-protected University of Hertfordshire folder, in line with ethics committee approval. Prior to analysis, transcripts were anonymised and stored separately from identifiable participant information. Participants were informed that data would be retained until completion of the PR's Clinical Psychology Doctorate (September 2026) and destroyed thereafter.

4.2.7. *Expert by Experience Consultant (EBE)*

An EBE with lived experience of the EUPD diagnosis was invited to consult on the study. The EBE was recruited following an expression of interest in a post shared within a Facebook group for individuals working in psychology who have lived experience of mental health difficulties. The EBE supported the refinement of participant interview questions, the participant information sheet and the consent form, prior to ethical approval and participant recruitment. Following analysis, the EBE also engaged in consultation with the PR during the

analysis and write-up phase to support reflexivity. The EBE was reimbursed for their time and input as a token of appreciation via Love2Shop vouchers following each consultation session.

4.2.8. Recruitment

Participant recruitment took place via opportunity sampling. Ethical approval was granted to advertise the study on social media and the researcher posted the recruitment poster (see Appendix L) on platforms including LinkedIn, the National Service User Network bulletin and Facebook groups such as “Psychologists with lived experience” and “UK Clinical Psychologists”. These platforms were selected with consideration given to spaces where individuals with relevant lived experience may be likely to engage as part of the recruitment strategy. Permissions were asked and permitted from platform holders where appropriate. When considering the possible stigma attached to being a mental health staff member with lived/living experience of mental health difficulties (Tay, et al 2018) and the additional stigma associated with the EUPD diagnosis (Bradbury, 2024), the researcher adopted a recruitment process that took place via social networking sites, independent of the workplace and reassurance was given in the participant information sheet that names of workplaces/services were not required for this study and that participants would be anonymised with a pseudonym. The poster included main aims of the study, a summary of the inclusion/exclusion criteria and the primary researcher’s university email address for participants to contact for further information.

4.2.9. Participant Inclusion/Exclusion Criteria

The researcher recruited 9 participants for this study, 4-10 being the recommended sample size for an IPA approach (Smith et al., 2022). The participant inclusion criteria for this study is presented below in Table 8.

Table 8

Participant inclusion criteria

Participant Inclusion Criteria	
Inclusion Criteria 1	Mental health staff, working in a clinical role within a mental health setting. Participants who were not currently working were asked to confirm that they have worked in a relevant role/setting within the last 2 years. Examples of types of roles suitable for the study were listed on the recruitment poster and participant information sheet - e.g. support workers, assistant psychologists' mental health nurses, therapists, clinical psychologists (including trainees), social workers, psychiatrists. Examples of 'mental health settings' were described on the participant information sheet to include those who were working in roles within primary, secondary,

	specialist and inpatient settings across public, private and third sector services.
Inclusion Criteria 2	Lived experience of being diagnosed with (or previously having a diagnosis) of BPD/EUPD (or borderline pattern specifier if diagnosed via the ICD-11).
Inclusion Criteria 3	Participants were to be 18 years of age or above
Inclusion Criteria 4	To ensure that all participants can fully engage with the study, it was a requirement that participants are able to speak and understand fluent English to enable clear communication and informed consent throughout the research process

Participants self-identified as having received an EUPD diagnosis from a mental health professional (e.g. psychiatrist or psychologist) and as currently working, or having worked, in a relevant role prior to interview. While reliance on self-identification introduced a risk of ineligible participants, no financial incentive was offered, which was considered a potential safeguard against inappropriate participation. This issue was discussed in supervision, where it was agreed that any concerns regarding eligibility or participant accounts would be reviewed, including consideration of whether transcripts should be included in analysis. No participants were deemed ineligible and all transcripts were retained.

As IPA advocates relatively homogeneous samples, consideration was initially given to restricting recruitment to a single professional group (e.g. clinical psychologists or support workers) to enhance homogeneity (Smith et al., 2022). However, IPA does not assume uniformity of experience and recognises variation within shared contexts. Even within a single professional role, differences would be expected in career pathways, settings, responsibilities and personal experiences.

Given the exploratory nature of the study and the lack of prior research on mental health staff diagnosed with EUPD, a broader yet conceptually coherent sample was adopted. The key inclusion criterion was participants' shared experience of occupying a dual role as both mental health practitioner and individual diagnosed with EUPD while working in mental health services. This was considered sufficiently homogeneous for IPA while still allowing exploration of convergence and divergence in participants' meaning-making.

4.2.10. *Data Collection*

4.2.10.1. Interview measures

The interview schedule for this study (see Appendix M) were created following Smith et al.'s (2022) guidance to address the core principles of IPA to allow the exploration of both

participant and researcher interpretation and meaning making. Therefore, the questions were designed to be open ended and reflective with the opportunity for follow up questions/prompts.

The EBE consultant supported the PR with the development of interview questions with oversight from both the primary and secondary supervisors. As previous research exploring the lived experience of mental health staff has highlighted themes of dual identity (Fisher, 2023), the present study, the research team included questions that included the possible intersection of personal identity, professional job role and interpersonal dynamics within the workplace.

4.2.10.2. Participants (Demographics)

Prior to interview, participants were sent a self-report demographic form. Consistent with the study's interpretivist epistemology and critical realist ontology, researcher interpretations and are understood to be shaped by both participants' individual meaning-making and broader social and organisational contexts. Collecting demographic data therefore enabled consideration of how workplace experiences may be influenced by intersecting identities, social positioning and structural inequalities during analysis.

To provide contextual detail relevant to participants' workplace experiences and to support interpretation of findings, information on participants' sex, gender identity, ethnicity, age, sexuality, religious/spiritual beliefs, disability/health conditions and neurodevelopmental presentations was collected. Demographic categories (see Table 9) were informed by guidance on the measurement of equality published by the Office for National Statistics (2021), as well as literature highlighting overlap between EUPD, physical health conditions (Thomas et al., 2023) and neurodivergent presentations (Guest, 2021).

Table 9

A summary of participant demographic information. A full list of demographic categories included in the questionnaire is presented in Appendix N.

Demographics Categories	**Participant Demographics**
Sex	9 x female
Gender Identity	1 x non-binary 8 x woman
Ethnicity	7 x White: English, Welsh, Scottish, Northern Irish or British 1 x White: Other 1 x Mixed or Multiple ethnic groups: Other Mixed or Multiple ethnic groups
Age Range	2 x 25-34 5 x 35-44 2 x45-54
Religious/Spiritual Belief	1 x Agnostic 2 x Atheist 2 x Christian 3 x Spiritual but not religious 1 x Prefer not to say
Sexuality	4 x Straight/Heterosexual 2 x Gay/Lesbian 2 x Asexual 1 x Queer

Participants were invited to provide details of any physical or mental health conditions disabilities, long-term health conditions, or neurodevelopmental presentations in addition to their EUPD diagnosis (See Tables 10-12).

While Table 10 presents the self-reported diagnostic information collected via the demographic questionnaire, several participants also described additional mental health experiences during interviews that were not reported as formal diagnoses. These included trauma, self-harm, suicidal ideation and/or behaviours and eating disorders. Where relevant, these experiences were considered as part of participants' broader accounts and are reflected in the results. As this information was not systematically collected through the demographic questionnaire, it is not presented below.

Table 10

Other self-reported mental health conditions, disabilities, neurodevelopmental presentations, long-term physical health conditions reported alongside participants' EUPD diagnosis

Type of difficulty	Number of participants
PTSD	1
CPTSD	2
Complex mental illness	1
OCD	1
Anxiety	1

Table 11

Neurodiversity

Type of neurodivergent presentation	Number of participants

ADHD	4
Autism	2
Awaiting autism assessment	1
Dyspraxia	1
Dyslexia	1
Dyscalculia	1
Other – 'Neurodiversity'	1

Table 12

Physical disability/long term health condition

	Number of participants
Presence of physical disability/long term health condition	8

Participants were asked to indicate their current and previous job roles, with the option to select multiple roles to reflect dual or split positions. They were also asked to specify current and previous workplace settings from a predefined list, with opportunities to provide additional detail or free-text responses where appropriate. In addition, participants reported their total length of experience working in mental health settings (see Tables 13-15). Capturing both current and previous roles and settings was important, as experiences of disclosure and workplace culture may be shaped by professional experiences across multiple contexts over time.

Table 13

Overview of both current and previous clinical job role experience amongst participants within mental health settings

Type of job roles within clinical mental health settings	**Number of participants with experience working in each type of role (either currently or previously)**
Support roles	9
Peer Support roles	2
Psychological services professional (having previously completed pre-qualification training roles)	3
Pre-qualification psychological services professional role (including those who may be in current trainee roles)	2
Nursing	1
Other Allied Health professional role	1

The inclusion criteria required participants to have experience working within a clinical mental health team in a role that was not explicitly based on lived experience expertise. All participants had experience working in clinical roles, as outlined above. However, some also described experiences from adjacent roles (past and present) that are not included in the table,

including lived experience practitioner, trainer and researcher roles. Although these positions are not typically considered clinical, participants indicated that they were often embedded within mental health settings alongside clinical staff. Where relevant, reflections from these contexts were also considered during analysis, as participants occasionally drew upon these experiences as part of their broader sense-making of working within mental health services across their careers.

Table 14

Overview of both current and previous clinical mental health settings participants have worked in

Type of mental health settings participants currently or previously have worked in	**Number of participants with experience working in each setting (either currently or previously)**
Primary Care	1
Secondary Care (Adult and Older Adults)	3
Other secondary care/specialist services	5
Voluntary Sector	4
Tertiary Mental Health Settings	8
Prison Settings	1
Private Sector	1

Table 15

Length of experience working in mental health settings

Less than 1 year	1

1-2 years	1
3-5 years	4
6-10 years	1
11-20 years	1

4.2.10.3. Participant interviews

Prior to each interview, the primary PR held an initial opening conversation with participants before recording began. During this, participants were reminded of the anticipated interview duration (40–60 minutes), asked about their preferred terminology for the EUPD diagnosis and given brief information about the research team's interest in lived experience. They were also informed that there were no "right" or "wrong" answers and that all experiences - positive, neutral, or negative - were of interest to the study.

In recognition of the potential for emotional distress when discussing sensitive experiences, participants were advised that the interview did not include questions specifically requiring of experiences that may have contributed to their EUPD diagnosis. They were also reminded that they were under no obligation to share any information they did not feel comfortable discussing. However, it was acknowledged that conversations about lived experience may evoke sensitive memories and participants were informed that a debrief would be offered after the interview recording had ended.

4.3.Analysis

4.3.1. Stages of IPA

The researcher reviewed all transcripts that were automatically generated from Microsoft Teams to identify any potential mistakes such as misheard/missing words. The stages of Interpretative Phenomenological Analysis (IPA) followed in this study are outlined below in Table 16.

Table 16

IPA stages of analysis taken by the PR (Smith et al., 2022)

Stage of Analysis	Actions taken by the PR
One	Analysis began with repeated reading and re-reading of each transcript to facilitate immersion in the participant's account and develop a detailed understanding of their lived experience. Analysis was conducted on one transcript at a time to maintain an idiographic focus. During this stage, the PR recorded reflections and observations within a reflective journal to support reflexivity and increase awareness of how their own perspectives may influence the analytic process. .
Two	

	The PR then generated exploratory notes (EN) for each transcript. These notes focused on descriptive content, linguistic features and conceptual reflections to capture the richness and complexity of participants' accounts. Descriptive comments examined the content of participants' narratives, linguistic comments explored language use and expression and conceptual comments considered participants' interpretations and sense-making of their experiences (See Appendix O)
Three	Drawing on the exploratory notes, the PR developed experiential statements (ES). These concise statements captured the psychological and experiential significance of sections of the participant's account while remaining grounded in the participant's own words and meanings (see also Appendix O)
Four	The PR examined connections between experiential statements and clustered related ES together. This iterative process involved reviewing, reorganising and refining clusters to identify meaningful patterns within the participant's account. Through this process, distinct clusters were developed that reflected important aspects of the participant's lived experience (see Appendix P).

Five	The PR then developed participant experiential themes (PETs) from these clusters. Theme titles were generated, reviewed and refined through an iterative process to ensure they accurately reflected the experiential meaning represented within each cluster. The final PETs captured key elements of each participant's experience (PETs) , see Appendix Q
Six	Steps one to five were repeated for each participant transcript, with each case analysed individually before moving to the next. This ensured that each participant's account was considered on its own terms prior to undertaking cross-case analysis.
Seven	Following the completion of individual case analyses, the PR reviewed all participant experiential themes collectively to explore patterns of convergence and divergence across participants. Through an iterative process of comparison, refinement and interpretation, related PETs were grouped together to develop group experiential themes (GETs) – see Appendix R. These themes underwent further revision until a final thematic structure comprising five GETs and their corresponding subordinate themes was established to represent shared and divergent aspects of participants' experiences. A recurrence of themes table highlighting which participant

	accounts contributed to the development of each GET and subtheme is presented in Appendix S

4.4. Reflexivity

The researcher maintained a reflective journal to document initial reactions, responses and feelings following each participant interview (see Appendix T). These reflections were practised throughout the study, to facilitate ongoing reflexivity by identifying any pre-existing beliefs, assumptions, or expectations regarding the research. The journal also enabled the researcher to critically examine personal reactions and interpretations that could potentially influence the analysis and interpretation of the data (Vicary, et al 2017).

4.5. Quality Assurance

The PR utilised the CASP (2018) Qualitative Checklist to appraise the quality of the present study and ensure consistency with the approach used in the SLR. The appraisal indicated that the study was of high quality (see Table 17).

Table 17

CASP (2018) Qualitative Checklist for the present study

Item Number	CASP Appraisal Question	Appraisal Decision
1	Was there a clear statement of the aims of the research?	Yes

2	Is qualitative methodology appropriate?	Yes
3	Was the research design appropriate to address the aims of the research?	Yes
4	Was the recruitment strategy appropriate to the aims of the research?	Yes
5	Was the data collected in a way that addressed the research issue?	Yes
6	Has the relationship between researcher and participants been adequately considered?	Yes
7	Have ethical issues been taken into consideration?	Yes
8	Was the data analysis sufficiently rigorous?	Yes
9	Is there a clear statement of findings?	Yes

10	How valuable is the research?	Valuable

5.0. Findings

5.1. Overview

This chapter begins with a table of Group Experiential Themes (GETs) presented in Table 18 and the corresponding subordinate themes representing the findings of this study. Following this, each GET and subtheme is explored in text, with extracts of relevant quotes presented alongside the findings. Some participant quotations have been amended to protect confidentiality. In addition, portions of text that did not contribute to the overall meaning of a quotation have been omitted. These omissions are indicated by "(...)".

5.2. Table of Group Experiential Themes (GETs) and Subthemes

The five GETs and corresponding subthemes are presented below in Table 18.

Table 18

Table of Group Experiential Themes and Subthemes

GETS	Subordinate themes
Early encounters with the diagnosis experienced as a 'double-edged sword'	The diagnosis opening some doors whilst closing others
	Alternative explanations of distress and questioning the diagnosis as a construct
The value and tension of integrating lived experience with professional identities	Lived experience as a source of connection and hope for others, despite its weight
	Navigating shifts between identity parts and contexts
	Expectations of reduced vulnerability to distress when working in mental health
	Boundary violations when repositioned as a patient by the workplace
Managing the emotional impact of stigma and discrimination towards 'people like me'	Hypervigilance whilst feeling a need to be undercover
	Heightened stigma and distancing from those diagnosed with EUPD compared to other more 'socially acceptable' difficulties
	Inner dialogue of 'what I wish I could say'
	Balancing hurt with understanding towards those who lack awareness
	Systemic influences on stigma and discrimination
Navigating authenticity, sharing and relational safety in the workplace	Safe workplace relationships as a foundation for belonging
	Weighing up the risks and benefits of sharing
	Testing the waters
	The mixed aftermath of sharing
	The emotional cost when authenticity is suppressed
Moving beyond reductionist narratives associated with EUPD	The reward of contributing to positive shifts in workplace culture
	Adaptive compartmentalisation versus 'EUPD splitting'
	'Turning lemons into lemonade' - healing alongside 'giving back' to others

5.3. GET 1: Early Encounters with the Diagnosis Experienced as a 'Double-Edged Sword'

This GET captures participants' varied experiences of receiving the diagnosis. Described by Lucy as a "double-edged sword", the diagnosis brought both opportunities for support and experiences of exclusion and misunderstanding.

5.3.1. Subordinate Theme: The Diagnosis Opening Some Doors whilst Closing Others

Some participants described the diagnostic process as collaborative and validating, particularly after prolonged periods of feeling "stuck" and struggling with experiences related to trauma, eating disorders, anxiety, depression and other mental health crises. For some, the diagnosis gave a name to experiences that had previously felt difficult to make sense of.

Olivia: *"..it gave the monster something real, something you could fight (...) Now I know what it is. It's got a name. It's got a face."*

Participant accounts described diagnosis as both opening and closing doors. Initially, for some, receiving a diagnosis opened doors by enabling access to specialist support and workplace adjustments. However, participants also described doors closing following diagnosis, as the label could narrow how their difficulties were understood and create barriers to accessing support for needs that were perceived as falling outside the diagnosis. One participant shared *"I'm now diagnosed with complex PTSD and anorexia and both of the treatments, for those things were held back because of BPD diagnosis"*

Whilst Olivia felt receiving the diagnosis was somewhat of a turning point in gaining a "name" and a "face" to their difficulties, knowledge of the negative perceptions surrounding the diagnosis also made her wonder "*Of all the diagnoses, why that one?".* This apprehension was echoed by other participants, some of whom were warned by mental health staff themselves that the diagnosis would "follow" them around "forever".

Kate: "the psychologist I was working with briefly actually said to me that 'you don't want to get that diagnosis because people won't work with you'."

Some participants spoke positively about being included in the diagnostic process, whereas others reported not being involved at all and instead, discovered the diagnosis unexpectedly through reviewing their medical records. Several participants later received neurodivergent or trauma-related diagnoses, including PTSD and CPTSD, which they felt better reflected their experiences. Some participants sought to challenge or remove the diagnosis but encountered difficulty with this. Julia shared how questioning the diagnosis was interpreted by a medical professional as evidence of EUPD in itself.

Julia: "..I got diagnosed with no assessment, no discussion or anything. Then I had a full assessment (...) they said 'you don't have BPD, it's autism and PTSD'.. Then I started with a new psychiatrist who, to be honest, just took a dislike to me and said 'no, it's BPD'.. His sort of exact words were 'only someone with BPD would try and challenge a doctor'."

Some participants shared that receiving the diagnosis initially reinforced negative beliefs about themselves, with one describing feelings of being “fundamentally broken”. However, after gaining greater understanding of their difficulties, participants were able to reframe these experiences as understandable responses to adversity rather than fixed deficits within themselves which allowed them to re-imagine their future and consider a career in mental health.

5.3.2. Subordinate Theme: Remaining Curious to Alternative Explanations of Distress and Questioning the Diagnosis as a Construct

Some participants felt that the EUPD diagnostic criteria reflected their experiences when they first received the diagnosis but over time identified less with both the criteria and the diagnosis as a broader construct. In making sense of their own experiences and those of the service users they worked with, participants often understood emotional distress through a lens broader than the EUPD diagnosis. Across accounts, they emphasised the importance of approaching people's experiences with curiosity and seeking to understand the "full story" behind their distress.

Bella: “I am always going in with curiosity. I don't care what label you've been given. I'm looking for what your story is (...) Not the cover of your book, I'm looking for the contents (...) we are all clumped together in this modernist group of this diagnosis, that we know a huge amount of variety and different stories exist within.”

Some concerns centred less on whether their experiences aligned with diagnostic criteria and more on the stigma and assumptions attached to the label itself. Some participants described the meaning attached to the terminology of the label as inherently critical, with it implying a fundamental defect in "personality", whilst overlooking the underlying causes of distress.

Julia: "..the main feeling now is just sort of anger. I don't really believe in the construct of personality disorders and I very much think it's a convenient diagnosis for mostly female, mostly neurodivergent, mostly traumatized people and a bit of a replacement for sort of hysteria as a diagnosis."

Drawing on their own experiences, they emphasised that with appropriate support and understanding, people diagnosed with EUPD can develop positive relationships, engage meaningfully in society and build fulfilling lives. Whilst all participants were able to view themselves beyond the diagnosis, some wondered whether the terminology itself led others to view them primarily through the label and to assume that traits associated with EUPD were fixed, inherently problematic and resistant to change.

Rose: *"You can have a physical health diagnosis and when you've done recovery, you might go into remission and you know, have five years clear (...) I wish that that was the same thing for BPD, but because it's so personality driven…do people really believe in the concept of personality change?"*

Participants also reflected on the possible variations within the diagnostic criteria, contributing to their doubts towards the construct itself.

Lucy: **"***..there are 9 symptoms of which you need what? I think five or six to have a diagnosis and the amount of kind of like, different manifestations and presentations that you can actually have within the diagnosis is very vast".*

5.4. GET 2: The Value and Tension of Integrating Lived Experience and Professional Identities

This GET captures the value participants draw from their lived experience in the workplace, whilst also navigating the tension it can bring alongside their identity as a staff member.

5.4.1. Subordinate Theme: Lived Experience as a Source of Connection and Hope for Others, Despite its Weight

Many participants described a positive integration of their lived experience, personal identity and professional identity. When reflecting across a range of roles and stages of their career, lived experience was regarded as a valuable aspect of practice, providing a sense of 'embodied' knowledge that enhanced their understanding of distress and their capacity to connect with those they supported.

Sammy: *"I don't think it makes me feel less professional, I think it makes me feel more professional because I've got that added insight of what it's like to have a diagnosis, to have a*

condition (...) I think it adds to my empathy - my capacity for empathy, both emotional and cognitive. (…) *it's kind of like having a sixth sense (...) like having a little superpower in a way, an extra like an extra degree of insight, which is very positive."*

Participants described a strong sense of hope for the service users they worked with, particularly in supporting them to work towards a "life worth living". Their ability to hold this hope was often informed by their own lived experience in journeying towards healing and recovery, which helped them to view others diagnosed with EUPD as capable of positive change. For some, working and progressing through their career represented a way of reclaiming agency and their relationship with past experiences of distress. Participants reflected on how they had not allowed the weight of their suffering to limit their hopes and aspirations.

Rose: *"people with BPD have so much to share and so much to offer (...) they genuinely have been through so much and have such an emotional capacity that to not tap into that emotional capacity as a therapist feels wrong"*

Rose also described the positive and negative aspects of lived experience as a "fruit salad", evoking an image of diverse experiences mixed, with both rewarding and challenging elements.

Rose*: "..it's like there are some parts of it that are so amazing (...) the power of using my lived experience in a therapeutic, constructive and ethical way (...) that's the beauty of*

the fruit salad. And then there are some parts that are so tough about it because there are still a lot of people out there that think people with BPD are completely broken and I hear that and it makes me cringe."

One participant described her lived experience and professional identity as being "fused" together. Although she valued the insight and understanding that lived experience brought to her clinical work, she also acknowledged the weight it can carry.

Grace**: "***I think I felt very.. this like real awareness that I'm kind of carrying.. that it goes with me wherever I - whatever I do (...) I can't get away. I can't pull these two things apart. You know? They feel very fused to me."*

Some participants described a different kind of weight associated with lived experience, such as concerns that colleagues might see them primarily through the lens of their diagnosis, leading to assumptions about their capability. Participants therefore emphasised the importance of being recognised for their broader skills and contributions beyond their lived experience, highlighting a wide range of professional strengths and personal qualities. These included values centred on helping others, organisational and administrative skills, teaching abilities and confidence in presenting to large audiences.

Maria: *"I'm not just my lived experience. I come with a lot of other skills and they're not taken away because of because of that."*

5.4.2. Subordinate Theme: Navigating Shifts Between Identity Parts and Contexts

Whilst some participants described their professional, personal and lived experience identities as integrated, they also emphasised that these aspects could feel distinct depending on the context, such as differing relationships and workplace dynamics they encountered. Participants described drawing on different forms of knowledge and insight in different situations. For example, psychological models, research evidence and clinical terminology were often used when communicating with colleagues or informing clinical decision-making as part of their professional identity, whereas empathy, authenticity, interpersonal understanding and emotional attunement were more closely associated with lived experience identities and personal qualities. Sammy: conceptualised her professional, lived experience and core identities as three distinct but interconnected parts.

Sammy: *"I have my core identity which doesn't have anything to do with patient hood or staff hood, it's the person I am and then I've got, you know, my lived experience (...) I've got my staff identity, but I think it all connects to my core identity of wanting to be useful you know, wanting to be useful as a human being, wanting to be useful as a member of staff".*

When reflecting on navigating shifts between identity parts and contexts, Sammy also described the experience of shifting in another context, from service user spaces to professional spaces.

Sammy: *"It was so interesting, you know, when you are a staff member to actually experience the other side and see how other staff discuss patients and you know the extent to which that maps onto how they talk to and relate to patients (...) it's been a revelation".*

Some participants described shifts in perspective when reflecting on tensions between professional and lived experience understandings in clinical decision-making. For example, some acknowledged, from a staff perspective, that supporting individuals diagnosed with EUPD, or those presenting with related difficulties, could be challenging due to the intensity of distress experienced and the often limited resources available within services. Sammy reflected on the differing benefits and limitations of community-based versus inpatient support, drawing simultaneously on both service user and professional perspectives.

Sammy: *"you can find yourself dealing or carrying greater risk when you're working with patients in the community because - I hate saying this because I have patient experience, they have more freedom - which is great for them but you know, you kind of do worry more because you don't know how they're doing because they're not on a ward and if they're in distress you kind of hope they'll reach out if they need it."*

At times, navigating tensions between how participants understood themselves and how people diagnosed with EUPD were perceived within services contributed to a sense of not fully fitting within either a 'professional' or 'lived experience' identity. Bella described this tension when reflecting on completing a professional training programme while also being aware of how individuals with an EUPD diagnosis are often viewed within mental health services.

Bella : *"..I was trying to figure out whether I could be a legitimate clinician while still having my lived experience (...) it was just layers and layers of confusion about my own legitimacy if this is how the system views people like me"*

Bella described this tension as a "tug of war" when reflecting the challenges of navigating both lived experience and professional identities. However, over time she came to view these different aspects of herself as complementary rather than conflicting, recognising how each informed and enriched the other.

Bella : "I wouldn't be me in my practise without my lived experience. I don't think I could bring what I do to my role without that. But at the same time, I clearly couldn't do what I do without my clinical training (...) my ability to hold both spaces and the tension between the two that pulls me one way one day and another way another day and can feel quite tug of war-ish."

5.4.3. Subordinate Theme: Expectations of Reduced Vulnerability to Distress when Working in Mental Health

Some participants described a perceived expectation from others, that emotional distress and vulnerability were incompatible with a career in mental health, with this assumption emerging across both professional and personal contexts. Some reported that people in their personal lives, as well as within service-user communities, questioned whether working in mental health was right for them, given their own experiences of difficulty. These reactions sometimes included surprise or doubt. Lucy shared an example of how she responded in such

an interaction, drawing a parallel with physical healthcare professionals who may experience personal health difficulties while continuing to practise competently.

Lucy: "I was like 'that is like literally saying to a doctor, why have you broken your leg? You're a doctor.'"

Participants described both implicit and explicit expectations that, as mental health staff, they would be less susceptible to emotional distress or personal difficulties. Working in mental health was often associated with assumptions of heightened resilience, emotional stability, or having "moved beyond" personal experiences of distress, rather than still living with it. Within this context, some participants reported a pressure to manage, conceal, or minimise their difficulties with colleagues in the workplace.

Bella described how she previously questioned the extent to which her "human" self, typically associated with emotional openness and lived experience, could be expressed alongside her developing professional identity earlier in her career.

Bella : "..'You're going to become a clinician now. You're a healthcare professional, which is what you're training for'.. Which then makes you very fearful of your vulnerability and your humanity and your natural tendency to have emotions as someone who is only human like everyone else and almost like you have to pretend you don't.. and you know, this whole 'sterilised' thing, which I almost kind of bought into at one point."

Some participants shared examples of others' perceptions of them as "high functioning" at work and therefore being viewed as unlikely to have experienced significant mental health difficulties. In these cases, they recalled being told that others "would never have expected" them to be someone who had struggled with their mental health. One participant highlighted this by saying *"people may see me now as high functioning and doing well and on the doctorate (...) people can make those assumptions all day long, that I might have had a nice easy life, but they don't know."*

5.4.4. Subordinate Theme: Boundary Violations When Repositioned as a Patient by the Workplace

This subtheme captures participants' experiences of mental health difficulties impacting their working lives. Some participants described a shift in how they felt viewed by their workplace, feeling that they moved from being regarded as a staff member to being positioned more as a patient. This was particularly apparent during periods of sickness absence or when accessing support outside of work, especially where colleagues were aware of their EUPD diagnosis. In these instances, workplace contact was experienced as overly clinical, with participants' distress understood in relation to service users or clinical cases.

One participant described an occasion where she was off sick receiving support for her mental health and her workplace called her suggesting that a reason behind her distress was that she had been influenced by a service user at work. She shared: **"***they basically said to me that they were concerned that I had mirrored the behaviours of a service user on a ward that I've not worked on."*

In some cases, participants felt they continued to be treated as though they were still not well enough to work, even after being deemed fit to return by occupational health. One participant shared their workplace had conducted a 'complex case review' and that this increased scrutiny of their practice and restrictions on clinical duties, which was inconsistent with the outcome of their occupational health assessment. She shared that *"I had my occupational health assessment, I was deemed fit to work and still they would not let me work* (…) *I obviously felt like I was being treated like more of a patient than a member of staff to be honest."*

Some participants sought advice from representatives independent of their workplace, who echoed their view that their situation was being managed in a clinical approach more suitable for a service user than as an employee. Grace reflected on the contrast between previously feeling positively appraised as a staff member and subsequently feeling that her autonomy and boundaries were no longer recognised when she was on sick.

Grace: "..'you have empathy when I'm well and I'm functioning well and I'm doing my job well" (...) but now I'm at home and I'm off sick. I feel like I'm you're interacting with me like I'm a patient. You're not giving me autonomy (...) You're not telling me when you're going to call, you call me out of the blue' (...) I was not given even a single inch of like, you know, freedom or autonomy or like, say, over any of that."

5.5. GET 3: Managing the Emotional Impact of Stigma and Discrimination in the Workplace Towards 'People Like Me'

This GET captures the emotional impact on participants of navigating stigma and discrimination within workplace environments.

5.5.1. Subordinate Theme: Hypervigilance Whilst Feeling a Need to Be Undercover

Participants described feeling a need to be "undercover" in the presence of colleagues when stigmatising or discriminatory attitudes towards people diagnosed with EUPD were expressed, often arising in case discussions within their teams. They reported feeling frustrated and offended when hearing negative responses to service users shaped by stereotypes associated with EUPD. Drawing on their own lived experience of an EUPD diagnosis, participants sometimes identified with these service users, at times recognising them as "people like me".

Bella : *"..I almost felt a little bit like a mole, obviously, because not everyone in that room knows that I carry the diagnosis, which feels like a covert social experiment (...) but listening to them talk about 'people like me' and some of the language used, I guess that also gave fuel to my frustration at the system"*

Participants described being highly attuned to comments, attitudes and interpersonal dynamics as a way of assessing team culture and their colleagues' views towards EUPD and other types of mental health difficulties. This appeared to reflect a form of hypervigilance, whilst monitoring their environments for indications of safety and potential stigma.

Maria: *"you can just see how they treat each other (...) Are they too hierarchical? Is the team scared of one particular member? (...) but then also in terms of like service user involvement stuff as well (...) It's hearing those things without the knowledge that there's someone with lived experience in the room (...) they are, you know, talking in a trauma informed way, they are using the correct pronouns (...) all of those things that just are good manners that sometimes disappear when people aren't actually in the room.."*

Julia described anticipating how her colleagues' comments or attitudes might affect her emotionally and feeling alert to the internal reactions these could evoke.

Julia: "that kind of - I guess sort of like recurring fear almost and just being very kind of on edge of 'ok, what are they going to say next? (...) How negative is the next comment going to be and how is that going to make me feel and is it going to be a kind of bad enough comment or viewpoint that it's going to make me kind of spiral a bit?'"

5.5.2. Subordinate Theme: Heightened Stigma and Distancing from those Diagnosed with EUPD Compared to Other More 'Socially Acceptable' Difficulties

For many participants, the extent of stigma attached to the EUPD diagnosis became more fully realised as they progressed through their careers. They reflected on how staff attitudes towards those diagnosed with EUPD differed from those directed towards other mental health difficulties and neurodivergent presentations. For some participants, this appeared to

influence the extent to which they felt able to share different aspects of themselves within the workplace.

Julia*: "somehow like a neurodevelopmental neurodivergence sort of thing, feels much more socially acceptable to talk about with colleagues than, you know, a mental illness (...) everyone seems to be very on board with that sort of thing (...) it's been nice to be able to share those bits. I just don't think that sharing BPD would have quite the same response."*

Participants also observed increased negative attitudes towards clients diagnosed with EUPD were evident in their colleagues' tendencies to distance themselves from service users with the diagnosis.

Bella : *"They are very quick to try and get rid of people off their caseload, or even moan about having these individuals on their caseload."*

Some participants described examples in which negative perceptions of people diagnosed with EUPD extended beyond stigma and prejudice views, to influencing discriminatory clinical decision-making. For example, Julia shared that a senior member of staff outwardly acknowledged that gatekeeping access to care for people diagnosed with a personality disorder was not formally permitted. However, she allowed it to continue anyway, based on her own prejudiced views towards the client group.

Julia: *"she said something kind of to the effect of, 'oh, you know, we've not put BPD in the exclusion criteria because, you know, we're not allowed to say that sort of thing, but I'd be very reluctant to ever accept a PD patient because they're not really capable of making change in their lives'* (…) *I think just hearing that (...) you know, they've they've got that diagnosis and they're just written off (...) they're not worth helping or putting.. you know, time and energy into helping.. that was hard to hear."*

Participants reflected on how individuals diagnosed with EUPD were frequently described in professional settings as "manipulative" and undesirable to work with. These accounts were reported across a range of workplace contexts and by staff in a variety of professional roles, including those with their own lived experience of significant mental health difficulties. Grace shared an example of witnessing this narrative from a colleague with lived experience of psychosis.

Grace: ".. she said, 'oh, I really enjoy working with psychosis patients because that's my experience, but I hate working with people with BPD.. They're so..' and it was this word, 'manipulative', it just kept on coming up repeatedly.

5.5.3. Subordinate Theme: Inner Dialogue of 'What I Wish I Could Say'

Throughout the interviews, many participants conveyed a rich "inner dialogue", expressing what they wished they could have said in response to comments or attitudes from colleagues that they experienced as stigmatising, discriminatory, or misinformed. These reflections were often communicated through imagined or indirect quotations directed towards those

expressing such views, allowing participants to articulate thoughts and emotional reactions that had remained unspoken in the moment. Whilst participants frequently challenged stigma openly, their accounts often suggested a depth of feeling that was not always able to be expressed within professional settings.

Rose: *"I'm just thinking about a meeting that I was in today (…) like, wow, how can someone with so much experience of mental health, use language that is so demeaning towards a person (…) and 'you do that because of their diagnosis, because you don't understand what has happened to a person, you're not interested in understanding. You're interested in just changing a behaviour.'"*

Although Olivia spoke positively of their core team's work culture, they expressed a sense of frustration when their work crossed paths with other colleagues and teams where they had observed stigmatising views.

Olivia: *"Sometimes I just want to be able to stand there and go 'I have that diagnosis and I'm a functioning human most of the time. You wouldn't say that about me. You wouldn't say you wouldn't say – put those labels on me, so why are you doing it to other people that are in a more vulnerable position that can't necessarily stand up and say it for themselves?'."*

Often, thoughts towards comments made would come from a place of wanting to humanise people diagnosed with EUPD. Bella spoke of an example in team meetings in which

colleagues appeared to respond to new referrals who had an EUPD diagnosis with a sense frustration or resignation before the service user's circumstances had been considered.

Bella : "..*'Oh, it's another EUPD one'.. 'Oh, I'm sorry. It's another human being. do you mean'?"*

As no one within Julia's workplace was aware of her EUPD diagnosis, her example of inner dialogue centred on wondering whether colleagues would speak differently about service users if they knew that she herself had once been the subject of similar conversations when she was accessing support.

Julia: *"would you be phrasing that differently if you knew that there was someone in the room who has sort of had these things said about them personally?"*

She shared that a lack of safety in expressing her views in the workplace, has led her to channel her inner thoughts and activism more freely through online spaces when at home.

Julia: *"You know, on social media, I do quite a lot of, kind of talking about BPD from my personal experience and yeah (...) you know when I'm at work hearing comments (..) it does make you feel crap, you know, regardless of if I believe in the diagnosis or not, that diagnosis is on my record".*

5.5.4. Subordinate Theme: Balancing Hurt with Understanding Towards Those Who Lack Awareness

There was a shared understanding amongst participants that, although stigmatising attitudes often evoked feelings of frustration prejudiced views often stemmed from colleagues' lack of awareness combined with miseducation, lack of resources and burnout.

Maria: "*Sometimes it's genuinely, genuinely miseducation, it's resources, it's compassionate burnout (…) it's the team are not ready yet to have an open mind to work in a different way to have their power challenged somewhat".*

Maria described how a colleague's beliefs about people diagnosed with EUPD had been shaped by misinformation and dominant narratives within the local team culture and how greater understanding developed as she progressed through her career.

Maria: *"She had her three years nursing and then everything else had been what she was told when she was on the ward by other people who were maybe more senior to her (..) she'd been very much told, you know, 'oh, watch out for the attachment with the BPD people', like, 'don't let them get attached', like 'it's going to be dangerous for everyone', (…) she thought that attachment was this really negative thing that people with BPD did to staff.."*

Maria continued to share an example of how her colleague adapted her clinical practice towards people diagnosed with EUPD, with the views her team held towards this client group in mind.

Maria: "She was like, 'well that's it, I'll just stay really cold, from away from people'.

Maria described how, over time, her colleague's perspective had shifted through increased education and greater awareness of the needs and difficulties of this client group.

Maria: "she's gone on to further study and understands attachment theory (...) and why people act the way they do and like how staff can help with this (...) she was like, 'wow, that's that's scary.. Like how much I believed that, because that was what I was being told. That was what the culture was'."

However, with these reflections in mind, her colleague also considered the barriers to change that may have existed, had she attempted to challenge or shift the narratives of those she worked with previously.

Maria: "she was like 'but if I'd have known what I know now and walked into a ward as a newly qualified, people wouldn't have wanted to listen to that'."

5.5.5. Subordinate Theme: Systemic Influences on Stigma and Discrimination

Participants held differing views about where stigma and discrimination towards people diagnosed with EUPD were most prevalent. They reflected on how wider systemic influences, such as service structures and a lack of appropriate resources, may shape attitudes

across settings. Bella shared an example of how short-term or inconsistent cycles of treatment could contribute to ongoing cycles of distress for people experiencing difficulties associated with an EUPD diagnosis.

Bella : "*I think it comes down to the model not really suiting the nature of the needs of the people they're going to see (...) the traits that may get you labelled with said diagnosis mean that you might need a bit more consistency in clinicians because you might have some issues that might look like attachment issues, or might affect your relationships or the way in which you relate to people.. whether that's trauma, whether it's neurodiversity.. So therefore, the model of having rolling clinicians roll in and out, trying to do short term pieces of work with you actually, can intensify and exacerbate what then reinforces the already ascribed label.*"

She then described how when staff see people in periods of crisis, this would likely influence their view towards the client group as a whole, likening this to a 'self-fulfilling prophecy'

Bella: "I think the biggest problem I have this label is a self-fulfilling prophecy (...) seeing you for very short periods of time, getting tiny snapshots of you when you're in crisis mode for whatever reason, it is likely only to reinforce that again (...) to perpetuate this idea that you know 'they are taking up space on our wards'. 'They're taking up a bed unnecessarily' or, you know, 'they're just draining our resources, they don't respond to anything we do'."

These insights led her to view crisis and inpatient support as the most stigma-laden workplace environments in comparison to other support offered in the community.

Bella: "I think generally, community services are more able, on some level to hold compassion for these individuals (...) whether that's because you have an individual worker who you can build up a relationship with who doesn't just see you in reactionary moments and actually they can get a longitudinal picture of what's going on for you and whether that then influences their attitudes towards the diagnosis, I don't know."

On the other hand, alternative perspectives amongst participants considered stigma to be worse in the community and less prevalent in inpatient units, as Grace describes.

Grace: "*people are sometimes a bit more caring in inpatient settings because initially you're just trying to get that person to stabilise and be like be safe, whereas I think some of the.. there are more relational kind of threats in the community in some ways, because you've got so many more relationships with so many people"*

Some participants described contrasting experiences within similar service contexts. For example, stigma associated with an EUPD diagnosis was reported as a barrier to accessing support for eating disorders, with staff focusing on the EUPD diagnosis at the expense of recognising the severity of eating difficulties. In contrast, one participant described an eating disorder service as the least stigmatising setting in which she had worked.

Participants also reflected that, for people diagnosed with EUPD - who often have histories of relational trauma, stigmatising, invalidating, or discriminatory interactions within services could compound prior relational harms and be experienced as re-traumatising.

Maria: "it's not necessarily about the person with BPD or the person who lived experience. It's about the teams around them and the structures around them (...) that's what stops it from being re-traumatising for people."

5.6. GET 4: Navigating Authenticity, Sharing and Relational Safety in the Workplace

This GET reflects participants' negotiations around sharing decisions in workplace contexts, shaped by considerations of emotional and relational safety, professional identity, authenticity and support needs.

5.6.1. Subordinate Theme: Safe Workplace Relationships as a Foundation for Belonging

Most participants shared examples of feeling safe enough to disclose their EUPD diagnosis to at least one colleague, supervisor or manager at some point in their career. The positive nature of these particular examples were associated with experiences of support and belonging within the workplace, with interactions in these instances characterised as non-judgemental, compassionate and understanding.

Olivia: *"The team that we've got are safe. I know that I can trust them with that information and that information helps them to help me* (…) *nearly all of the staff there know that I have some difficulties and they are absolutely brilliant, absolutely amazing (...) If I'm having a bad time, then they're there. If I'm having a good time, they're there".*

Where participants felt respected, valued and confident that their experiences would not lead to discrimination or professional discreditation, they were more able to speak openly about their diagnosis and mental health needs. Olivia further shared how the openness she has with her colleagues helps to improve their overall working relationship together.

Olivia: "If I'm able to be open and honest with them, it makes working together a lot easier (...) if I had to hide it, perhaps to bury it, then it would make working relationships much more difficult."

Some participants described feelings of safety and acceptance beginning with 'one supportive other', referring to trusted individuals who responded with empathy, validation and curiosity after learning of their diagnosis. These relationships often provided participants with their first experience of feeling accepted in the workplace in relation to their diagnosis. They also appeared to lay the foundation for a wider "ripple effect" of acceptance, as these individuals modelled positive responses that encouraged other colleagues to view them in a similar light. Experiencing this sense of safety also helped participants feel that acceptance could be possible again in future if they chose to share their diagnosis with others.

Maria: *"they very much took me at face value and that was a really helpful like 'soft in', I guess, to understand that people can know that's my diagnosis and not presume how I'm going to behave or whatever and they can see other things, other skills and whatnot apart from that."*

Maria also shared that throughout her career, finding safety with others has sometimes begun outside of her immediate team in wider networks in a process that Maria describes as "finding your gang";

Maria: *"It's about finding your gang, that might be people who are in your department, it might be people who are outside of your department. I was very isolated when I first started working (...) I found my gang from other areas (...). and it just sort of grew and grew and grew, until my team themselves were also one of that gang."*

5.6.2. Subordinate Theme: Weighing Up the Risks and Benefits of Sharing

Collectively, sharing decisions appeared as a complex and highly relational process involving ongoing assessments of risk versus benefits of sharing. Julia described a potential advantage that she considers when thinking about whether to share with her colleagues.

Julia: "*I think about it quite a lot and I think about telling people and yeah, I weigh up the pros and cons a lot (...) if I did share it, then I do hope that people would be a bit more sensitive (...) if I were to share it, there could then be, you know, conversations around, 'actually I've experienced this like this, so maybe your patient is experiencing it like this'."*

However, on the other side of this, doubt crept in thinking about whether colleagues' perceptions would genuinely shift following sharing or whether stigmatising assumptions would continue to exist beneath outwardly supportive responses

Julia: *"I guess the con of that is I would then constantly be thinking, 'OK, well, are they thinking these things but just not saying it because I'm here?'."*

Participants expressed concerns around sharing their diagnosis when thinking about if something were to "go wrong" at work, whether this would be viewed through the lens of their mental health, with fears of others potentially viewing them as less capable. Some participants also wondered whether colleagues may change how they act around them if they were to share. For example, some wondered whether typical day-to-day interactions in the workplace, may subsequently become interpreted through the lens of the EUPD traits.

Julia: *"..the big con for me would be not wanting people to feel like they have to kind of be on high alert (...) I would just be worrying about, 'OK, what are people thinking and what are they - how are they viewing me now with that?' Kind of yeah.. a shifted understanding of how and why I function like I do"*

A key motivator for participants considered when thinking about sharing their lived experience with the diagnosis was to use themselves as an example to challenge stigmatising narratives. Another frequent benefit participants considered prior to sharing with supervisors and managers was rooted in the knowledge that it may help them access support or reasonable adjustments within the workplace if they needed it later on.

Lucy: *"I guess while I didn't necessarily have to disclose, I was willing to do so, if it was going to kind of.. like the transparency would essentially make everything smoother (...) it'd be important for also, the reasonable adjustments."*

Some participant accounts gave a snapshot of the types of worries that would cross their mind when considering sharing their EUPD diagnosis within the workplace.

Bella: *"it could go either way, you know? Are they going to reject me? Are they going to judge me? Are they going to think.. 'Oh my gosh, we've just let a crazy lady into the team?'"*

Similarly, hesitations towards choosing not to share their diagnosis sometimes appeared form a sense of self protection.

Kate: *"if they don't know, they can't discriminate against you for it"*

A frequent concern among participants when considering sharing information about their mental health, particularly their EUPD diagnosis, centred on fears of potential breaches of confidentiality. These concerns were evident both in workplace settings and when accessing mental health support. For some participants, these contexts overlapped where the team they worked in, fell within the same wider organisation from which they would also need to seek support. In these cases, apprehension and fear around sharing decisions in both settings, were shaped by previous experiences in which their status as both staff member and patient within the same organisation, caused a risk to unintended exposure or 'sharing' beyond their control.

Participants expressed concerns that routine clinical systems could inadvertently lead to identification of their dual identity as both service users and employees by colleagues and mental health staff involved in their care. These included electronic records that automatically flagged when a patient was also an employee of the wider organisation, as well as multi-disciplinary team discussions, interdepartmental liaison and A&E mental health reports. While participants did not generally anticipate deliberate breaches of confidentiality, they expressed anxiety about the possibility of unintentional exposure or 'sharing' through these routine clinical processes.

Kate: *"There's always that fear that somebody was going to read your notes, even though they shouldn't do, or somebody's going to speak to someone in your team (…) I'm like (as a service user)'please don't mention me, MDT' and they're like, 'we won't'. But then it's like, what if they forget?".*

One participant described how because of one of the routine clinical processes listed above, her colleagues ended up being made aware of her mental health difficulties without her consent. As a result, she was removed from clinical duties and told she was unable to work, despite no concerns being raised through formal workplace channels and whilst simultaneously being reassured by management that she did her job *"really well".*

Participants reflected on the significant emotional impact that occurred when two key 'protective factors' for their wellbeing - working in a job role they highly valued and their ability to access mental health support, were under threat to one another.

Lucy: "*How can I access mental health services if there's a constant threat that my job's at risk?"*

5.6.3. Subordinate Theme: Testing the Waters

Some participants described using cautious or partial sharing in the workplace, referring more broadly to experiences of "trauma" or "some difficulties" rather than explicitly naming their EUPD diagnosis. This broader language allowed them to acknowledge aspects of their lived experience while retaining control over the extent of what they shared. For many, this reflected an attempt to balance authenticity with self-protection in contexts where they anticipated stigma, misunderstanding, or negative assumptions associated with the diagnosis. Participants also described carefully managing future decisions about sharing in response to others' reactions to the unintended exposure of aspects of their lived experience beyond their control, such as the visibility of previous self-harm scars, including in settings where staff were required to comply with "bare below the elbow" uniform policies.

Bella: *"A certain element of disclosure was done for me by my body by virtue of the fact that I exist, I can't really do much about it (…) 'you know, I've had some difficulties in my life' was my standard party line"*

In such situations, participants described a tension between resisting shame about past difficulties and navigating others' potentially negative perceptions, particularly in light of prior experiences of judgement and assumption, as Lucy described.

Lucy: "*They (management) essentially said to me, 'I'm concerned that you're going to be a safeguarding concern' if this patient was to see my scars and subsequently be motivated to engage in self-harm (…) I was like, 'I cannot help the fact that I have scars, they're not going away, it's not fresh self-harm' (…) 'I'm more than happy to cover them if that is like what you think would be beneficial' however, I was like, 'I personally have like no problem, having my arms out.'"*

In these instances, rather than actively "testing the waters," participants spoke with a sense that the "waters" were tested for them. For some, reactions to these visible indicators of their mental health history shaped whether it felt safe to share further information about their mental health at work in the future.

Lucy: *"I was just more like cautious (…) you just don't know what other people's perceptions of the diagnosis is and I think having the negative experiences I have had, I would yeah.. just be careful"*

Kate described "testing the waters" in a different way by gauging others' attitudes towards an EUPD diagnosis without revealing her own experience of the diagnosis. She did this by asking how they would respond to the idea of a mental health worker sharing their experience of the diagnosis.

Kate: *"I was at one of the professional body career talks or something (…) I actually asked anonymously (in the online chat) to whoever was doing the talk. I was like, 'would you disclose?' (the diagnosis) and then literally the reaction was ' why the hell would you want to disclose?' and again, I always remembered that, like, 'oh, ok, maybe I'll be seen as attention seeking if I do disclose or something'"*

Some participants described indirectly "testing the waters" through observing colleagues' language, communication and tone when discussing service users.

Grace: "As soon as I got into that workplace, I was like, 'don't go there..it doesn't feel safe' (...) the attitude of people was 'oh, we've got another one of those psychotic people ringing us again, using up our resources' (...) It's like a lack of understanding and familiarity with different types of mental health."

Following this, Grace, described upholding a firm boundary, choosing to distance herself from conversations that could inadvertently lead to sharing her own personal experiences.

Grace: *"I think it just made me feel like, I mean, 'absolutely not - not in a million years would I ever even touch any of these subjects ever'."*

Many participants described testing feelings of safety before sharing, often choosing one-to-one conversations or familiar settings where they felt less vulnerable to judgement. They

appeared highly attuned to situations that felt unsafe or carried a greater risk of misunderstanding and negative reactions.

Bella*: "There are lots of situations I don't disclose, like in MDT (…) It's not going to achieve anything. I might challenge you on your reasoning potentially, but I'm not about to say 'by the way'.. In this room full of 20 other individuals, 'you're talking about me', it just wouldn't exactly go down well would it? It would be like letting a bomb off in there."*

Several reported feeling more comfortable sharing aspects of their mental health with colleagues who had openly discussed aspects of their own lived experiences, suggesting that mutual vulnerability helped normalise mental health difficulties amongst staff.

5.6.4. Subordinate Theme: The Mixed Aftermath of Sharing

Participants reported mixed responses after sharing that they had lived experience of being diagnosed with EUPD with colleagues in the workplace. Some described receiving comments such as "you don't seem like someone with BPD" after sharing. These experiences were often received as backhanded compliments as they reinforced the idea that there was a fixed or stereotyped way that someone with the diagnosis was expected to appear or behave.

Bella: *"..the confusion around how my image does not fit with someone who is labelled with this diagnosis, which obviously they mean as a compliment, but they don't really understand that giving that as a compliment is actually an insult because it insults that the broader category of people like me".*

Some participants described using conversations of this nature to promote learning and greater understanding of people diagnosed with EUPD among their colleagues.

Maria: *"I've had quite a lot of people being like ' you're not really like most people with BPD' Like, yeah, OK, I don't have that diagnosis anymore but I'm like, 'maybe you're just not meeting them in the right context or, you know, in a place where they feel they're able to be comfortable and speak and aren't triggered by things.'"*

For participants who spoke positively of their workplace culture, there was a sense of unconditional positive regard after sharing their diagnosis, with positive judgements based on character and a sense of being seen as a whole person.

Olivia: "*They just don't care (about her diagnosis) 'Are you a good person? You're a nice person.. Yeah, well, that's what - that's what matters'."*

Some participants described how sharing their diagnosis within the workplace enabled them to access support and reasonable adjustments that had previously been difficult to obtain.

Grace: "And all of a sudden it was like, oh, now we understand that we have to give you this. You know, we have to give you reasonable adjustments and we have to offer you this or we have to offer you that because you are protected under the Equality Act"

Some participants reflected on how their positive experiences of workplace support helped them share with other professionals the kind of workplace culture that can enable staff with lived and living experience of mental health difficulties to "thrive" at work.

Many participants described feeling uneasy after sharing. Although some noticed positive changes in how colleagues spoke in conversations related to EUPD, they often remained uncertain about what they truly thought.

Bella: "..you can see people editing their thoughts and you can tell there's a little bit more going on before the mouth activates (...) 'I don't know whether you (they) worry that I'm then going to attack you for talking about a patient like that', in which case I'm wondering wonder what you were thinking about said patients'."

5.6.5. Subordinate Theme: The Emotional Cost when Authenticity is Suppressed

All participants identified occasions where they actively chose not to share their diagnosis to supervisors, managers, or colleagues after weighing the perceived risks and benefits.

One participant described how fears about the potential risks of sharing, extended into personal therapy, where they felt unable to speak openly about the fact they had the diagnosis. She described being *"too petrified"* of the potential consequences of sharing openly and reflected that part of this suppression was shaped by narratives such as *"you're too difficult, you're too hard to handle."* She attempted to challenge these beliefs by reminding herself, *"well, I'm doing a doctorate, I can't be that difficult."*

Participants described the need to make a deliberate effort to separate their professional identity from their lived experience. This process was often experienced as frustrating and tiring and contributed to feelings of inauthenticity. For some, it felt particularly strained because it conflicted with their natural tendency towards openness in relationships outside the workplace.

Kate: *"..it is frustrating in a way that I do have to hide that part of me (...) I think in a lot of respects, I'm a really open person and I have to remind myself, 'you can't be open about that and you can't share that part of you' but then that just fuels that kind of anger and that kind of injustice, that 'why should I have to keep part of me hidden just because of other people's reactions'?*

She shared detail around the extra efforts she took to try and prevent herself from sharing with others.

Kate: *"I feel like I'm planning to constantly, like, slow myself down to not lose control and just blurt it out (...) 'don't say anything that could, like, lend people to think that maybe that is the case for you' (...) having that kind of like filter on myself."*

She then went on to share inner thought process of how she reasons with the felt injustice of not being able to be her inauthentic self;

Kate: "*somebody said to me years ago that 'you know how other people should react to things but you can't control how they're going to react' and I always stick to that (...) you've*

got to be prepared for anything.. and if you're not prepared for anything and the consequences you've got to keep your mouth shut.'"

One participant shared that whilst she did not feel able to be open about the diagnosis now, they had hopes for the future that things could be different. She shared this by saying *"maybe one day in an ideal world when I'm qualified, I would feel brave enough to tell people openly and that would be the dream, but I think it's just not a reality".*

5.7. GET 5: Moving Beyond Reductionist Narratives Associated with EUPD

This GET describes participants' experiences of the rewards of contributing to more positive workplace cultures, while also providing insight into their ongoing healing and sense of *"giving back".*

5.7.1. Subordinate Theme: The Reward of Contributing to Positive Shifts in Workplace Culture

Participants described experiencing a sense of emotional reward when observing shifts towards more compassionate and less stigmatising workplace cultures, both for service users and for themselves as staff. Some felt that sharing lived experience and engaging in open conversations fostered greater understanding and humanity within teams.

Maria: *"Others brought up the fact that having me in the team and having me wear vulnerabilities on my sleeve has allowed everyone else to do the same (...) everybody's looking out for each other (...) I didn't know that they attributed it to me being there. It was really nice to hear."*

Participants also reflected on the benefits of staff training within some organisations, describing it as a valuable way to challenge stigmatising narratives surrounding people diagnosed with EUPD. Training that encouraged staff to understand the experiences of service users diagnosed with EUPD as expressions of distress, trauma, or unmet emotional needs, rather than as intentionally manipulative or deliberately difficult behaviour, was viewed positively.

Olivia: *"my organisation has got some fantastic training (...) I've just pushed it out to everybody and everyone that's gone on that training has been like, 'oh my god, this is eye opening' (...) it is just breaking down the complex emotional needs and what things are and perhaps why things are done in certain ways and trying to break those negative associations and reframe them."*

Participant accounts highlighted factors they perceived as contributing to a positive workplace culture. One participant described mutual openness and support within her team, reflecting on how her workplace had supported her and how, together, they had found ways to make it "work" over several years. She drew on this experience as an example of the kind of positive workplace culture she seeks to promote more widely.

Maria: *I talk to people about, how they might help an employee with lived experience stay and thrive in a job because so many people don't".*

5.7.2. Subordinate Theme: Adaptive Compartmentalisation Versus 'EUPD Splitting'

Participants described compartmentalising personal difficulties from workplace responsibilities as a way of maintaining professional functioning during challenging periods. This separation appeared to help them remain effective in their roles and meet the emotional and practical demands of their work and was generally viewed as an adaptive coping strategy. However, Julia described how this ability was sometimes re-pathologised through the lens of her EUPD diagnosis and interpreted by others as evidence of "splitting" — a term used in relation to EUPD to suggest a fragmented sense of self or the expression of different 'parts' of the self across contexts (Kernberg, 1975).

Julia: "With the kind of BPD label hanging around, I don't think actually helps me as a patient because other people can see those kind of two (staff and patient) selves and they take that as evidence of, 'well that it's a form of splitting' (...) I don't really see any other way around it. I think if I was how I sometimes am in a crisis whilst at home, all of the time, I would not be able to hold down a job. So I need to be able to, yeah, sort of separate that out."

Rose similarly reflected on her ability to move between the differing demands in the workplace describing how role-switching could feel reminiscent of "splitting,"

Rose: *"I think that it feels to me a little bit like, you know, the term on BPD of 'splitting'. I have to split myself in two because of because of my different roles and that's something that I'm busy kind of working on in terms of congruence."*

Compartmentalisation also served as an important coping strategy when discussing lived experience, particularly given the emotional intensity that could be triggered by revisiting past experiences alongside the high demands of the workplace.

Kate: "*This role.. it's intensive enough and crazy is enough.. dealing with the pressures and work issues and dealing with high risk clients, dealing with your own personal therapy."*

Several participants described deliberately limiting the depth of sharing or self-exploration in professional contexts to protect their emotional wellbeing and maintain stability. For example, Kate described balancing the need to process difficult experiences in personal therapy with the need to remain emotionally resourced for work.

Kate: "I've actually in a way consciously shut a lot of my experience off (in therapy) because it would be too much to be able to deal with at the time (...) if I start accessing that then that would impact my work, so I have to have a clear boundary within myself to when I do and when I don't."

5.7.3. Subordinate Theme: 'Turning Lemons into Lemonade' - Healing Alongside 'Giving Back' to Others

Several participants described a process of personal and professional growth. With some moving from silence and concealment towards an increased sense of confidence in advocating for themselves and others in situations that felt safe enough to do so. Sammy described her journey as *"feeling stronger through supporting others"* and Others framed

their clinical work as “giving back.” Participants’ meaning-making in this area was often shaped by reflections on the impact of support they had received from mental health staff in their own care.

Rose: *“I just kind of felt like I needed to be giving something back (...) I think that that's been really powerful in terms of my recovery.”*

In relation to healing alongside developing their careers in academia and clinical training, participants described how engaging with psychological theory and academic perspectives helped them to understand mental health difficulties from a broader perspective.

Rose: “I'm not always looking at things from a personal perspective, I'm looking at the academia on trauma (...) I'm not necessarily looking at my trauma, I'm looking at the concept of trauma and then take my understanding of my trauma experiences into therapy.”

For some, feelings of being silenced, misunderstood, or unseen had originated not only within the workplace but also during previous experiences as service users, where they felt reduced to diagnostic labels or viewed primarily through moments of distress.

Bella : *“It gives me a way of giving back and shaping my own future out of the past so that it doesn't have a hold over me anymore.”*

Over time, many participants described developing a stronger sense of agency, enabling them to challenge stigma in the workplace more confidently, even if this did not involve them sharing their diagnosis. For several, this growth extended beyond their local teams into wider forms of advocacy, such as training, teaching and conference presentations.

Participants often described healing as ongoing processes rather than a journey with a fixed endpoint but that this did not prevent them from working or pursuing personal goals.

Maria: "I'm not recovered.. far from it.. but in terms of my outlook and where I want to be, it's been massive. Like.. it's been huge. I guess it's the turning lemons into lemonade type thing, isn't it?."

6.0. Discussion

6.1. Overview

The primary aims of this empirical study were to explore the workplace experiences of mental health staff with lived experience of a diagnosis of EUPD and to explore the meanings participants attached to these experiences. This chapter begins with a summary of the overarching themes and subordinate themes identified in the analysis, before discussing the findings in relation to the wider literature. A critical evaluation of the thesis is then presented, including the strengths and limitations of the research process. Finally, the clinical implications of the study, its potential contributions to wider clinical practice and recommendations for future research are considered.

6.2. Summary of Findings

Participant accounts revealed both shared and varying experiences, contributing to five central Group Experiential Themes (GETs): Early encounters with the diagnosis experienced as a ‘double-edged sword’; The value and tension of integrating lived experience with professional identities; Managing the emotional impact of stigma and discrimination towards ‘people like me’; Navigating authenticity, sharing and relational safety in the workplace and Moving beyond reductionist narratives associated with EUPD. Within each GET, a number of subordinate themes were identified, providing further understanding of the processes, tensions and meanings that shaped experiences. The GETs are discussed in relation to the broader literature below.

6.3. Positioning the Findings Within the Broader Literature

6.4. GET 1 - Early Encounters with the Diagnosis Experienced as a Double-Edged Sword

This GET highlighted participants' initial experiences receiving the diagnosis as both validating and constraining.

Subtheme 1 - The Diagnosis Opening Some Doors Whilst Closing Others

Participants described the diagnosis as providing somewhat of a framework through which to understand and make sense of their distress, while also facilitating access to certain forms of support. However, participants shared that this simultaneously exposed them to stereotyping and limited their access to other forms of care as service users. Many participants reported an awareness of the negative perceptions associated with the EUPD diagnosis from early on, which became increasingly apparent as they progressed throughout their careers. These findings extend wider research on mental health staff lived experience and stigma by highlighting the experiences of staff diagnosed with EUPD specifically. For example, one participant captured their concerns around stigma by asking, "of all the diagnoses, why this one?", this is an example that highlights how concerns were not simply about experiencing mental health difficulties or receiving a diagnosis, but instead highlighted apprehension towards the specific consequences that receiving this diagnosis in particular may bring. This tension reflects wider debates within mental health literature, in which diagnosis is understood as both a source of meaning, validation and identity (Probst, 2015), a mechanism that can shape self-understanding and access to care through processes of labelling and categorisation (Dobransky, 2011), whilst also a contributor to stigma and discrimination (Corrigan, 2004).

Subtheme 2 - Alternative Explanations of Distress and Questioning the Diagnosis as a Construct

Many participant accounts questioned the EUPD as a diagnostic construct, whilst considering alternative explanations of distress amongst those who have the diagnosis. In particular,, participants drew on trauma-informed understandings of distress, positioning behaviours and emotional difficulties as a result of adverse and/or traumatic experiences rather than viewing them primarily as manifestations of an inherently flawed or 'disorder' of one's personality.

Some participants questioned the appropriateness of EUPD as a single diagnostic label for capturing the wide variety of presentations encompassed by the diagnosis. They reflected on how diagnostic frameworks can encompass different combinations of difficulties within the same diagnostic category. For example, the DSM-5 (American Psychiatric Association, 2022) states that if someone meets five out of nine of the possible criteria points for BPD (EUPD), they would meet criteria for the diagnosis. This was further informed by participants' experiences of subsequently receiving alternative formulations, including trauma-related diagnoses such as PTSD and CPTSD and neurodevelopmental diagnoses such as ADHD and autism. Furthermore, these experiences appeared to prompt reflection on whether EUPD adequately captured the nature and origins of their distress.

These findings offer a distinctive contribution to the literature, as for some participants, professional knowledge and clinical experience within mental health services appeared to provide additional resources through which to critically engage with the EUPD diagnosis, alongside their personal experience of it. Their professional and personal perspectives therefore appeared to intersect, enabling some participants to question not only how the

diagnosis applied to their own experiences but also how distress is conceptualised, explained and categorised more widely within mental health services.

6.5. GET 2 - The Value and Tension of Integrating Lived Experience with Professional Identities

This GET captured participants' experiences of integrating lived experience with their professional identities when working within mental health settings.

Subthemes 1 - Lived Experience as a Source of Connection and Hope for Others, Despite its Weight

Participants described lived experience as enhancing their capacity to connect with, understand and instil hope in others, which is consistent with literature recognising lived experience as a valuable source of knowledge within mental health practice (Taylor, 2025).

However, the findings of the present study extend this literature by suggesting that for mental health staff diagnosed with EUPD, this connection was accompanied by a distinctive emotional burden, often related to their awareness that EUPD is associated with more negative attitudes among other mental health staff than other mental health diagnoses (McKenzie et al., 2022).

Participants' reflections on their own journey also appeared to provide a tangible source of hope for others. Working within the mental health field requires staff to develop and maintain effective, trusting relationships with both service users and colleagues (Beyene et al., 2024). Furthermore, participants' accounts highlighted their ability to establish and sustain these relationships throughout their careers, which challenge deficit-based understandings of people diagnosed with EUPD, which often refer to long standing difficulties in forming or

maintaining meaningful relationships with others (Lazarus et al., 2014). Therefore, it is suggested that participants' presence within the mental health workforce highlighted in this study, may offer a visible counterpoint to these assumptions, by demonstrating that EUPD does not necessarily determine an individual's capacity for connection, professional development, or a fulfilling life.

Subtheme 2 - Navigating Shifts Between Identity Parts and Contexts

Whilst participants described a sense of integration of lived experience and professional identities, within this, some gave insight into a sense of shifting between these different parts of their identity in response to varying contexts. Tajfel & Turner's (1974) SIT proposes that people hold multiple social identities that become more or less prominent depending on context. Findings of this study help to expand current understanding of this process in greater detail by highlighting the work involved in navigating identities that carry differing levels of legitimacy, status and social value in varying contexts. The findings of the present study highlight the nuance within the SIT, as rather than describing professional and lived experience identities as totally distinct categories, participants appeared to often move fluidly between positions depending on the context, audience within their environment, which is consistent with literature describing the complexities of occupying dual identities within mental health services (Richards et al., 2016). Participants' accounts suggest that identity negotiation was shaped not only by belonging to multiple groups, as proposed by the SIT, but also by the fluctuating external factors such as perceived legitimacy and stigma from others attached to those identities within workplace contexts. As such, these findings may be better explained by theories of concealable stigmatised identities (Quinn & Earnshaw, 2013), which emphasise how people make ongoing decisions about whether aspects of themselves can be safely shared or concealed in response to anticipated stigma.

Subtheme 3 - Expectations of Reduced Vulnerability to Distress When Working in Mental Health

Participants described expectations from others that associate mental health staff with reduced vulnerability to distress. Some participants described how this expectation was conveyed from people in their personal life or from others in service user spaces, who questioned why they would choose to work in mental health given their own experiences. Other participants recalled colleagues expressing surprise upon learning of their lived experience. Such responses align with previous literature on lived experience of mental health difficulties in the workforce (King, 2020), reflecting broader societal assumptions about helping professions, where staff are positioned as resilient, psychologically robust and experts in managing distress, with limited recognition that vulnerability and professional competence can coexist . When considering, Goffman's (1963) stigma theory, these findings suggest that stigma may emerge not only through the explicit devaluation of mental health difficulties, but also through expectations about the type of person who is considered vulnerable to distress. In the context of this study, participants' experiences highlight how such expectations may contribute to the reproduction of stigma within mental health services, despite these settings being intended to support individuals experiencing psychological distress.

Subtheme 4 - Boundary Violations When Repositioned as a Patient by the Workplace

While some participants described workplaces where vulnerability and professional identity were more balanced, the dominant experience within this subtheme was of being repositioned as a patient in ways that undermined participants' degree of agency within their professional

role. During periods of distress or sickness absence, some participants felt they were viewed and managed as patients rather than staff, which was experienced as disempowering and misaligned with their professional identity in the workplace.

These findings extend literature on dual identities by suggesting that such shifts are not solely individually negotiated processes of social categorisation, as proposed within the SIT (Tajfel & Turner, 1974) but are also shaped by organisational responses to distress, where risk management may overshadow autonomy and professional capability. In this way, staff distress may be interpreted through a clinical lens within mental health settings. Collectively, these findings suggest that organisational responses to staff distress may inadvertently reinforce boundaries between "staff" and "patient" by constructing vulnerability as incompatible with professional identity, rather than acknowledging the possibility of holding both simultaneously. These accounts may also be understood in tension with recovery-oriented approaches in mental health services (Winsper et al., 2020), as although such frameworks emphasise empowerment and collaboration, participant accounts suggest their application becomes more complex when staff themselves require support.

6.6. GET 3 – Managing the Emotional Impact of Stigma and Discrimination Towards 'People Like Me'

This GET captures participants' experiences of managing the emotional impact of witnessing stigma and discrimination from colleagues towards service users diagnosed with EUPD. Across accounts, stigma was not experienced as a static or external phenomenon, but as something actively negotiated in everyday interactions.

Subthemes 1: Hypervigilance whilst Feeling a Need to be Undercover

Participants' accounts suggest that hypervigilance operated at both an interpersonal and intrapersonal level, involving anticipation of how they might be perceived if their own relationship with EUPD became known, alongside heightened sensitivity to negative judgements towards service users with whom they identified as "people like me". Participants also described monitoring how they might internally and externally respond to such comments, particularly where witnessing discriminatory or prejudicial views elicited feelings of hurt or frustration that they felt needed to be contained or carefully managed within the workplace. This reflected an ongoing negotiation between responding authentically to comments that impacted them personally whilst at times, simultaneously working to not draw attention to their own lived experience. Whilst anticipatory stigma has previously been reported among healthcare professionals with lived experience of more commonly reported mental health difficulties (Zamir, 2022), the present findings suggest that EUPD may introduce an additional layer of perceived interpersonal threat for mental health staff with this diagnosis, particularly given its association with negative stereotypes of 'manipulation' and 'attention seeking' behaviours (McKenzie, et al., 2022). Furthermore, these findings highlight how stigma shaped participants' workplace experiences, even in the absence of direct discrimination towards them individually.

Subtheme 2: Heightened Stigma and Distancing from Those Diagnosed with EUPD Compared to Other More 'Socially Acceptable' Difficulties

Participants described EUPD as being more negatively judged than other mental health difficulties, across colleagues in a range of roles and settings, with some participants providing examples of colleagues showing a reluctance to working with this client group. These findings are consistent with literature highlighting diagnostic hierarchies within mental health services, where some diagnoses are constructed as more "acceptable" or

understandable than others (McKenzie et al., 2022). Participants' accounts highlighted how this hierarchy extended to their own experiences of sharing lived experience within the workplace. Some felt able to discuss general experiences of mental health difficulties, trauma or neurodivergence but perceived greater risk in disclosing their EUPD diagnosis specifically.

This suggests that participants were not simply navigating a general concern about mental health difficulties as highlighted in previous literature (Zamir, 2022), but making distinctions between aspects of their identity that felt more or less socially acceptable to share.

The particular stigma associated with EUPD may, in part, reflect longstanding understandings of personality disorder as relating to enduring aspects of who a person *is*, rather than difficulties that are experienced. Historically, this distinction was reflected in psychiatric classification, with the DSM-IV placing personality disorders on Axis II, separately from conditions such as depression and anxiety classified on Axis I (American Psychiatric Association, 1994). Although the multiaxial system was intended to distinguish different aspects of clinical presentation, the separation of personality disorders from other mental health conditions may have contributed to perceptions of personality disorder as fundamentally different from other forms of mental health presentations, potentially reinforcing understandings of associated difficulties as characteristic of the individual rather than expressions of psychological distress.

Previous literature has highlighted that some health practitioners perceive people with EUPD as having greater control over their actions and responsibility for their difficulties than people with other mental health conditions (Baker & Beazley, 2022; Markham & Trower, 2003) with behaviours associated with EUPD consequently more likely to be interpreted as intentional rather than expressions of distress (Sulzer, 2015). This may help explain participants' observations that their colleagues' descriptions of service users as "manipulative" or

"difficult" appeared to extend beyond uncertainty about how to work with this client group and were often experienced by participants as derogatory. Furthermore, when behaviours are understood primarily in terms of character or presumed intention, opportunities to understand distress within its broader psychological and social context may be narrowed, potentially limiting trauma-informed approaches to care (Klein et al., 2022).

Subtheme 3: Inner Dialogue of 'What I Wish I Could Say'

While many participants gave examples of challenging misconceptions about people diagnosed with EUPD in the workplace, some also described internal dialogue that emerged when reflecting on witnessing stigmatising, prejudiced, or discriminatory behaviour from colleagues. This was characterised by unexpressed or less filtered thoughts within participant interviews, alongside imagined alternative responses such as *"I just want to be able to stand there and go 'I have that diagnosis and I'm a functioning human most of the time. You wouldn't say that about me."*

This 'unsaid' dimension of experience may reflect the internalisation of impression management processes described in Goffman's (1963) stigma theory, where individuals anticipate how their responses may be received and regulate what is expressed to avoid social risk or devaluation. These findings offer a detailed account of impression management in practice, illustrating how it influences not only the presentation of self to others but also the regulation of internal thoughts, feelings and unexpressed reactions in social interactions.

At times, these internal responses were linked to concerns about being viewed through the lens of the diagnosis, reflecting processes of internalised stigma as outlined in Corrigan's (2005) framework, which describes how anticipated public stigma can be incorporated into self-judgement. However, not all filtering of responses reflected self-stigma; for some

participants it was driven by anticipated interpersonal judgement within specific workplace contexts, rather than internalised negative beliefs about the self. This internal dialogue was evident among both those who had shared their diagnosis and those who had not, suggesting that these processes were shaped by anticipated stigma rather than by the act of sharing itself.

Subtheme 4: Balancing Hurt with Understanding Towards Those Who Lack Awareness

Participants described layered emotional responses when witnessing stigmatised and discriminatory actions from colleagues in the workplace, often involving a tension between feeling hurt or frustrated and attempting to understand or contextualise others' lack of awareness. In some cases, colleagues' attitudes and behaviours were reframed as arising from limited knowledge, systemic constraints, or broader cultural narratives rather than individual malice.

The critical realist epistemological stance adopted throughout this thesis assumes that social phenomena such as stigma have a real and consequential existence, while also recognising that they are only accessible through individuals' situated, interpreted and context-dependent accounts (Bhaskar, 1975). From this position, participants' accounts offer insight into both stigma as a socially embedded mechanism and how it is experienced and made sense of within relational and organisational contexts.

The findings suggested that stigma was not always met with immediate feelings of rejection or anger, but was instead managed through cognitive and emotional reframing. This reflects a degree of psychological negotiation in which participants balanced relational stability with colleagues alongside their own wellbeing. Overall, these findings highlight the relational complexity of stigma-related experiences (Link & Phelan, 2001), where individuals may simultaneously resist, accommodate and reinterpret such encounters depending on context,

available meanings and their relationships with those expressing these attitudes or behaviours.

Subtheme 5: Systemic Influences on Stigma and Discrimination

Participants' differing accounts of stigma across crisis and community settings suggest that it may be shaped not only by the type of service, but by the organisational conditions within which care is delivered. In crisis services, some participants described a "self-fulfilling prophecy", whereby people diagnosed with EUPD risked being understood primarily through distress observed during acute presentations. In contrast, others associated greater stigma with community settings, where high caseloads, repeated presentations and limited capacity to contain risk were perceived to contribute to clinician frustration. Rather than indicating that stigma is specific to particular service settings, these differences suggest that it may be reproduced through different organisational pathways. Risk-focused models may narrow attention towards acute behaviour, while resource pressures may contribute to negative interpretations of repeated or complex presentations (Miller et al., 2024). This extends understandings of stigma beyond individual attitudes to consider how structural and institutional conditions within systems of care may shape how people diagnosed with EUPD are understood and responded to (Stuart & Knaak, 2019).

Participants' concerns about rotating clinicians and short-term models of care suggest that service fragmentation may further limit opportunities to develop contextualised understandings of individuals, increasing reliance on common assumptions tied to diagnostic labels or presentations during periods of acute distress (Lam et al., 2016). This may also affect therapeutic relationships, given evidence that stronger therapeutic alliances are associated with improved outcomes across treatment contexts (Flückiger et al., 2020). Taken

together, the findings suggest that continuity of care may be relevant not only to therapeutic relationships and clinical outcomes, but also to enabling individuals to be understood within a broader personal and developmental context.

6.7. GET 4 – Navigating Authenticity, Sharing and Relational Safety in the Workplace

This GET captures participants' experiences of deciding whether, when and how to share their EUPD diagnosis within workplace settings. Considerations around sharing was described as an ongoing, context-dependent process shaped by workplace culture, need for support, relational safety and anticipated consequences.

Subthemes 1: Safe Workplace Relationships as a Foundation for Belonging

Participants consistently described trusting workplace relationships as a key factor during decisions around sharing. Participants appeared to distinguish between workplaces where openness felt possible and those in which sharing was viewed as carrying significant interpersonal or negative professional consequences.

These findings align with literature highlighting the importance of supportive workplace relationships in facilitating disclosure of mental health difficulties (King et al., 2020). Participant accounts suggest that sharing was not simply an isolated decision but a relational process embedded within wider workplace dynamics. Feelings of belonging appeared to emerge when participants experienced acceptance of both their professional and lived experience in tandem. This reflects previous research indicating that perceived psychological safety and trust within teams are key determinants of sharing decisions, with fear of judgement or altered professional perceptions acting as a barrier (Zamir et al., 2022).

These findings further align with literature on supervision informed by Bowlby's (1969) attachment theory, where senior or supervising colleagues may function as a 'secure base', providing support, validation and safety that enables sharing. However, in contexts where senior staff also hold assessment roles, relational safety could be compromised due to dual-role power dynamics (King, et al, 2020). While this concern may be particularly pronounced for trainees whose assessors influence progression, qualified staff may also experience apprehension given appraisal processes and broader professional accountability requirements, which can similarly constrain openness. Subtheme 2: Weighing Up the Risks and Benefits of Sharing

Participants described weighing the potential benefits of sharing their EUPD diagnosis, including access to support, reduced isolation and greater authenticity within professional relationships. These benefits were balanced against concerns about stigma, perceived competence, discrimination and career progression, which reflects existing literature conceptualising sharing as a process of balancing anticipated benefits and risks (Corrigan, 2004; Tay et al., 2011). However, the findings of the present study suggest that this process may be particularly complex for mental health staff diagnosed with EUPD, with concerns extending beyond general mental health stigma to how the EUPD diagnosis might affect professional identity and credibility. Participants' professional position may therefore have provided an additional context in which the potential consequences of sharing were considered, with general concerns about mental health disclosure intersecting with professional identity, participants' position within the mental health system awareness of EUPD-specific stigma.

Subtheme 3: Testing the Waters

Participants frequently described engaging in gradual forms of sharing, to assess the likely reactions of others. This involved selectively sharing information to trusted colleagues first,

or making indirect references to mental health experiences in others or in general terms, before deciding whether to specifically mention the EUPD diagnosis itself in relation to their lived experience. In some instances, participants shared a sense of ‘testing the waters’ through observing colleagues’ responses and attitudes towards service users associated with the EUPD diagnosis or other types of severe mental health presentations. Goffman's (1963) concept of ‘information control’ provides a useful framework for understanding these accounts in cases where participants appeared to actively manage information about their diagnosis and lived experience, carefully controlling when, how and to whom information was shared. These strategies enabled participants to maintain a degree of agency whilst assessing whether workplace relationships were sufficiently safe to support more detailed levels of sharing. As established in previous literature (King, 2020), findings of the current study suggest that sharing was experienced as an iterative process, rather than a singular decision, reflecting ongoing negotiations between openness and self-protection in the workplace. Furthermore, ‘testing the waters’ may be understood as a form of anticipatory risk assessment, allowing participants to gather information about workplace attitudes towards those diagnosed with EUPD while retaining control over whether to share further.

Subtheme 4: The Mixed Aftermath of Sharing

Participants’ experiences following sharing were often characterised by complexity and uncertainty. While some described feeling understood and supported after sharing their EUPD diagnosis with colleagues, many also reported discomfort or increased concern about how they were perceived, even when initial responses appeared supportive. These findings are consistent with previous research suggesting that sharing can facilitate openness and support while simultaneously increasing exposure to stigma or scrutiny (King et al., 2020). Some participants remained uncertain about the impact of sharing, questioning whether it had

genuinely shifted colleagues' views of the client group or whether pre-existing attitudes remained unchanged. Others questioned whether colleagues' perceptions of them had shifted, particularly whether they were now viewed as more emotionally fragile or whether interactions in the workplace were being reinterpreted as possible EUPD symptoms.

Some participants described receiving responses from others, such as "you don't seem like someone with BPD." Participants acknowledged that, although these comments were intended positively by colleagues, they did not experience them in this way. Instead, they felt that such remarks were insulting because they reflected negative assumptions about people diagnosed with EUPD as a group, with whom participants expressed a sense of solidarity with.

In contrast, some participants felt that their openness in sharing had strengthened relationships with colleagues, contributing to a workplace culture that normalised human distress among mental health staff and encouraged greater authenticity amongst others they worked with, experiences like this appear to challenge expectations of mental health staff to uphold the image of being 'superhuman' and less susceptible to emotional vulnerabilities (Farley et al., 2025). This progression aligns with the intentions behind the Power Threat Meaning Framework (PTMF), which conceptualises distress as an understandable response to life experiences rather than a marker of a fundamentally different or disordered group (Johnstone & Boyle, 2018). From the perspective of the PTMF, mental health difficulties would be part of the spectrum of human experience as opposed to being fused with issues of professional competence. Furthermore, participants' openness may therefore be understood as promoting a workplace culture that recognises vulnerability as a shared human experience in efforts to reduce stigma and foster a greater sense of authenticity in the workplace.

Subtheme 5: The Emotional Cost When Authenticity is Suppressed

Findings suggested that, for mental health staff diagnosed with EUPD, emotional labour arose not only from concealing their diagnosis but also from suppressing aspects of themselves that they experienced as natural to express in relationships outside work. Participants described feeling unable to be fully authentic in the workplace, requiring ongoing self-monitoring that was experienced as tiring and emotionally costly. This may extend research showing that mental health staff negotiate the sharing and concealment of mental health difficulties more broadly (Zamir, 2022). The present findings highlight how, for participants diagnosed with EUPD, authenticity could be constrained by both self-stigma and concerns that others may perceive them as ‘too difficult’.Such concerns appeared to be reinforced by participants’ awareness of how colleagues spoke about patients with EUPD.

6.8. GET 5 - Moving Beyond Reductionist Narratives Associated with EUPD

This GET captures participants’ accounts of moving beyond reductionist narratives associated with the EUPD diagnosis towards meaning-making, growth and agency within their professional roles, whilst being a part of a workplace culture that challenges stigmatising narratives.

Subtheme - 1 The Reward of Contributing to Positive Shifts in Workplace Culture

Participants described experiencing a sense of purpose when contributing to positive shifts in workplace attitudes towards service users diagnosed with EUPD. Rather than experiencing their lived experience solely as a source of difficulty or vulnerability, they appeared to make sense of these experiences as opportunities to draw on their experiential knowledge in ways that could challenge stigma and support alternative understandings of distress among colleagues and those in leadership positions.

Findings within this subtheme align with recovery-oriented literature, which emphasises the importance of social contribution, empowerment and connectedness in mental health recovery (Winsper et al., 2020). However, the present findings provide greater insight into contribution as an active process of cultural change among mental health staff diagnosed with EUPD. Participants appeared to derive meaning and reward from working with others to foster greater openness, understanding and trauma-informed approaches, while challenging potential misunderstandings about people diagnosed with EUPD. Although this was most evident at a local team level, some participants described extending this contribution to wider organisational and systemic contexts, including conference and educational settings.

Subtheme 2 - Adaptive Compartmentalisation Versus 'EUPD Splitting'

Participants often described compartmentalisation as a way to manage the emotional demands of both their work and their own mental health during challenging periods and when drawing upon different skillsets required at work. Some reflected critically on how their ability to do this had been viewed through traditional pathologized frameworks associated with EUPD, particularly the concept of ‘splitting’ different parts of their personality to manage these multiple demands (Kernberg, 1975). These accounts highlight a tension between clinical interpretations of behaviour and participants’ own understandings of adaptive coping. Rather than reflecting pathology, compartmentalisation was often described by participants as a functional and positive way of coping. This challenges reductionist interpretations of diagnostic criteria and aligns with contemporary perspectives that question purely pathological understandings of “splitting”, by instead conceptualising these processes as context-dependent responses to emotional and interpersonal pressures (Bateman & Fonagy, 2019). From this perspective, participants’ accounts suggest that the meaning and

function of their positive beliefs on their ability to manage daily life may be obscured when viewed solely through a diagnostic lens.

Subtheme 3 - 'Turning Lemons into Lemonade' - Healing Alongside 'Giving Back' to Others

Participants also described a more personally restorative process when drawing on their lived experience to support clients they worked with, often framing this as both a source of meaning and a mechanism for their own personal healing. This was described by one participant as "turning lemons into lemonade," reflecting a process of transforming personal adversity into a resource to support others. Through helping others, participants described gaining perspective, consolidating their own recovery journeys and developing a strengthened sense of identity and purpose.

The notion of "giving back" further suggests that this process was reciprocal. For participants who had experienced positive care, supporting others provided an opportunity to extend the understanding and compassion they had themselves received; for those who had experienced inadequate support, it appeared to offer a way of creating a different experience for others. These findings extend literature on post-traumatic growth and meaning-making (Tedeschi & Calhoun, 2004) by suggesting that restorative change may occur relationally, through the process of helping others. "Giving back" therefore appeared to connect participants' past experiences as service users with their present professional identities, allowing adversity to be reinterpreted as a source of connection, purpose and professional value.

.

6.9. Critical Review

A key strength of the present study lies in its exploration of a relatively under-researched population. Whilst considerable literature exists regarding the experiences of service users diagnosed with EUPD, far less attention has been paid to mental health staff who hold this diagnosis. The use of IPA enabled an in-depth exploration of participants' experiences and the meanings they attached to them. The sample of nine participants generated rich, nuanced accounts, allowing both shared and divergent experiences to be explored.

One limitation of this study is that participants self-selected for participation and may therefore, their experiences may differ from those or who not drawn to or unable to discussing their diagnosis and its relationship to the workplace. The sample also lacked racial diversity, meaning that intersectional influences on sharing lived experience, stigma and belonging were not fully captured. Additionally, all participants were assigned female at birth; eight identified as women and one as non-binary. Although this reflects the gender distribution commonly reported in EUPD diagnostic populations (Choi-Kain et al., 2024), men and individuals of other gender identities may have different experiences that were not fully represented within this sample.

The study was underpinned by an interpretivist epistemology (Schwartz-Shea & Yanow 2012), which assumes that knowledge is co-constructed, context-dependent and inherently subjective. Within IPA, this is reflected in the double hermeneutic, where participants make sense of their experiences and the researcher interprets this sense-making (Smith et al., 2022). Findings are therefore presented as interpretative accounts rather than objective truths, recognising that alternative researchers may generate different interpretations.

The researcher's position as an "insider" within the mental health field is predominantly acknowledged as a strength of this study. While insider status may risk assumptions influencing interpretation, IPA emphasises reflexivity rather than objectivity and proximity to the context under may enhance sensitivity to participants' accounts and support rich analysis (Smith et al., 2022) Furthermore, reflexivity was supported through reflective journaling, regular supervisory discussions, including the bracketing of emerging interpretations and consultation with an Experts by Experience (EBE) group.

6.10. Implications of the Empirical Study

The findings of the present study have implications for individuals at multiple levels of mental health services, including service users, staff with lived experience, clinical and organisational leaders and those involved in service development.

Although the population sample for this study was centred on mental health staff, the findings may also have implications for service users diagnosed with, or presenting with difficulties associated with the EUPD diagnosis. For instance, participants described the value of being recognised as individuals beyond their diagnosis, highlighting the importance of nuanced and person-centred understandings within mental health services. This is particularly relevant given evidence that clinicians' expectations and attitudes can influence therapeutic relationships and outcomes (Wampold & Imel, 2015), which reinforces the need to avoid reductive interpretations based solely on diagnostic labels. In addition, participants' accounts demonstrate that people diagnosed with EUPD can develop and sustain meaningful careers in professions that rely heavily on interpersonal relationships with colleagues and service users. This contributes to a broader understanding of the potential scope of recovery, particularly where EUPD-related difficulties, may be perceived as barriers to sustained professional functioning (Juurlink et al. (2019). Furthermore, sharing examples of staff who have

sustained careers alongside significant mental health difficulties may therefore promote hope and encourage service users and staff working with them to consider possibilities beyond periods of distress, while challenging recovery narratives that focus predominantly on risk and crisis reduction (Ng et al., 2016).

Although recent policy and professional guidance, including the Division of Clinical Psychology position statement (British Psychological Society, 2020), have emphasised the value of lived experience within the mental health workforce, the findings suggest that these developments may not be experienced equally across all types of lived experience. Furthermore, findings from the present study highlight the need for continued efforts to address staff attitudes towards EUPD and reduce stigma within mental health services for both staff and service users with the diagnosis. Therefore, A further implication of this study is that future anti-stigma initiatives may extend beyond increasing clinicians' knowledge of EUPD-related presentations to address how stigma is reproduced by staff through interpersonal and organisational practices. Reflective training incorporating lived-experience perspectives, including opportunities for people with lived experience of EUPD to contribute to education and service development, may help challenge pathologising language, assumptions about interpersonal functioning and promote person-centred approaches to care. Participants of this study demonstrated how lived experience, informed by their own journeys and observations from both staff and service-user perspectives offered valuable and experiential knowledge. However, the findings also highlight that lived experience does not need to be fully shared to hold value within the workplace.

Findings from this study that highlight, participants' positive experiences of support, acceptance and belonging have implications in demonstrating that more inclusive workplace cultures are achievable. The findings underscore the importance of psychologically safe environments in which staff can share mental health difficulties without fear of judgement,

discrimination, or breaches of confidentiality. Such environments may support staff wellbeing, openness within teams and subsequently have indirect benefits on service delivery for service users. Creating conditions in which staff can choose whether to share without fear of professional consequences may reduce the emotional burden associated with concealment while supporting belonging and wellbeing. However, involvement in such initiatives should remain voluntary and should not create expectations for staff to share information beyond what they are comfortable with sharing. More broadly, the findings of this study highlight the importance of fostering workplace cultures in which both shared and unshared lived experience are recognised, respected and held in mind.

Participants described concerns that sharing their lived experience with the EUPD diagnosis could lead to their competence or routine workplace interactions being interpreted through the lens of their diagnosis. These accounts have implications for supervisors and those in leadership roles within mental health services, highlighting the importance of distinguishing supportive or restorative supervision from performance management. Although supervisors do hold responsibilities for monitoring practice, this does not prevent the creation of clearly defined spaces in which staff can discuss wellbeing and emotional experiences, without these automatically being interpreted as evidence of impaired professional functioning. Where possible, organisations could clarify the boundaries between restorative, reflective and performance-focused discussions, ensuring that concerns about competence or risk are considered on the basis of observed practice rather than assumptions associated with an employee's diagnosis or wider lived experience.

Further implications at an organisational level, invite greater consideration of how staff access mental health support when they are employed within the same organisation, service or wider locality in which they receive care. Although staff may choose to access support from another organisation, confidentiality concerns can potentially become difficult to

navigate before care even begins (Zaman et al., 2022). Processes such as referral triage, multidisciplinary team discussions, inter-team communication and routine information sharing may create anxiety about colleagues becoming aware of an individual's mental health history. Organisations should therefore review whether existing pathways adequately protect confidentiality for staff accessing care and whether staff are given clear information about who may have access to their information and under what circumstances. Greater confidence in such processes could help reduce the perceived risk of sharing lived experience in the workplace and make it more likely that staff seek support at an earlier stage rather than delaying or avoiding care because of concerns about professional consequences.

6.11.Suggestions for Future Research

Future research could explore the experiences of mental health staff with lived experience of EUPD across a wider range of clinical settings and professional roles, given the relatively small sample used in the present study. Comparative research across diagnostic groups may also help clarify how experiences of stigma, sharing experiences and identity differ according to diagnosis.

In addition, longitudinal or mixed-methods studies could provide insight into how the sharing of lived experience, workplace relationships and professional identity evolve over time, particularly in response to changes in organisational culture and staff wellbeing initiatives. Further research may also benefit from exploring the perspectives of colleagues and managers of staff diagnosed with EUPD to better understand how organisational responses shape staff experiences and how psychologically safe workplace cultures are developed and maintained.

6.12. Conclusion

The findings of the present study suggest that participants occupied a complex position through navigating the intersection of professional identity, lived experience of a stigmatised diagnosis and workplace dynamics. Five experiential themes captured these processes: Early encounters with the diagnosis as a ‘double-edged sword’; The integration of lived and professional identities; The emotional impact of stigma and discrimination; Navigating authenticity and sharing in the workplace; and moving beyond reductionist narratives associated with EUPD.

Overall, the findings highlight the importance of inclusive, psychologically safe workplace cultures that support the integration of professional identity and lived experience, while identifying important directions for future research.

References

Alase, A. (2017). The interpretative phenomenological analysis (IPA): A guide to a good qualitative research approach. International journal of education and literacy studies, 5(2), 9-19.

Alvesson, M., & Sköldberg, K. (2017). Reflexive methodology: New vistas for qualitative research.

American Psychiatric Association. (2022). Diagnostic and statistical manual of mental disorders (5th ed., text rev.; DSM-5-TR). American Psychiatric Publishing.

American Psychiatric Association. (1994). Diagnostic and statistical manual of mental disorders (4th ed.). American Psychiatric Association.

Aviram, R. B., Brodsky, B. S., & Stanley, B. (2006). Borderline personality disorder, stigma and treatment implications. Harvard Review of Psychiatry, 14(5), 249–256. https://doi.org/10.1080/10673220600975121

Bailey, A., Tickle, A., & Sabin-Farrell, R. (2024). 'Isn't it mad that we're all psychologists and we can't talk about our feelings?': A mixed-methods study exploring trainee clinical psychologists' experience of (non) disclosure of psychological distress during training. Clinical Psychology & Psychotherapy, 31(1), e2941.

Baker, J., & Beazley, P. I. (2022). Judging personality disorder: A systematic review of clinician attitudes and responses to borderline personality disorder. *Journal of Psychiatric Practice, 28*(4), 275–293. https://doi.org/10.1097/PRA.0000000000000642

Bamber, G., Caygill, L., & Craven-Staines, S. (2025). "I am a clinician, but I'm also a service user…" Navigating doctoral training as a trainee clinical psychologist (TCP) with lived mental health experience (LMHE). The Journal of Mental Health Training, Education and Practice, 20(2), 85-98.

Barnett, J. E. (2011). Psychotherapist self-disclosure: ethical and clinical considerations. Psychotherapy, 48(4), 315.

Beyene, L. S., Strand, E. B., Misund, A. R., Barder, H. E., Brente, T. L., & Størksen, H. T. (2024). Conceptualizing healthcare professionals' relational competence in mental healthcare: An integrative review. International Journal of Nursing Studies Advances, 7, 100266. https://doi.org/10.1016/j.ijnsa.2024.100266

Bhaskar, R. (1975). A realist theory of science (2nd ed.). Leeds Books.

Black, D. W., Pfohl, B., Blum, N., McCormick, B., Allen, J., North, C. S., Phillips, K. A., Robins, C., Siever, L., Silk, K. R., Williams, J. B. W., & Zimmerman, M. (2011).

Attitudes toward borderline personality disorder: A survey of 706 mental health clinicians. CNS Spectrums, 16(3), 67–74. https://doi.org/10.1017/S109285291200020X

Bowlby, J. (1969). Attachment and loss (No. 79). Random House.

Bowman, V. (2023). You Can't Put the Genie Back in the Bottle": Psychologists' Decisions Around Sharing Lived Experience of Mental Health Difficulties at Work (Doctoral dissertation, Canterbury Christ Church University (United Kingdom)).

Bradbury, D. (2024). Borderline Personality Disorder: Stigmatisation experiences of accessing and participating with frontline services in England (Doctoral dissertation, University of Gloucestershire).

Brooks, S.K., Gerada, C. and Chalder, T. (2011) Review of literature on the mental health of doctors: Are specialist services needed? Journal of Mental Health, 20(2), pp.146–156.

Burke, E. M., Pyle, M., Machin, K., & Morrison, A. P. (2018). Providing mental health peer support 2: Relationships with empowerment, hope, recovery, quality of life and internalised stigma. International Journal of Social Psychiatry, 64(8), 745–755. https://doi.org/10.1177/0020764018810307

Byrne, D., Platania-Phung, C., Happell, B., Harris, S., & Bradshaw, J. (2015). Changing horses: The process of disclosure for mental health professionals with lived experience of mental illness. Issues in Mental Health Nursing, 36(3), 213–221. https://doi.org/10.3109/01612840.2014.962676

Campbell, K., Clarke, K. A., Massey, D., & Lakeman, R. (2020). Borderline Personality Disorder: To diagnose or not to diagnose? That is the question. International journal of mental health nursing, 29(5), 972-981.

Chapman, A. L. (2019). Borderline personality disorder and emotion dysregulation. Development and psychopathology, 31(3), 1143-1156.

Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: understanding disclosure decision making and postdisclosure outcomes among people living with a concealable stigmatized identity. Psychological bulletin, 136(2), 236.

Choi-Kain, L. W., Zimmerman, M., Harned, M. S., et al. (2024). The National Education Alliance for Borderline Personality Disorder: A systematic review of borderline personality disorder and sex/gender. Harvard Review of Psychiatry, 32(4), 230–248. https://doi.org/10.1007/s11920-024-01456-2 (check final journal DOI formatting via your library access if needed)

Clarissa, C., Quinn, S., & Stenhouse, R. (2021). 'Fix the issues at the coalface and mental wellbeing will be improved': a framework analysis of frontline NHS staff experiences and use of health and wellbeing resources in a Scottish health board area during the COVID-19 pandemic. BMC Health Services Research, 21(1), 1089.

Clarke, V. (2010). Review of the book “Interpretative Phenomenological Analysis: Theory, Method and Research”. Psychology Learning & Teaching, 9, 57-56

Cleary, R., & Armour, C. (2022). Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy. Counselling and Psychotherapy Research, 22(4), 1100-1111.

Cooke, A., Smith, D., & Booth, A. (2012). Beyond PICO: the SPIDER tool for qualitative evidence synthesis. Qualitative health research, 22(10), 1435-1443.

Cooper, R. E., Lyons, N., Nicholls, V., Foye, U., Shah, P., Mitchell, L., & Johnson, S. (2025). Understanding the roles and experiences of mental health peer support workers in England: a qualitative study. medRxiv, 2025-01.

Corrigan, P. W. (2004). How stigma interferes with mental health care. American Psychologist, 59(7), 614–625. https://doi.org/10.1037/0003-066X.59.7.614

Corrigan, P. W., & Rao, D. (2012). On the self-stigma of mental illness: Stages, disclosure and strategies for change. Canadian Journal of Psychiatry, 57(8), 464–469. https://doi.org/10.1177/070674371205700804

Corrigan, P. W., & Watson, A. C. (2002). The paradox of self-stigma and mental illness. Clinical Psychology: Science and Practice, 9(1), 35–53. https://doi.org/10.1093/clipsy.9.1.35

Corrigan, P. W., & Watson, A. C. (2002). Understanding the impact of stigma on people with mental illness. World Psychiatry, 1(1), 16–20.

Corrigan, P. W., Kerr, A., & Knudsen, L. (2005). The stigma of mental illness: Explanatory models and methods for change. Applied and preventive Psychology, 11(3), 179-190.

Corrigan, P.W., Druss, B.G. and Perlick, D.A. (2014) The Impact of Mental Illness Stigma on Seeking and Participating in Mental Health Care. Psychological Science in the Public Interest, 15(2), pp.37–70.

Covidence systematic review software. (n.d.). Covidence. https://www.covidence.org

Critical Appraisal Skills Programme. (2018). CASP qualitative checklist. https://casp-uk.net

Davies, S., Rushworth, I., & Fisher, P. (2023). “Being human”: A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees. Counselling and Psychotherapy Research, 23(4), 919-929.

Deutsch, C. J. (1985). A survey of therapists' personal problems and treatment. Professional Psychology: Research and Practice, 16(2), 305.

Dobransky, K. (2011). Labelling, looping and social control: Contextualizing diagnosis in mental health care. In B. A. Pescosolido, J. K. Martin, J. D. McLeod, & A. Rogers (Eds.), Advances in Medical Sociology (Vol. 12, pp. 111–131). Emerald Group Publishing. https://doi.org/10.1108/S1057-6290(2011)0000012010

Donella H. Meadows. (2008). Thinking in systems: A primer. Chelsea Green Publishing.

Earnshaw, V. A., & Chaudoir, S. R. (2009). From conceptualising to measuring HIV stigma: A review of HIV stigma mechanism measures. AIDS and Behavior, 13(6), 1160–1177. https://doi.org/10.1007/s10461-009-9593-3

Eatough, V., & Smith, J. A. (2017). Interpretative phenomenological analysis. The Sage handbook of qualitative research in psychology, 193-209.

Elliott, M., & Ragsdale, J. M. (2020). Mental health professionals with mental illnesses: A qualitative interview study. Community Mental Health Journal, 56(5), 827–835. https://doi.org/10.1007/s10597-019-00512-5

Farley, S., Karwatzki, E., & Mason, B. (2025). 'It would probably do more harm than good': mental health nurses' experiences of nondisclosure within individual clinical supervision. British Journal of Mental Health Nursing, 14(1), 1-11.

Fisher, J. (2023). Who am I? The identity crisis of mental health professionals living with mental illness. Journal of Psychiatric and Mental Health Nursing, 30(5), 880-884.

Flood, A. (2010). Understanding phenomenology. Nurse researcher, 17(2).

Flückiger, C., Del Re, A. C., Wlodasch, D., Horvath, A. O., Solomonov, N., & Wampold, B. E. (2020). Assessing the alliance–outcome association adjusted for patient characteristics and treatment processes: A meta-analytic summary of direct comparisons. Journal of Counseling Psychology, 67(6), 706.

Ford, J. D., & Courtois, C. A. (2014). Complex PTSD, affect dysregulation and borderline personality disorder. Borderline Personality Disorder and Emotion Dysregulation, 1(9). https://doi.org/10.1186/2051-6673-1-9

Gallagher, S. (2022). What is phenomenology?. In Phenomenology (pp. 1-10). Cham: Springer International Publishing.

Gillett, G., Leeves, L., Patel, A., Prisecaru, A., Spain, D., & Happé, F. (2023). The prevalence of autism spectrum disorder traits and diagnosis in adults and young people with personality disorders: A systematic review. Australian & New Zealand Journal of Psychiatry, 57(2), 177–193. https://doi.org/10.1177/00048674221114603

Glaser, B. G., Strauss, A. L., & Strutzel, E. (1968). The discovery of grounded theory; strategies for qualitative research. *Nursing research*, *17*(4), 364. Alam, S., O'Halloran, S., & Fowke, A. (2024). What are the barriers to mental health support for racially-

minoritised people within the UK? A systematic review and thematic synthesis. The Cognitive Behaviour Therapist, 17, e10.

Goffman, E. (1963). Stigma: Notes on the management of spoiled identity. Prentice-Hall.

Goodwin, L. D., & Goodwin, W. L. (1984). Qualitative vs. quantitative research or qualitative and quantitative research?. Nursing research, 33(6), 378-384.

GOV.UK. (2020). COVID-19 mental health and wellbeing recovery action plan. https://www.gov.uk/government/publications/covid-19-mental-health-and-wellbeing-recovery-action-plan

Greene, M. J. (2014). On the inside looking in: Methodological insights and challenges in conducting qualitative insider research. The qualitative report, 19(29), 1-13.

Groves, S., Hawton, K., & Lascelles, K. (2026). 'Not Angels but Humans' An Exploratory Qualitative Study of Female Nurses With Lived Experience of Self-Harm and Suicidal Behaviours. Journal of Advanced Nursing, 82(1), 780-790.

Guest, K. (2021). Addressing misdiagnosis: towards a better understanding of how to clinically differentiate autism and borderline personality disorder (Doctoral dissertation, UCL (University College London)).

Gyollai, D. (2020). Getting into it in the wrong way: Interpretative phenomenological analysis and the hermeneutic circle. Nursing Philosophy, 21(2), e12294.

Hannah, S. (2023). Experiences of Trainee Clinical Psychologists and Workplace Supervisors When Mental Health Difficulties are Shared (Doctoral dissertation, Lancaster University (United Kingdom)).

Harzing, A. W. (2007). Publish or Perish [Computer software]. Retrieved from https://harzing.com/resources/publish-or-perish

Helmus, K., Schaars, I. K., Wierenga, H., De Glint, E., & Van Os, J. (2019). Decreasing stigmatization: Reducing the discrepancy between "us" and "them". An intervention for mental health care professionals. Frontiers in psychiatry, 10, 243.

Hopewell, S., McDonald, S., Clarke, M. J., & Egger, M. (2006). Grey literature in meta-analyses of randomized trials of health care interventions. Cochrane Database of Systematic Reviews, (2).

Hörz-Sagstetter, S., Ohse, L., & Kampe, L. (2021). Three dimensional approaches to personality disorders: A review on personality functioning, personality structure and personality organization. Current Psychiatry Reports, 23(8), Article 45. https://doi.org/10.1007/s11920-021-01250-y

Jackson, S. W. (2001). The wounded healer. Bulletin of the History of Medicine, 75(1), 1–36. https://doi.org/10.1353/bhm.2001.0025

Johnson, J., Hall, L. H., Berzins, K., Baker, J., Melling, K., & Thompson, C. (2018). Mental healthcare staff well-being and burnout: A narrative review of trends, causes, implications and recommendations for future interventions. International journal of mental health nursing, 27(1), 20-32.

Johnstone, L., & Boyle, M. (2018). The power threat meaning framework: Towards the identification of patterns in emotional distress, unusual experiences and troubled or troubling behaviour, as an alternative to functional psychiatric diagnosis. British Psychological Society. https://www.bps.org.uk/guideline/power-threat-meaning-framework

Juurlink, T. T., Vukadin, M., Stringer, B., Westerman, M. J., Lamers, F., Anema, J. R., Beekman, A. T. F., & van Marle, H. J. F. (2019). Barriers and facilitators to employment in borderline personality disorder: A qualitative study among patients, mental health practitioners and insurance physicians. *PLOS ONE, 14*(7), e0220233. https://doi.org/10.1371/journal.pone.0220233

Kandel, B. (2020). Qualitative versus quantitative research. Marsyangdi Journal, 1(1), 1-5.

Kendler, K. S. (2016). The nature of psychiatric disorders. World Psychiatry, 15(1), 5–12. https://doi.org/10.1002/wps.20292

Kernberg, O. F. (1975). Borderline conditions and pathological narcissism. Jason Aronson

King, A. J., Brophy, L. M., Fortune, T. L., & Byrne, L. (2020). Factors affecting mental health professionals' sharing of their lived experience in the workplace: A scoping review. Psychiatric Services, 71(10), 1047-1064.

Klein, P., Fairweather, A. K., & Lawn, S. (2022). Structural stigma and its impact on healthcare for borderline personality disorder: A scoping review. *International Journal of Mental Health Systems, 16*, Article 48. https://doi.org/10.1186/s13033-022-00558-3

Lam, D. C. K., Poplavskaya, E. V., Salkovskis, P. M., Hogg, L. I., & Panting, H. (2016). An experimental investigation of the impact of personality disorder diagnosis on clinicians: Can we see past the borderline? *Behavioural and Cognitive Psychotherapy, 44*(3), 361–373. https://doi.org/10.1017/S1352465815000351

Lame, G. (2019). Systematic literature reviews: An introduction. In Proceedings of the design society: international conference on engineering design (Vol. 1, No. 1, pp. 1633-1642). Cambridge University Press.

Landis, J. R., & Koch, G. G. (1977). An application of hierarchical kappa-type statistics in the assessment of majority agreement among multiple observers. Biometrics, 363-374.

Lazarus, S. A., Cheavens, J. S., Festa, F., & Rosenthal, M. Z. (2014). Interpersonal functioning in borderline personality disorder: A systematic review of behavioral and laboratory-based assessments. Clinical psychology review, 34(3), 193-205.

Liberati, E., Richards, N., Willars, J., Scott, D., Boydell, N., Parker, J., ... & Jones, P. B. (2021). A qualitative study of experiences of NHS mental healthcare workers during the Covid-19 pandemic. BMC psychiatry, 21(1), 250.

Link, B. G., & Phelan, J. C. (2001). Conceptualizing stigma. Annual Review of Sociology, 27, 363–385. https://doi.org/10.1146/annurev.soc.27.1.363

Mahapatra, A., & Sharma, P. (2024). Biopsychosocial approach to mental health. In Mental Health Care Resource Book: Concepts and Praxis for Social Workers and Mental Health Professionals (pp. 87-100). Singapore: Springer Nature Singapore.

Markham, D., & Trower, P. (2003). The effects of the psychiatric label "borderline personality disorder" on nursing staff's perceptions and causal attributions for challenging behaviours. *British Journal of Clinical Psychology, 42*(3), 243–256. https://doi.org/10.1348/01446650360703366

Matthies, S. D., & Philipsen, A. (2014). Common ground in attention deficit hyperactivity disorder (ADHD) and borderline personality disorder (BPD): Review of recent findings. Borderline Personality Disorder and Emotion Dysregulation, 1(3). https://doi.org/10.1186/2051-6673-1-3

McKenzie, K., Gregory, J., & Hogg, L. (2022). Mental health workers' attitudes toward individuals with a diagnosis of borderline personality disorder: A systematic literature review. Journal of Personality Disorders, 36(1), 70-98 — finds that clinicians show more negative attitudes toward BPD than toward other diagnostic categories such as depression.

Mercer, J. (2007). The challenges of insider research in educational institutions: Wielding a double-edged sword and resolving delicate dilemmas. Oxford Review of Education, 33(1), 1–17. https://doi.org/10.1080/03054980601094651

Morse, G., Salyers, M. P., Rollins, A. L., Monroe-DeVita, M., & Pfahler, C. (2012). Burnout in mental health services: A review of the problem and its remediation. Administration and Policy in Mental Health and Mental Health Services Research, 39(5), 341–352. https://doi.org/10.1007/s10488-011-0352-1

National Institute for Mental Health in England. (2003). Personality disorder: No longer a diagnosis of exclusion – Policy implementation guidance for the development of services for people with personality disorder. Department of Health.

Ng, F. Y. Y., Bourke, M. E., & Grenyer, B. F. S. (2016). Recovery from borderline personality disorder: A systematic review of the perspectives of consumers, clinicians, family and carers. *PLOS ONE, 11*(8), e0160515. https://doi.org/10.1371/journal.pone.0160515

NHS England Digital. (2025). Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/24 – Chapter 1: Common mental health conditions. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/common-mental-health-conditions

NHS England. (2022, February 24). *NHS health and wellbeing framework*. https://www.england.nhs.uk/supporting-our-nhs-people/health-and-wellbeing-programmes/nhs-health-and-wellbeing-framework/

NHS England. (2023). Staff mental health and wellbeing hubs. https://www.england.nhs.uk/supporting-our-nhs-people/support-now/staff-mental-health-and-wellbeing-hubs/

NHS England. (2025). Chapter 8: Personality disorder. In Adult Psychiatric Morbidity Survey: Survey of Mental Health and Wellbeing, England, 2023/4. NHS England. https://digital.nhs.uk/data-and-information/publications/statistical/adult-psychiatric-morbidity-survey/survey-of-mental-health-and-wellbeing-england-2023-24/personality-disorder

Nightingale, G., Mohan, K., Ribe, E., Popov, V., Wang, S., Calia, C., Brondi, L., Seth, S. (2026). Modeling mental health trajectories during the COVID-19 pandemic using UK-wide data in the presence of sociodemographic variables. https://arxiv.org/abs/2601.10445

Office for National Statistics. (2021). Measuring equality: a guide for the collection and classification of ethnic group, national identity and religion data in the UK.

Page, M. J., McKenzie, J. E., Bossuyt, P. M., Boutron, I., Hoffmann, T. C., Mulrow, C. D., ... & Moher, D. (2021). The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. bmj, 372.

Probst, B. (2015). Queen of the owls: Metaphor and identity in psychiatric diagnosis. Social Work in Mental Health, 13(3), 235–251. https://doi.org/10.1080/15332985.2014.893946

Quinn, D. M., & Earnshaw, V. A. (2013). Concealable stigmatized identities and psychological well-being. Social and Personality Psychology Compass, 7(1), 40–51. https://doi.org/10.1111/spc3.12005

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), 1–14. https://doi.org/10.1177/2158244015621348

Riessman, C. K. (1993). Narraave analysis (Vol. 30). Sage. Riessman, C. K. (2008). Narrative methods for the human sciences. Sage.

Riessman, C. K. (2008). *Narrative methods for the human sciences*. Sage.

Royal Australian and New Zealand College of Psychiatrists. (2023, February). *Safety and wellbeing of psychiatrists and those in psychiatry training* (Position Statement PS #48). https://www.ranzcp.org/clinical-guidelines-publications/clinical-guidelines-publications-library/safety-and-wellbeing-of-psychiatrists

Ryan, S. (2020). The Wounded Healer: Personal experiences of mental health difficulties and trauma and their influence on the professional practice of Clinical Psychologists and other therapy professionals (Doctoral dissertation, Staffordshire University).

Saidin, K. (2016). *Insider researchers: Challenges & opportunities*. *Proceedings of the ICECRS, 1*(1), 849–854. https://doi.org/10.21070/picecrs.v1i1.563

Schwartz-Shea, P., & Yanow, D. (2012). Interpretive research design: Concepts and processes. Routledge.

Scior, K., Rüsch, N., White, C., & Corrigan, P. W. (2020). Supporting mental health disclosure decisions: The Honest, Open, Proud programme. The British Journal of Psychiatry, 216(5), 243–245. https://doi.org/10.1192/bjp.2019.256

Sciriha Camilleri, R. (2024). Emotionally unstable personality disorder: an in-depth analysis in clinical practice.

Sheikh, S., & Furnham, A. (2000). A cross-cultural study of mental health beliefs and attitudes towards seeking professional help. Social psychiatry and psychiatric epidemiology, 35(7), 326-334.

Skinner, B. F. (1953). Science and human behavior. Macmillan.

Smith, J. A. (1996). Beyond the divide between cognition and discourse: Using interpretative phenomenological analysis in health psychology. Psychology and health, 11(2), 261-271.

Smith, J. A., Flowers, P., & Larkin, M. (2009). Interpretative phenomenological analysis: Theory, method and research. SAGE.

Smith, J. A., Flowers, P., & Larkin, M. (2022). Interpretative phenomenological analysis: Theory, method and research (2nd ed.). Sage.

Smith, J. A., Larkin, M., & Flowers, P. (2021). Interpretative phenomenological analysis: Theory, method and research.

Smith, L. T. (2021). Decolonizing methodologies: Research and Indigenous peoples (3rd ed.). Zed Books.

Snider, C. J., & Flaherty, M. P. (2020). Stigma and mental health: The curious case of COVID-19. Mental Health: Global Challenges, 3(1), 27-33.

Stoll, C. R., Izadi, S., Fowler, S., Green, P., Suls, J., & Colditz, G. A. (2019). The value of a second reviewer for study selection in systematic reviews. Research synthesis methods, 10(4), 539-545.

Stuart, H., & Knaak, S. (2019). Mental health-related stigma in health care and mental health-care settings. In W. Gaebel, W. Rössler, & N. Sartorius (Eds.), *The stigma of mental illness: Strategies against stigma* (pp. 235–257). Springer. https://doi.org/10.1007/978-3-319-27839-4_14

Sulzer, S. H. (2015). Does "difficult patient" status contribute to de facto demedicalization? The case of borderline personality disorder. *Social Science & Medicine, 142*, 82–89. https://doi.org/10.1016/j.socscimed.2015.08.008

Sutton, L., Rowe, S., Hammerton, G., & Billings, J. (2022). The contribution of organisational factors to vicarious trauma in mental health professionals: A systematic review and narrative synthesis. European Journal of Psychotraumatology, 13(1), 2022278. https://doi.org/10.1080/20008198.2021.2022278

Tajfel, H., & Turner, J. C. (1979). An integrative theory of intergroup conflict. In W. G. Austin & S. Worchel (Eds.), The social psychology of intergroup relations (pp. 33–47). Brooks/Cole.

Tay, S. (2016). Lived experience of mental health problems among clinical psychologists, stigma and its impact on disclosure and help-seeking (Doctoral thesis). University College London. https://discovery.ucl.ac.uk/id/eprint/1531981/

Tay, S., Alcock, K., & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking. Journal of Clinical Psychology, 74(9), 1545-1555.

Taylor, S. (2025). The wounded healer: The history and implications of lived experience in mental health care. Australasian Psychiatry, 33(3), 339-341.

Tedeschi, R. G., & Calhoun, L. G. (2004). Posttraumatic growth: Conceptual foundations and empirical evidence. Psychological Inquiry, 15(1), 1–18. https://doi.org/10.1207/s15327965PLI1501_01

Terry, G., Hayfield, N., Clarke, V., & Braun, V. (2017). Thematic analysis. The SAGE handbook of qualitative research in psychology, 2(17-37), 25.

Thambinathan, V., & Kinsella, E. A. (2021). Decolonizing methodologies in qualitative research: Creating spaces for transformative praxis. International journal of qualitative methods, 20, 16094069211014766.

The King's Fund. (2024). 10 actions the government can take to improve NHS working conditions. https://www.kingsfund.org.uk/insight-and-analysis/briefings/10-actions--improve-nhs-working-conditions

Thomas, E. S., Smith, O., & Berry, V. (2023). Improving Physical Health Monitoring for Patients Diagnosed With Emotionally Unstable Personality Disorder. BJPsych Open, 9(S1), S181-S181.

Thomas, J., & Harden, A. (2008). Methods for the thematic synthesis of qualitative research in systematic reviews. BMC Medical Research Methodology, 8, 45. https://doi.org/10.1186/1471-2288-8-45

Turner, K., Moses, J., & Neal, A. (2022). 'I think it does just opens it up and… you're not hiding it anymore': Trainee clinical psychologists' experiences of self-disclosing mental health difficulties. Clinical Psychology & Psychotherapy, 29(2), 733-743.

UCL Unit for Stigma Research. (n.d.). Tackling mental health stigma among mental health professionals through supporting decisions around sharing of lived experience (HOP-MHP). University College London. Retrieved March 28, 2026, from https://www.ucl.ac.uk/pals/research/research-mental-health-stigma-and-disclos

Vicary, S., Young, A., & Hicks, S. (2017). A reflective journal as learning process and contribution to quality and validity in interpretative phenomenological analysis. Qualitative social work, 16(4), 550-565.

Victor, S. E., Devendorf, A. R., Lewis, S. P., Rottenberg, J., Muehlenkamp, J. J., Stage, D. R. L., & Miller, R. H. (2022). Only human: Mental-health difficulties among clinical, counseling and school psychology faculty and trainees. Perspectives on Psychological Science, 17(6), 1576-1590.

Wampold, B. E., & Imel, Z. E. (2015). The great psychotherapy debate: The evidence for what makes psychotherapy work. Routledge.

Weatherstone, S. J., & Dodd, L. (2022). Experiencing mental health when treating others. Experiences of mental health workers in relation to mental health problems: stigma, perception, and employment. European Journal of Mental Health, 17(3), 5-22.

Winsper, C., Crawford-Docherty, A., Weich, S., Fenton, S. J., & Singh, S. P. (2020). How do recovery-oriented interventions contribute to personal mental health recovery? A systematic review and logic model. Clinical psychology review, 76, 101815.

Zaman, N., Mujahid, K., Ahmed, F., Mahmud, S., Naeem, H., Riaz, U., Ullah, U., & Cox, B. (2022). What are the barriers and facilitators to seeking help for mental health in NHS doctors: A systematic review and qualitative study. *BMC Psychiatry, 22*, Article 595. https://doi.org/10.1186/s12888-022-04202-9

World Health Organization. (1992). The ICD-10 classification of mental and behavioural disorders: Clinical descriptions and diagnostic guidelines. World Health Organization.

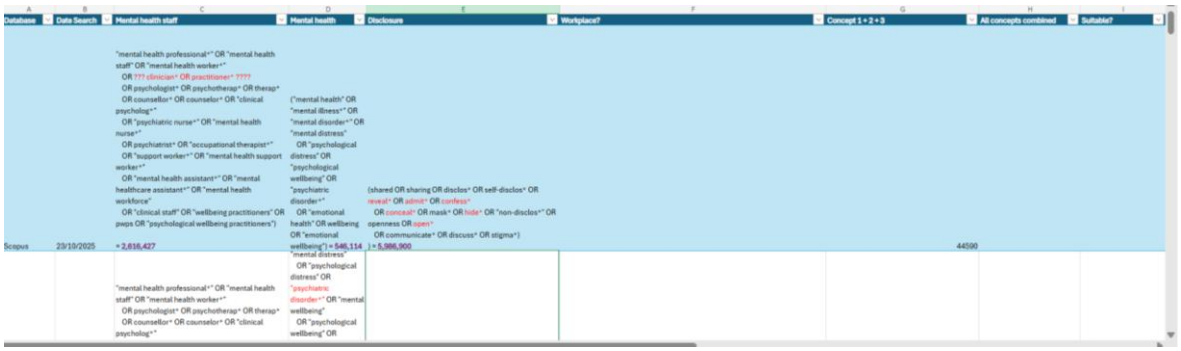
World Health Organization. (2019). International classification of diseases 11th revision (ICD-11): Personality disorder. https://icd.who.int/

Zerubavel, N., & Wright, M. O. D. (2012). The dilemma of the wounded healer. Psychotherapy, 49(4), 482–491. https://doi.org/10.1037/a0027824

Appendices

Appendix A – Example Pilot Searches for SLR

Carried out during the PR's familiarisation the literature and prior to finalising 4 concept blocks and prior to the inclusion of more specific mental health difficulties in the search string.







Appendix B – Final grey literature search terms

Used for google scholar used for the Publish or Perish (PoP) software. Search terms adapted from database search terms in Table 3.

PoP:

FINAL POP: ("mental health professional" | "mental health staff" | psychologist | therapist | psychotherapist | counsellor | "mental health nurse" | psychiatrist | "support worker" | "mental health assistant") ("lived experience" | "dual experience" | prosumer) (disclose | disclosure | disclosing | nondisclosure | "non-disclosure" | "not disclosing" | share | sharing | "not sharing" | "non-sharing") (supervision | "occupational health" | "fitness to practice" | workplace | colleagues)

Appendix C – SLR Data Extraction Table

Title and Author	Location & publication status	Aims	Sample	Research Design and Method	Key Relevant Findings	Limitations
'Isn't it mad that we're all psychologists and we can't talk about our feelings?': A mixed-methods study exploring trainee clinical psychologists' experience of (non)disclosure of psychological distress during training Bailey, et al. (2024)	UK - published	-To explore trainee clinical psychologist experiences of disclosure and/or concealment of psychological distress during their doctoral training -To explore the beliefs, assumptions or predictions that are associated with trainee disclosure -To explore responses experienced by trainees after disclosure	13 trainee clinical psychologists on UK doctoral programmes. depression, low mood, generalised and social anxiety, panic, trauma, eating disorders, bipolar, self-harm and dissociation	Mixed Methods - only qualitative elements analysed for this SLR. Methodology included semi-structured interviews and a Reflective Thematic Analysis	Core themes: (1) Diagnostic or psychological conceptualisations (2) Worries about judgement complicate disclosure decisions (3) Disclosure likelihood is determined by relationships (4) Emotional support versus practical responses (5) Desired changes that could increase disclosure (6) Legacies of disclosure experiences	Findings may not be generalisable to those not working within a clinical psychology/therapeutic role The population of participants was made up of more trainees who had experience of disclosing than those who had not (7.7%), this may be due to self-selection bias given the context of the study. Only 9% of study population were male
"I am a clinician, but I'm also a service user..."	UK - published	-To explore how Trainee Clinical Psychologists	12 Trainee Clinical Psychologists on UK Doctoral Programmes.	Data Collection carried out via semi-	The end model included the following categories:	Researcher notes the potential for researcher bias as the study was carried out by an

Navigating doctoral training as a trainee clinical psychologist (TCP) with lived mental health experience (LMHE)" Bamber, et al., (2025)		with Lived Mental Health Experience Navigate Doctoral Training"	Depression (including postnatal depression) and anxiety disorders, or trauma related presentations.	structured interviews and analysis was of Constructivist Grounded Theory approach	(1) The Pressured System – factors that negatively impact trainee mental health (2) Narratives about lived experience within the profession - stigmatising "us vs them" dynamics and "sensing a change" in unhelpful narratives, led by trainees. (3) Developing trainee identity and sense of self – difficulties when balancing personal and professional aspects of identity (4) Disclosing lived experience within the professional context – considerations around both sharing and hiding lived experience (5) Building safe, balanced and reciprocal relationships – the significance of cohort peers and safe supervision spaces (6) Drawing upon lived experience within clinical practice – difficulties with countertransference and	'insider researcher'. The paper discusses that the scale of this limitation may be subjective depending on the audience's own epistemological position. Findings may not be generalisable to those not working within a clinical psychology/therapeutic role Study collected very few participant demographics (gender, age, sex, ethnicity etc are not specified).

					benefits in understanding/empathising in clinical work	
"You can't put the genie back in the bottle": Psychologists' decisions around sharing lived experience of mental health difficulties at work – SECTION B ONLY (Empirical Paper): "The importance of perceptions of "NHS Culture" for clinical psychologists considering a workplace self-disclosure of their lived experience of mental health difficulties" Bowman, V. (2023)	UK – Grey Literature (doctoral thesis)	-To investigate the experiences of clinical psychologists with lived experience of mental health difficulties within the NHS -To produce a theory to explain the interactions between participants' perceptions of "NHS culture" and their decision-making around self-disclosure.	9 clinical psychologists with experience working in the NHS specifically. Anxiety disorders, depression/mood disorders (including bipolar). Trauma related experiences, eating disorders, self-harm, dissociation	Data collection was carried out via semi-structured interviews and Grounded Theory was used for analysis.	The core category was: 'weighing the decision – to disclose or not to disclose?' The sub categories were (1) NHS Culture (responses to distress, structure, resources, keeping up appearances, participants' perceptions of public ideas about the NHS) (2) Motivation (Benefits of lived experience and disclosure, asking for reasonable adjustments and sick leave, feeling forced to disclose (3) Safety (Confidentiality, relational safety, fear of consequences, local factors and dynamics, stigma) (4) Identity (Clinical Psychologist identity (perfectionism, dual identity, seniority and pay, imposter syndrome, family of origin culture)	-Little variation reported ethnicity of participants (8 participants where white British) - findings may not be generalisable to those in other ethnic groups were matters of intersectionality are concerned. Researcher undertook an 'adapted' approach to Grounded Theory methodology due to resource/time constraints. Whilst the positionality of the researcher was noted to be an expert by experience in the scope of insider research, a secondary expert-by-experience was not appointed to the project to help manage potential researcher bias. Grey literature – although as a doctoral thesis, this study has undergone scrutiny via

						viva examination, the breadth of peer review is limited when compared to published studies.
Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy Cleary, & Armour. (2022)	UK - published	To explore the ways in which lived experience of mental health issues influence counselling and psychotherapy practice and how lived-experience practitioners may be supported in disclosing and valuing their experience.	3 psychotherapists/counsellors. Third sector and private organisations Low mood, anxiety, post-traumatic stress	Data collection was carried out via semi-structed interviews. The methodology and analysis undertook IPA	The four themes developed were: (1) identity as a practitioner (2) self-disclosure as enhancing therapeutic relationships (3) importance of supervision; and (4) healing and recovery	Small sample size limits generalisability of the findings. The researcher notes that self-nominating as a sampling strategy may mean participants may hold greater insight into the dual experience. Those who would have less motivation to nominate themselves for participation may hold different levels/types of insight which may not have been captured in this study. Whilst one participant describes experiencing severe depression, the types of mental health difficulties were not collected explicitly and therefore less likely to be picked up on during analysis.
"Being human": A grounded theory	UK - Published	To explore the processes and factors involved for qualified	9 qualified clinical psychologists working as trainers on Clinical Psychology Doctorate Programmes in the UK	Data collection was carried out via semi-structured	Four main theoretical categories with subcategories were found:	All participants who took part valued disclosures, findings may have been different if voices from

approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose personal experiences of psychological distress to clinical psychology doctorate trainees Davies, et al (2023)		clinical psychologists when deciding whether or not to disclose personal experiences of psychological distress to trainees	Mental health difficulties shared by participants included experiences of anxiety, depressions, life stressors (within workplace, relationships, parenting), experiences of childhood trauma	interviews and analysis undertook a constructivist grounded theory approach	(1) Default position: disclose (if useful and appropriate) - valuing disclosure -wary of risk (2) Being safe - Being contained and containing - Stigma and shame - Professional consequences (3) Considering helpfulness -Being relevant -Keeping the trainee central -Monitoring intent and being purposeful (4) Outcomes -Receiving positive feedback -Experiencing a negative outcome -Identity cohesion and well-being	those who do not value disclosure were captured. The primary researcher was a trainee at the time of the study.
'It would probably do more harm	UK - published	To explore mental health nurses'	10 mental health nurses working in the NHS. Participants were all	Data collection was carried out via	Five central themes were identified from findings across multiple levels (on	Data collection took place during the COVID-19 pandemic,

than good': mental health nurses' experiences of nondisclosure within individual clinical supervision Farley, et al., (2025)		perspectives of clinical supervision and nondisclosure in this setting.	permanent staff (at band 5 or 6 level) and had previous experience working on inpatient units within the last 3 years. Difficulties stemming from burnout and stress related work pressures	semi-structured interviews, data was analysed using thematic analysis	an individual, supervision and cultural level): (1) The expectation to be superhuman (2) Being part of a team (3) A poorly defined space (4) Feeling relationally unsafe (5) Strategies to stay safe The researcher highlighted a need for regular, structured, defined, predictable and safe supervision	researchers note difficulties in relation to this when trying to reach a wider range of participants. Study focuses primarily on non-disclosure. This may have meant that participants may be sharing experiences in relation to topics that they might not feel comfortable to share not only at work but also potentially within the research setting of this study
'Not Angels but Humans' An Exploratory Qualitative Study of Female Nurses With Lived Experience of Self-Harm and Suicidal Behaviours Groves, et al., (2026)	UK - published	To explore the experiences of qualified nurses who have lived experience of self-harm (with or without suicidal intent) during nursing training or practice. To examine characteristics and contributing factors and ideas for	8 qualified nurses within the NHS who had experience of self-harming whilst training or during a period of their practice. Of the 8 participants, 5 were trained as mental health nurses. Self-harming and suicidal ideation and behaviours.	Data collection was carried out via semi-structured interviews, data analysis carried out via reflexive thematic analysis	Four themes were derived from the process: (1) 'I don't think work triggered it, but I don't think it helped': characteristics and contributors to self-harm, (2) 'You're a nurse now you can't talk about that': nursing culture and barriers to workplace support seeking, (3) 'Are you a nurse or are you a lived experience practitioner – can you be both?': navigating a dual	Whilst the majority of participants were mental health nurses, some participants were trained as general nurses. General nurses are able to work within mental health settings; however the study does not specify the type of settings each participant was working in. Experiences may differ based on workplace context (e.g. inpatient vs community, mental health settings vs

		tailored suicide prevention interventions.			identity as a nurse with lived experience and (4) 'We need the permission that it's ok to put us first': workplace support and suggestions for suicide prevention	physical health settings) The researcher noted that participants were comfortable in talking about their experiences, findings may lack generalisability to those who would be less comfortable to talk about these difficulties.
Experiences of trainee clinical psychologists and workplace supervisors when mental health difficulties are shared. Hannah, (2023)	UK – Grey Literature (doctoral thesis)	To explore the experiences of sharing and discussing their own mental health difficulties with supervisors during training. To identify influencing factors and the effects of sharing over time. Mental health difficulties experienced amongst participants are as follows (from most	12 qualified clinical psychologists. Participants had qualified within 5 years prior to the interview. Depression, low mood, anxiety disorders, stress and burnout.	Data collection was carried out via narrative informed interviews. Data was analysed via a reflexive thematic analysis.	Four main themes were found with subthemes within each: (1) Weighing up whether to share -Reason for sharing -Being selective -Fear of sharing -Factors influencing the development and exacerbation of fears (2) Creating safety to share and feeling supported -Reliability of supervision	The researcher used a narrative approach to constructing the interview schedule. They then later used a reflective thematic analysis to identify themes when analysing. It is possible that the narrative element of the interviews may have been lost when changing to the thematic approach. Grey literature – although as a doctoral thesis, this study has undergone scrutiny via viva examination, the breadth of peer review is limited when compared to published studies.

		common to least): depression, anxiety, eating disorders, bipolar, PTSD			-Normalising difficulties, therapeutic skills but not therapy -Practical problem solving -Sharing information (3) Dilemmas, feeling vulnerable and powerless to challenge perceptions -Power imbalance - Supervisor and tutor perceptions being skewed by knowledge of trainee mental health difficulties -contrasting experiences (4) Experience shaping their practice and identity -Template for the future	
The Wounded Healer: Personal experiences of mental health difficulties and trauma and their influence on the		To explore whether traumatic experiences and mental health difficulties are perceived as influential in clinical	17 qualified clinical psychologists Anxiety and depression most frequently reported, some eating disorder and self-harm, 1 report of previous difficulties with EUPD	Data collection was carried out via semi-structured interviews, data analysis was carried out via	Three themes were identified, along with sebthemes : (1) Experience as a clinical tool - skills -empathy -connection, -something to monitor and manage	The researcher noted that a larger sample size (when compared to recommendations for other qualitative approaches) coupled with the broader approach of thematic analysis may have taken away from the

professional practice of Clinical Psychologists and other therapy professionals Ryan, (2020).		psychologists' professional practice and if so, in what ways.		thematic analysis	(2) The interaction of personal and professional -impact on career choices -impact on the self (3) Secrecy, with subthemes -self-preservation -standards for a psychologist -changing over time.	depth reached in analysis. Grey literature – although as a doctoral thesis, this study has undergone scrutiny via viva examination, the breadth of peer review is limited when compared to published studies.
I think it does just opens it up and … you're not hiding it anymore': Trainee clinical psychologists' experiences of self-disclosing mental health difficulties Turner, et al., (2022).	UK - published	To investigate the process of self-disclosure of lived experience of mental health difficulties of trainees	12 trainee clinical psychologists UK doctoral training programmes. Anxiety, low mood/depression, emotion regulation difficulties, PTSD/CPTSD, self-harm, suicidal behaviour and bipolar.	Data collection was carried out via semi-structured interviews. Data analysis was carried out via a constructivist grounded theory approach.	Six core categories were derived from the analysis: (1) Motivations (Describes trainee motivations for self-disclosure. Motivations, enablers and barriers appeared to all contribute to the occurrence of the disclosure event together (2) Enablers (Describes factors that facilitated self disclosure, alongside motivations and barriers) (3) Barriers (Describes factors that inhibited self-disclosure, alongside enablers and motivation) (4) Features of disclosure (Describes features i.e content and methods of how trainees self-	The researcher highlights how the nature of the approach taken offers a limited insight as to how the variables (categories) interact if at all. The researcher suggests that as participants volunteered for the study, they may have a heightened interest in the topic at hand which may contribute to self-selection bias.

					disclosed). Features of disclosure appeared to be in a reciprocal relationship with responses, so that individuals may alter content and methods depending on response received. (5) Responses (Describes responses of receivers during self-disclosure experience). (6) Impact Describes perceived individual, relational and social impacts of self-disclosure. These impacts appeared to exert influence back on motivations, enablers and barriers, influencing future likelihood of disclosures	
Experiencing Mental Health when Treating Others. Experiences of Mental Health Workers in Relation to Mental Health Problems: Stigma, Perception and Employment Weatherston & Lorna, (2022)	UK – published (study took place in UK and 90% of participants reported to live in the UK)	To explore the barriers to disclosure and help-seeking in employment, identify gender differences and understand how stigma relates to specific mental health disorders. The qualitative data extracted	4 mental health professionals. Wellbeing difficulties/stress, sometimes reported to be to be intensified by the workplace	Data collection was carried out via semi-structured focus group interviews, data analysis was carried out using thematic analysis.	The researchers reported an overarching theme - "Changes needed for disclosure" Sub themes for mental health professionals were also identified: -Lack of support (workplace pressure and lack of trust with colleagues at work made it more difficult to seek support, gender barriers when seeking support)	Whilst as part of the overall study it is reported that 90% of participants (of the wider mixed methods study) resided in the UK, the study does not confirm the breakdown of demographics for the four mental health professionals who took part in the qualitative focus group. This therefore reduces the level of generalisablity of results.

		for this SLR was part of a wider mixed methods study with groups of mental health professionals and non-mental health professionals. Only qualitative data applying to the non mental health professioanls is reported in this SLR. Mental health difficulties reported by participants included anxiety, depression			-Future after disclosing (participants reported a fear of being the subject of gossip and concerns about being viewed as weak or subject to negative consequences -What affects someone's decision to disclose (participants reported they would only disclose mental health difficulties if they reached a crisis point or if the difficulties started to impact on patient safety or their clinical work -Increasing knowledge to reduce stigma (participants spoke of knowing terminology, treatment and their own experience and supportive colleagues with lived experience helped reduce stigma. However they noted that this was not the case for less common diagnoses (eating disorders, personality disorders or psychosis)	The researchers suggested that adopting a retrospective design encouraging participants to reflect on previous experiences rather than hypothetical future ones may increase the validity of the results

Appendix D - Quality Appraisal Tool for SLR (CASP checklist)

	Item 1	**Item 2**	**Item 3**	**Item 4**	**Item 5**	**Item 6**	**Item 7**	**Item 8**	**Item 9**	**Item 10**
Title/Author										
	Was there a clear statement of the aims of the research?	Is qualitative methodology appropriate?	Was the research design appropriate to address the aims of the research?	Was the recruitment strategy appropriate to the aims of the research?	Was the data collected in a way that addressed the research issue?	Has the relationship between researcher and participants been adequately considered?	Have ethical issues been taken into consideration?	Was the data analysis sufficiently rigorous?	Is there a clear statement of findings?	How valuable is the research?
'Isn't it mad that we're all psychologists and we can't talk about our feelings?': A mixed-methods study exploring trainee clinical psychologists' experience of (non)disclosure of psychological distress during training Bailey, et al. (2024)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
""I am a clinician, but I'm also a	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable

service user...” Navigating doctoral training as a trainee clinical psychologist (TCP) with lived mental health experience (LMHE)” Bamber, et al., (2025)										
“You can’t put the genie back in the bottle”: Psychologists’ decisions around sharing lived experience of mental health difficulties at work – SECTION B ONLY (Empirical Paper): “The importance of perceptions of “NHS Culture” for clinical psychologists considering a	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable

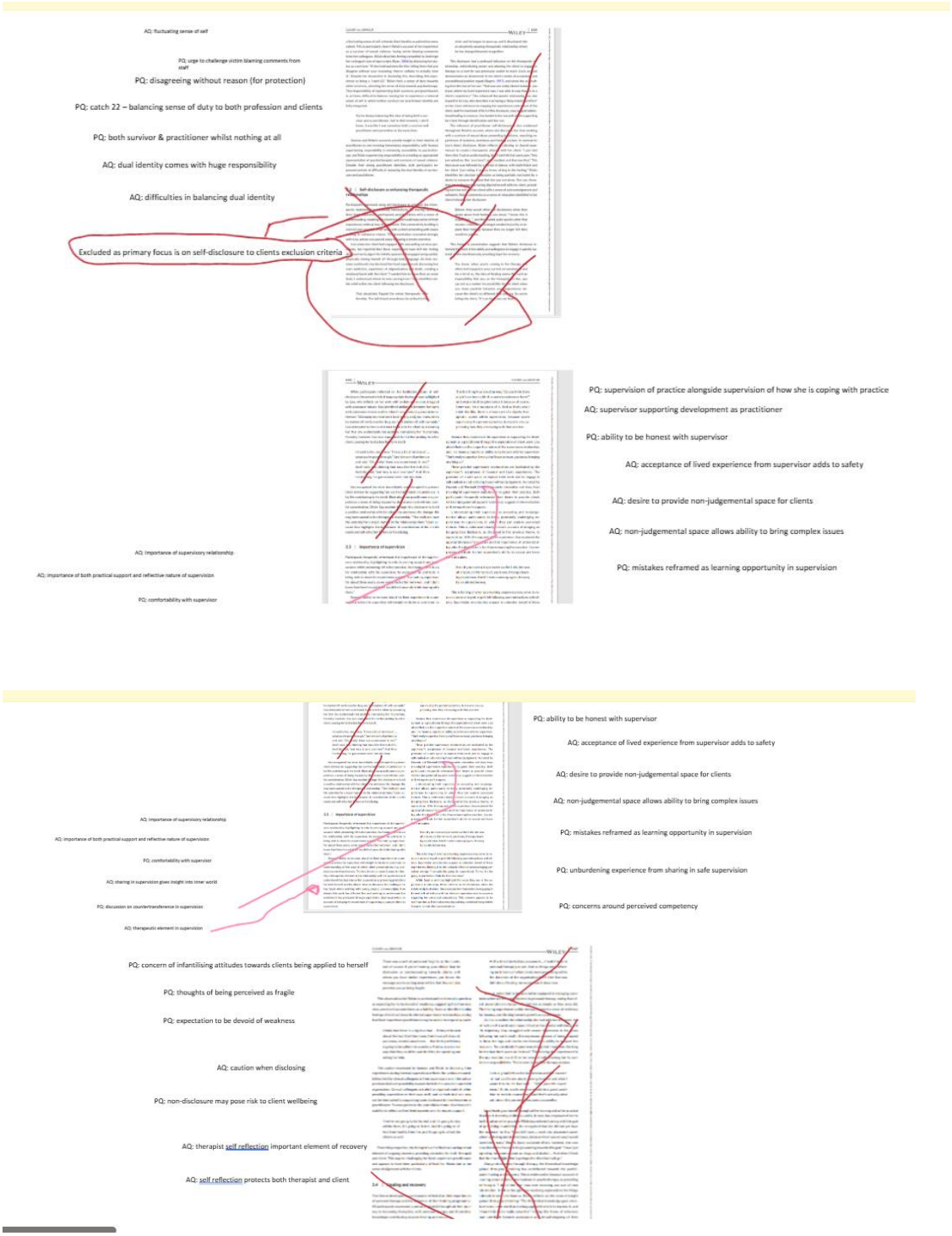
workplace self-disclosure of their lived experience of mental health difficulties" Bowman, V. (2023)										
Exploring the role of practitioner lived experience of mental health issues in counselling and psychotherapy Cleary, & Armour. (2022)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
"Being human": A grounded theory approach to exploring how trainers on clinical psychology doctorate programmes decide whether or not to disclose	Yes	Yes	Yes	Yes (with limitations considered)	Yes	Yes	Yes	Yes	Yes	Valuable

personal experiences of psychological distress to clinical psychology doctorate trainees Davies, et al (2023)										
'It would probably do more harm than good': mental health nurses' experiences of nondisclosure within individual clinical supervision Farley, et al., (2025)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
'Not Angels but Humans' An Exploratory Qualitative Study of Female Nurses With Lived Experience of Self-Harm and Suicidal Behaviours	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable

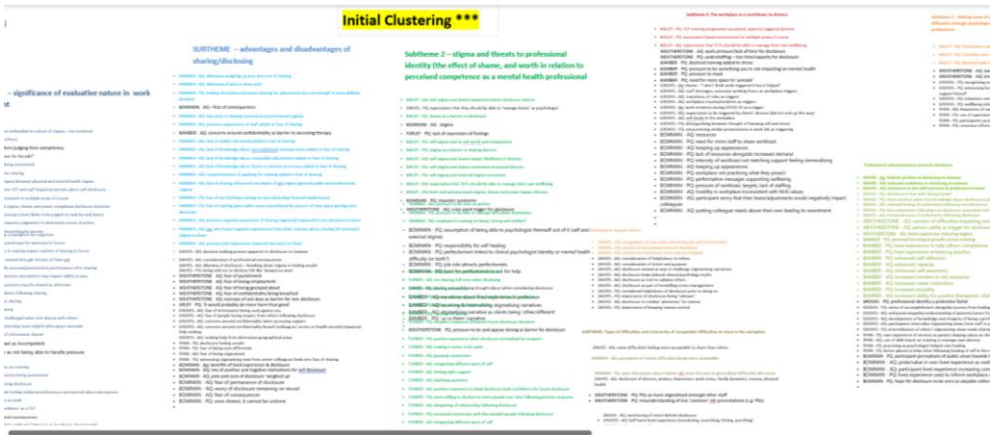
Groves, et al., (2026)										
Experiences of trainee clinical psychologists and workplace supervisors when mental health difficulties are shared. Hannah, (2023)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
The Wounded Healer: Personal experiences of mental health difficulties and trauma and their influence on the professional practice of Clinical Psychologists and other therapy professionals Ryan, (2020)	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable

I think it does just opens it up and … you're not hiding itanymore': Trainee clinical psychologists' experiences of self-disclosing mental health difficulties Turner, et al., (2022).	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Valuable
Experiencing Mental Health when Treating Others. Experiences of Mental Health Workers in Relation to Mental Health Problems: Stigma, Perception and Employment Weatherston & Lorna, (2022)	Yes	Yes	Yes	Yes	Yes	Partially. The researcher reports that the study followed an ethics protocol but the researcher's position is not reported in the paper	Yes	Yes	Yes	Valuable

Appendix E – Example coding during Thematic Synthesis Process



Appendix F – Example coding clusters in SLR synthesis



Appendix G – Initial Descriptive Subthemes for SLR



Further refining and merging of subthemes (prior to finalisation of subtheme and overarching Analytical themes 'in text')


SUBTHEME – Dual identity – interaction between the personal and professional self
Previous lived experience shaping professional identity
Privilege, accessibility, and intersectionality
Navigating dual identity
Professional identity and career shaping
Interaction with personal experience
Development of trainee identity / sense of self
Fluctuating or evolving sense of self
Disclosure supporting integration of personal and professional identity
Identity and well-being thought about when considering disclosure
Disclosure used to challenge stigma and professional myths
Disclosure as a way of validating and supporting others
Disclosure as modelling healthy coping or stress management
Healthcare workers as disposable / superhuman
Prioritising others over self
Public and societal expectations of healthcare workers
Pressure to appear resilient and strong
Fear of being seen as weak
SUBTHEME: Types of difficulties and a hierarchy of 'acceptable' difficulties to share in the workplace
Common and 'acceptable' workplace difficulties
Less common or stigmatised difficulties
Self-harm and high-risk behaviours
Life events/circumstances outside of work as trigger of mh difficulties
Disparity of stigma (mental vs physical)
SUBTHEME – previous positive experiences informing disclosure decision
Positive feedback reinforcing openness
Disclosure outcomes shaping future disclosure (feedback loop)
Positive or better-than-expected reactions
Growing confidence and safety over time
Significance of positive experience being upheld after initial disclosure phase
Influence of local workplace dynamics
Positive disclosure experiences
Disclosure shaping future help-seeking decisions (positive)
Fear reinforced by previous or observed negative experiences
SUBTHEME - Previous negative experience shaping likelihood of disclosure
Negative professional consequences following disclosure
Negative responses from management or colleagues
Impact on future disclosure and distress
Disclosure shaping future help-seeking decisions (negative)
Subtheme: wider actions/workplace values to destigmatise
Lack of modelling and unspoken lived experience
Professional narratives reinforcing stigma and 'othering'
Need for cultural shift and systemic change
Supportive colleagues and positive workspaces
Barriers in organisational culture and hierarchy
Lack of compassion and defensive workplace culture
Structural or contextual factors increasing fear of disclosure
Negative impact of poor leadership or breaches of trust
Local factors and dynamics
Need for safe spaces to talk about mental health
Clarification of policies and procedures reducing anxiety about support
'in road' as facilitator to disclose
Relational safety with wider colleagues/training cohort
Professional values/opinions towards disclosure
Disclosure as aligned with personal & professional values
Authenticity & wellbeing associated with disclosure
Client wellbeing as prompt in considering disclosure
Professional growth and competence through lived experience

Appendix H – Notification of Ethical Approval

To: Eleanor Idowu

Your application for ethics approval for the study listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Exploring the workplace experience of mental health staff who have a diagnosis of Borderline Personality Disorder/Emotionally Unstable Personality Disorder

Your UH protocol number is:

0997 2025 Jul HSET

This reference must be quoted on all paperwork, including advertisements for participants.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval (instructure.com.

This ethics approval expires on 01/12/2025

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team

ethicsadmin@herts.ac.uk

To: Eleanor Idowu

Your application for an amendment of the existing protocol listed below has been approved by the Health, Science, Engineering and Technology Ethics Committee with Delegated Authority. **Please read this letter carefully.**

Study Title: Exploring the workplace experience of mental health staff who have a diagnosis of Borderline Personality Disorder/Emotionally Unstable Personality Disorder

Your UH protocol number is:
0997 STa HSET 2025

This reference must be quoted on all paperwork, including advertisements for participants.

The Protocol Number issued for your amended approval appears in a different format to the originally issued Protocol Number.

If you wish to use the UH Ethics Committee logo disclaimer in your communications with participants, please find it in our UH Ethics Canvas site under 'Units - Application Forms': UH Ethics Approval - Ethics Forms.

This ethics approval expires on 01/10/2026

Amending your protocol

Individual protocols will normally be approved for the limited period of time noted above. Application for minor amendments (including time extensions) of a protocol, may be made for a maximum of 4 working weeks after the end date of that protocol.

It is expected that any amendments proposed via the online system will be minor. Should substantial modification be required, it would be necessary to make a fresh application for ethical approval.

Note that you must obtain approval from the relevant UH Ethics Committee with Delegated Authority **prior to implementing any changes**. Failure to do so constitutes a breach of ethics regulations (UPR RE01).

Adverse circumstances
Any adverse circumstances that may arise because of your study/activity must be reported to ethicsadmin@herts.ac.uk as soon as possible.

Permissions
Any necessary permissions for the use of premises/location and accessing participants for your study/activity must be obtained in writing prior to any data collection commencing. Failure to obtain adequate permissions may be considered a breach of this protocol.

Ethics Administration Team
ethicsadmin@herts.ac.uk

Appendix I - Participant Information Sheet

University of Hertfordshire UH Ethics Committee

PARTICIPANT INFORMATION SHEET

Title of study: Exploring the workplace experience of mental health staff who have a diagnosis of Borderline/Emotionally Unstable Personality Disorder (BPD/EUPD)

Invitation

Thank you for expressing an interest in taking part in this study. My name is Ellie and I am a trainee Clinical Psychology doctoral student at the University of Hertfordshire.

Before you decide whether to take part, it is important that you understand the study that is being undertaken and what your involvement would include. Please take time to read the following information carefully and discuss it with others if you may find this helpful.

Please feel free to ask me anything that does not feel clear or request any further information about what the process would involve.

What is the purpose of this study?

The primary purpose of this study is to explore the workplace experience of mental health staff who have a diagnosis of Borderline Personality Disorder (BPD), also known as Emotionally Unstable Personality Disorder (EUPD). Whilst some research has been carried out on the lived experience of mental health difficulties amongst mental health staff, there is currently very limited research on the experience of those who have been diagnosed with BPD/EUPD.

The primary researcher, supervisors and expert by experience consultant of this study collectively have lived experience of mental health difficulties, including lived experience of being diagnosed with BPD/EUPD. The interview will involve a series of open-ended questions to give you the opportunity to share your experience of what it is like working in the mental health profession whilst also holding a diagnosis of BPD/EUPD - this may include

positive and/or potential challenges that you have experienced within this context and the meaning/values that have arisen from this.

Who can take part? (inclusion criteria)

Please see the inclusion criteria for this study below – please note that all criteria must be met for participation of this study:

- Individuals working in a mental health setting/service (or those who have worked in a relevant role/setting in the past 2 years). Examples of specific job roles may include (but are not necessarily limited to): support workers, therapists, assistant psychologists, psychiatrists, therapists, mental health nurses, clinical psychologists (including trainees) – please note that to protect confidentiality, sharing of specific service names/organisations is not required to for this study.

- Individuals who's experience of working (or previous work) in a relevant setting (as above) is within the UK

- Individuals who have lived experience of being diagnosed with Borderline Personality Disorder (BPD), Emotionally Unstable Personality Disorder (EUPD) or Borderline Pattern Specifier (if diagnosed via the ICD-11).

- By participating in the study, participants of the study will self-confirm that they have been given the BPD/EUPD diagnosis by a mental health professional, such as a psychiatrist or clinical psychologist – please do not send copies of medical records!

- To ensure that all participants can fully engage with the study and have informed consent throughout the process, it is a requirement that participants are able to speak and understand fluent English.

- Participants must be at least 18 years old to participate in this study.

- If you are currently experiencing mental health crisis or significant distress, it is important to note that some of the interview questions prompt the reflections of past experiences within the workplace, which can bring up a range of emotions for some people, so it would not be recommended to take part in this study at this time.

What would taking part involve?

If you wish to take part, you will be given a consent form to read through, sign and return. Once you have completed and returned the signed consent form, I will contact you via email to arrange a time and date for your interview to take place.

Participating in this study would involve taking part in a online semi-structured interview, which is anticipated to take around 45 minutes – 1 hour.

Prior to the interview, participants will be asked to voluntarily provide demographic information (e.g. age range, ethnicity, gender) to help contextualize the research findings via a short online questionnaire – there will be a "prefer not to share" option for each category if this applies to you.

Within this questionnaire, participants will also be asked general questions such as the title of their role/previous roles) and to provide self-confirmation of relevant information (nature of duties related to role, overall time span spent working in mental health settings etc – *please note that we do* ***not*** *require details about specific names of services/organisations you work/have worked for or the sharing of professional ID badges).*

Once a time/date for your interview has been confirmed, you will be emailed a Microsoft Teams link where you may access the video call. The interviewer (myself) will ask a series of semi-structured questions exploring the workplace experience of mental health staff who have a diagnosis of EUPD/BPD. Once the interview has been completed, you will be offered the opportunity to have a debrief with me if you should find this helpful.

For the purpose of this study, interviews will be recorded within Microsoft Teams so that an automatic transcript of the interview can be produced. This transcript will then be reviewed by the researcher promptly after the interview to check and amend any transcription inaccuracies in the text and to remove any personally identifiable information/names of services that may have been shared. If you have any questions following the study, or wish to withdraw your interview responses, you will be able to contact me to request this via the email address below.

Do I have to take part?

Participation in this study is completely optional. If you do wish to take part, you will be asked for consent before continuing, however, agreeing to join the study does not mean that you have to complete it. All participants are free to withdraw from the study without giving reason for up to four weeks after completion of the interview – the reason for this timeframe is that because beyond this point, it is likely that analysis of the interviews would have been completed and collated with other responses.

What will happen to the information I provide?

Any demographic information collected will be stored separately from your interview data and will only be used to report the breakdown of participant characteristics in the write up of the study when summarising participant demographics as a whole. This information will not be written alongside specific interview quotes/responses. No names or other identifiable information will be reported in text. All interview information collected and written up will be anonymised.

Interview transcripts will be stored under a pseudonym (fake name). Interview transcripts and demographic information will be stored in the University of Hertfordshire OneDrive system in separate password protected folders.

Transcripts will be reviewed by myself as the primary researcher promptly after the video call, where I will check for and remove any identifiable information (e.g. names, places, organisations) from the written transcript.

Video recordings will be stored on my University of Hertfordshire Onedrive account under password protection where only I have access. Recordings will be permanently deleted following completion of my thesis examination (viva), which is anticipated to take place between June-August 2026. In very rare cases, examiners may request evidence of recordings if the legitimacy of the study is questioned. In the very unlikely event of this, examiners will be bound by the same rules of confidentiality and ethical principles as myself and with any request and I would work to protect the identity of participants.

Consent forms (dated and signed) will be stored in the University of Hertfordshire OneDrive system in separate password protected folder which is only accessible by myself as the primary researcher. Consent forms will be stored separately from the pseudonym interview responses (transcripts) and demographic information.

The other people who may access to interview transcript data will be my research supervisors Dr Natalie Kemp and Dr Gen Wallace (Clinical Psychologists).

The write up of this study will be deposited in the University of Hertfordshire research archive in the form of a doctoral thesis that will be publicly accessible. The researcher anticipates writing up the findings for a peer-reviewed journal with hopes of this also being publicised. These write ups may involve the inclusion of short sentences/extracts from participant interviews in quotation marks which will be fully anonymised and all efforts will be made to ensure confidentiality is not compromised.

The latest that all the above data will be kept is until September 2029. All above data will be destroyed after this point (or before this point if journal submission for publication occurs before this.

Are there any situations where my information will be shared beyond this?

In order to maintain a duty of care to participants during the course of interview, if you share information highlighting concerns about the safety of yourself and/or others that would require my support/management I will need to speak to my supervisory team to consider the best next steps. If this situation were to occur, I would work to inform and involve you in the process of the sharing of this information. If I am made aware of any immediate and urgent risk to yourself or others, I may be required to share this information outside of my supervisory team with emergency services.

What are the possible disadvantages, risks or side effects of taking part?

There is the potential that exploring lived experience of mental health difficulties may be emotive for some people as interviews will involve discussing and reflecting on previous experiences. Whilst a post interview debrief will be available to participants, it is important to know that participation in this study is optional and there will be no pressure to share information that you do not feel comfortable in sharing.

What are the possible benefits of taking part?

There are no financial incentives/rewards for those who take part and participation is entirely optional. Participation in this study is really appreciated as this is an under-researched topic. If the findings of our study are published and/or shared we intend to share findings to the platforms used to advertise the study.

Will the data be required for use in further studies?

No

Who can I contact if I wish to ask further questions or raise a concern about this study?

If you have any questions or concerns please contact myself in the first instance ei23aat@herts.ac.uk, or my primary supervisor Dr Natalie Kemp n.kemp4@herts.ac.uk.

Who has reviewed this study?

This study has been viewed by the ethics panel at the University of Hertfordshire:

- The University of Hertfordshire Health, Science, Engineering and Technology Ethics Committee with Delegated Authority

The UH protocol number is: 0997 2025 Jul HSET

Although we hope it is not the case, if you have any complaints or concerns about any aspect of the way you have been approached or treated during the course of this study and you do not feel comfortable raising this with myself or my supervisor as detailed above, you may write any concerns to the University's Secretary and Registrar at the following address:

The University's regulation, UPR RE01, 'Studies Involving the Use of Human Participants' can be accessed via this link:

https://www.herts.ac.uk/about-us/governance/university-policies-and-regulations-uprs/uprs

Secretary and Registrar

University of Hertfordshire

College Lane

Hatfield

Herts

AL10 9AB

Thank you very much for reading this information and giving consideration to taking part in this study.

Appendix J – Participant Consent Form

Appendix C – Participant Consent Form

University of Hertfordshire UH Ethics Committee

CONSENT FORM

Study: Exploring the workplace experience of mental health staff who have a diagnosis of Borderline/ Emotionally Unstable Personality Disorder (BPD/EUPD)

I confirm that I have read the Participant Information Sheet in full which outlines the particulars of the study, including its aim(s), methods/design, the names and contact details of key people and, as appropriate, the risks and potential benefits, how the information collected will be stored and for how long, and any plans for follow-up studies that might involve further approaches to participants. I have also been informed of how my responses will be stored. I have been given details of my involvement in the study.

I confirm that I meet all of the inclusion criteria highlighted on the participation information sheet

I consent that I am at least 18 years old.

I confirm that I have access to a private space for the duration of the online interview (45-60 minutes) where I will not be overheard or interrupted.

I understand that the write up of this study will be deposited in the UH research archive in the form of a doctoral thesis that will be publicly accessible and that the researcher anticipates writing up the findings for a peer-reviewed journal with hopes of this also being publicised. I understand that a write up of this study will involve the inclusion of

short sentences/extracts from participant interviews in quotation marks which will be fully anonymised, and all efforts will be made to ensure confidentiality is not compromised.

I understand that if there is any revelation of unlawful activity or any indication of non-medical circumstances that would or has put others at risk, the University may refer the matter to the appropriate authorities.

By entering my name and the date below I confirm to participating in this study.

I understand that I am able to withdraw from the study at any time, up to four weeks after completion my interview, as beyond this point, analysis of the interview will have been completed.

**** Please only enter your name/date below if you consent to all of the above – if you have any questions about this form or the study before confirming, please email the primary researcher on ei23aat@herts.ac.uk****

Participant Signature/name

Date:

Researcher Signature

Date:

Appendix K – Participant Debrief Form

University of Hertfordshire UH Ethics Committee

Participant follow up debrief sheet

Thank you for participating in this research study (Exploring the workplace experience of mental health staff who have a diagnosis of Borderline/Emotionally Unstable Personality Disorder (BPD/EUPD). If following your interview, you have any questions or concerns about your involvement in the study, please do not hesitate to email me via ei23aat@herts.ac.uk. If you do not feel comfortable to contact me directly you may wish to contact my supervisor/University via the contact details listed on the participant information sheet.

If after speaking and thinking about your experiences today you would like to complain or raise concerns about your care or discrimination within the workplace, we recommend utilising support systems such as your workplace's bullying/harassment services (such as the Freedom to Speak Up service) and/or the Patient Advice and Liaison Service (PALS):

https://www.england.nhs.uk/ourwork/freedom-to-speak-up/

https://www.nhs.uk/nhs-services/hospitals/what-is-pals-patient-advice-and-liaison-service/

The 'NHS People' platform may be of interest if you wish to access staff mental health and wellbeing hubs or a range of wellbeing apps:

https://www.england.nhs.uk/supporting-our-nhs-people/

You can also access immediate support 24/7 by texting FRONTLINE to 85258. FRONTLINE is available to all NHS staff who may need to talk through problems they are facing at work.

You can also contact your occupational health department if you would like to explore the possibility of reasonable adjustments at the workplace.

The organisations below may also be of interest in supporting ways to access mental health support or peer support for mental health staff with lived experience of mental health difficulties:

Hub of Hope *(UK Mental Health Support Directory – including NHS, third sector, private sector and local authority services): https://www.hubofhope.co.uk/*

in2gr8mentalhealth *(a centre for valuing, supporting and destigmatising lived experience of mental health difficulties): https://www.in2gr8mentalhealth.com/*

If you are struggling with your mental health and would like to explore your options of support, please meet with your GP. If you require more urgent support you may wish to seek support via the following resources:

Samaritans

116 123 or jo@samaritans.org

SaneLINE

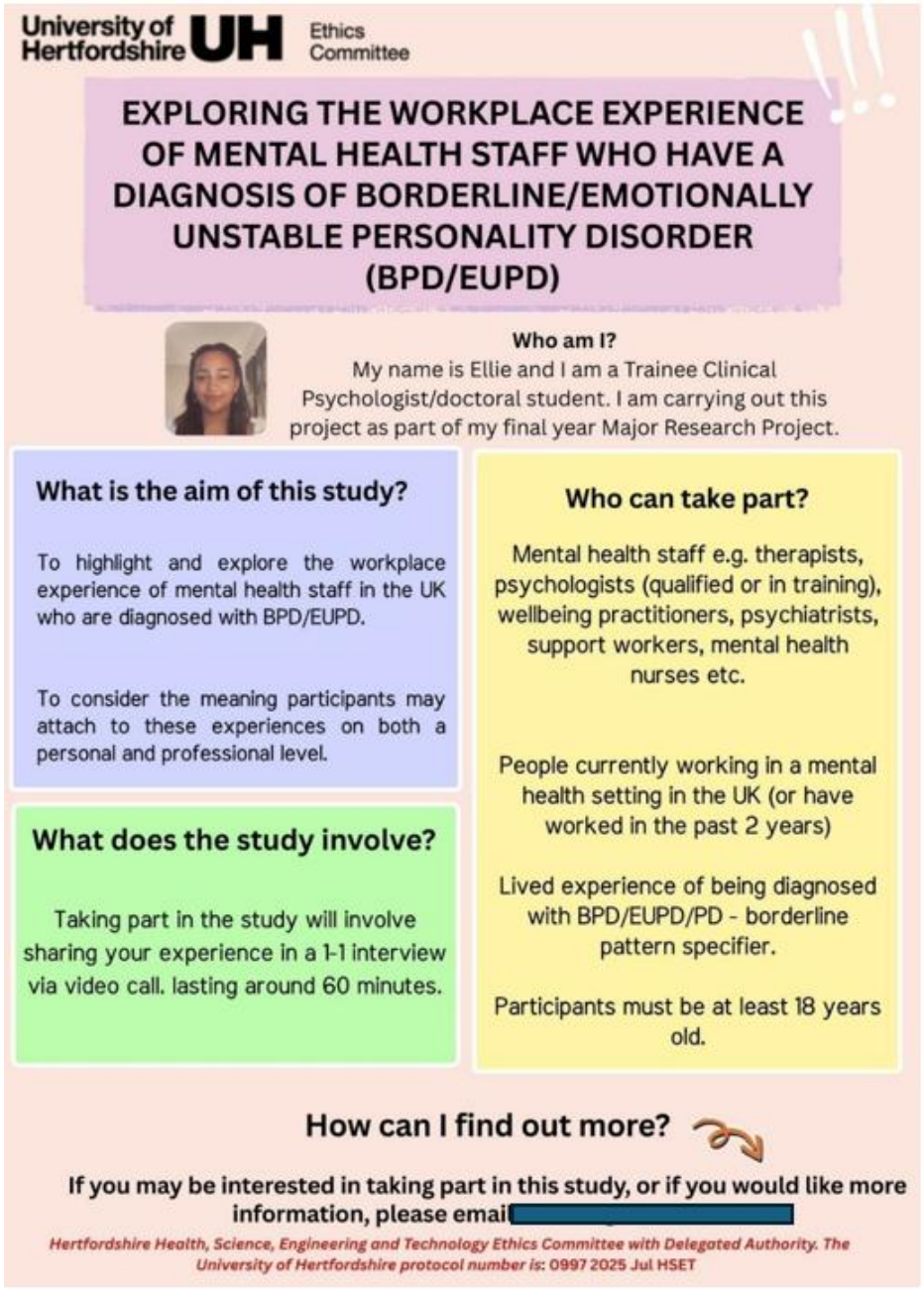
03003047000

Shout

Text SHOUT to 85258

You can also contact the NHS for immediate support by calling 111. If you are at immediate risk of harm, please call 999 or visit your local A&E department.

Appendix L – Participant Recruitment poster



Appendix M – Participant Interview Schedule

Interview Schedule

The following questions will involve the initial exploration of your initial feelings about being diagnosed and whether the nature of your career pathway influenced these thoughts. Please note that any reference to work (or the workplace) is in relation to you experience working in mental health services.

1. *" Please tell me what it was like for you receiving a diagnosis of BPD/EUPD?*

Prompts/sub questions:

- Did you have any initial thoughts, feelings or emotions surrounding receiving this diagnosis?
-Have these thoughts, feelings, emotions changed for you over time?
-Was there anything about working in mental health (or wanting to work in mental health) that impacted how you felt about receiving the diagnosis?

The remaining questions will explore further about the relationship between the BPD/EUPD diagnosis and the workplace and consider experiences on both a personal level and professional level.

2. *Please can you tell me what it is (or has been) like working in the mental health field with your lived experience of the BPD/EUPD diagnosis?*

prompts/sub questions:
- what was this experience like within your service/with colleagues (if not mentioned)? have you noticed any difference in your experiences between workplaces?

3. *"In what way (if any), has receiving a diagnosis of BPD/EUPD influenced your sense of professional identity (or identity as a mental health worker)?*

4. *In what ways (if any), has your work as a mental health professional/worker influenced your sense of personal identity*

Prompts/sub questions:
-e.g. has your work in mental health services impacted how you view yourself as someone who has accessed mental health services?

5. Some people decide to share parts about there mental health and others do not, this may depend on the people we are working with and the type of workplace environment. Can you tell me about any considerations (if any you remember experiencing before sharing about your lived experience?)

Prompts/sub questions:

- *How were you left feeling after the experience of sharing?*

6. Have there been times when you actively avoided sharing your information a lived experience BPD/EUPD with others in a professional setting?)

- *How were you left feeling after the experience of choosing not to share?*

7. What made you come to your decision to share (or not share) with colleagues? (if not already covered in previous questions)

Prompts/sub questions:

- *Please could you tell me more details in decision making both for times that you have chosen to share and times when you have chosen not to share?*

- *What type of responses did you receive (e.g. from colleagues?)* after sharing

8. Have you noticed any patterns (e.g. recurrent thoughts/feelings that come up within yourself when navigating dynamics in the context of your lived experience in the workplace?

9. Have you noticed anything about the way people at work interact (or have interacted) with you, or how you interact with others (in the context of BPD/EUPD)

Prompts/sub questions:

- What about with colleagues/clients (if not specified)?

Any other questions

10. *Are there any other reflections about your lived experience carrying the BPD diagnosis in the workplace that you think would be useful to share for this study?*

    Prompts/sub questions:

    - can you tell me how that experience(s) made you feel?

Appendix N - Participant Demographics Form

Exploring the workplace experience of mental health staff who have a diagnosis of BPD/EUPD

In order to contextualise the findings of this research and consider areas of intersectionality, I am collecting demographic information ahead of the main video call interview. Please note that the categories used to create these questions are drawn from the UK census/office for National Statistics, there may be questions where you prefer to select the "other" box to self-describe, or select "prefer not to say" if you do not wish to share the information.

****Please note that the settings for this form are set to "anonymous", e.g. results will not be listed next to your email address - however, myself as the primary researcher (interviewer) will view the results in the order in which they are completed by participants and therefore, this may be an indicator of which participant completed each form. However, please note that demographic information will be stored and written up separately from interview transcripts. To prevent participant identification, demographic information across participants will be combined, e.g. "40% of participants in this study had work experience as a support worker".****

1. Please indicate the sex you were assigned at birth *

Select your answer

2. Please select your gender identity *

Select your answer

3. Which of the following best describes your ethnicity? (please note, these categories are taken from the UK census, if you would prefer to specify your ethnicity/self describe please do so in the 'other' text box *

Select your answer

4. Please select your age-range *

Select your answer

10. Please select the role(s) *you are currently working in* (or training in - if you are a trainee) . **You may select more than one or 'none at the moment' if this applies to you** *

- [ ] Support Worker/healthcare assistant
- [ ] Assistant Psychologist
- [ ] Wellbeing Practitioner (e.g. PWP/CWP/EMHP)
- [ ] Clinical Associate Practitioner (CAP)
- [ ] Psychotherapist (e.g. CBT, Psychodynamic, Integrative, other talking therapies etc)
- [ ] Psychiatrist
- [ ] Clinical Psychologist
- [ ] Counselling Psychologist
- [ ] Forensic Psychologist
- [ ] Mental Health Nurse/Nurse in mental health role or setting
- [ ] Social Worker
- [ ] Occupational Therapist
- [ ] None at the moment
- [ ] Other

11. Are you currently a trainee in the role you are working in? *

12. Please select any other previous relevant roles you have worked in throughout your career *in the past* that you may be referring to in the main interview (**you may select multiple if this applies)** *

- [ ] Support Worker/healthcare assistant
- [ ] Assistant Psychologist
- [ ] Wellbeing Practitioner (e.g. PWP/CWP/EMHP)
- [ ] Clinical Associate Practitioner (CAP)
- [ ] Psychotherapist (e.g. CBT, Psychodynamic, Integrative, other talking therapies etc)
- [ ] Psychiatrist
- [ ] Clinical Psychologist
- [ ] Counselling Psychologist
- [ ] Forensic Psychologist
- [ ] Mental Health Nurse/Nurse in mental health role or setting
- [ ] Social Worker
- [ ] Occupational Therapist
- [ ] I have not worked in any other previous roles
- [ ] Other

13. Without sharing the specific service/organisation please select the *current* mental health setting(s) you are working in **(you may select multiple if this applies,** please list any that are missing in the 'other' box) *

- [ ] GP services
- [ ] IAPT/CYP-IAPT/NHS Talking Therapies (primary care level)
- [ ] Adult Community Mental Health Team (CMHT)
- [ ] CAMHS
- [ ] Older Adults Mental Health Services
- [ ] Autism/ADHD assessment teams
- [ ] Specialist Community Teams - Eating Disorder
- [ ] Speciallist Community Teams - Personality Disorder Pathway
- [ ] Specialist Community Teams - Psychosis
- [ ] Inpatient mental health unit
- [ ] Forensic mental health unit
- [ ] Learning Disablity Services
- [ ] Charity/Voluntary mental health services (community)
- [ ] Online/Telephone support (e.g. Shout/Samaritans)
- [ ] Perinatal mental health services
- [ ] Private mental health services (community)
- [ ] Private mental health services (inpatient)
- [ ] Other

14. Without sharing the specific service/organisation please select the other relevant types of mental health settings *you have previously worked in* **(you may select multiple it this applies**. please list any that are missing in the 'other' box) *

- [ ] GP services
- [ ] IAPT/CYP IAPT/NHS Talking Therapies (primary care level)
- [ ] Adult Community Mental Health Team (CMHT)
- [ ] CAMHS
- [ ] Older Adults Mental Health Services
- [ ] Autism/ADHD assessment teams
- [ ] Specialist Community Teams - Eating Disorder
- [ ] Speciallist Community Teams - Personality Disorder Pathway
- [ ] Specialist Community Teams - Psychosis
- [ ] Inpatient mental health unit
- [ ] Forensic mental health unit
- [ ] Learning Disability Services
- [ ] Charity/Voluntary mental health services (community)
- [ ] Online/Telephone support (e.g. Shout/Samaritans)
- [ ] Perinatal mental health services
- [ ] Private mental health services (community)
- [ ] Private mental health services (inpatient)
- [ ] I have not worked in any other previous mental health settings
- [ ] Other

15. Overall, how long have you been working in mental health settings, such as those listed above? *

Select your answer

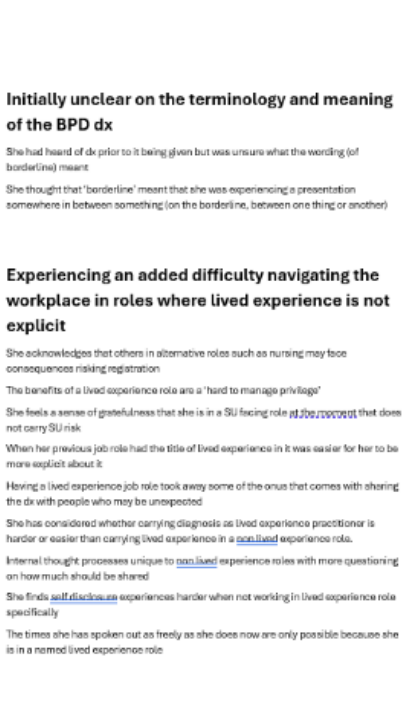
Appendix O - Example of initial coding during IPA analysis

Exploratory Notes Coding Key: **Descriptive Linguistic Conceptual**

Experiential Statements	Transcript Extract ('Grace')	Exploratory Notes
Experiencing a need to understand the nature of difficulties was prevalent in the lead up to diagnosis	In mind, they'd always been conceptualized as being part of like having a poor recovery from an eating disorder.	**Making sense of what caused development of symptoms that led to PD dx**
	You know, not really thinking. OK. Yes. Well, sometimes I can feel depressed or I can feel very anxious so I can feel this, but it didn't quite cover it. I never felt like it was – it was making that much sense to me.	**Experience of not having a complete explanation for her experiences.**
	But I didn't have any.. I wasn't under a team. I wasn't in under ___ at that time. I got discharged from ___ and that. I was just left. And so yeah, I think by the time I then worked in inpatient mental health services, I was like, oh, OK, there's so many similarities, like the histories of these people. And obviously I was very drawn to the work. And I do believe that, you know, we're all drawn to doing this work because there's something familiar about it. And so I think it was through that, but I sort of started to like piece things together and think, 'oh, ok, maybe it wasn't just like, you know, a mismanaged recovery from an eating disorder that just f****d me up'. And, like, I've never really managed to get back on an even keel. You know, it's something to do with my own failing.. Maybe there is something else going on here, so to receive that diagnosis was empowering because I sought it, so it would not - well, yeah, kind of sought it. So I sought help. So I went to.. I actually ended up going to a private psychiatrist. and she was a medical psychotherapist. Initially it was kind of more sort of for medication because I was in a really, really bad low and she was an excellent clinician. Just everything about her. She was just so you know, I guess in some ways maybe like you get what you pay for, but the 'IT' was she was very 'it' - look, I think it was like 5 hours of assessment. You know, lots of stuff about life history, lots of stuff about me as a whole person and it was very focused on like, not just like, 'OK, what, what are these issues that have gone on' but also, you know, 'what do you, what would you	**Lack of support from services, she was 'left'**
Drawn to working as mental health professional when recognizing similarity between patients and herself		**Recognising similar difficulties in her own experiences and experiences of patients she was working with.**
		Links this with being drawn to work with others with similarities
Feelings of self blame and 'failing' to manage difficulties were prominent in the lead up to diagnosis		**Reflecting on sense of familiarity in the work that she does as mental health staff**
		Swearing, indicative of a more powerful emotion
		An element of self-blame contributing to feelings of 'failing' recovery
		Consideration of deeper issues that have not previously been accounted for
		Seeking own help felt empowering – marking new stage in healing journey.
A turning point in healing journey came from positive experience of treatment "excellent clinician"		**Showing appreciation for positive experience with psychiatrist**
		Significance of experiencing an "excellent" and 'it' clinician
		Thorough process of assessing difficulties
Seeking own help felt empowering		**Being seen as a whole person**
Being seen as a "whole person" through a thorough assessment in this treatment was a new experience		**Describing more positive support experiences**

More positive treatment included acknowledging the past and looking towards the future	like to do in the future? Like how do you, what do you think would be a way of like this doesn't sound like something that you want to live with. So like, how would you like? To you know, what would recovery focus on? '.. very focused me as a person, so I felt very seen. And so overall I think in, in for all of those reasons you know, because it was like a solution at the end of it, you know there was like a halfway for therapy. Like, really understood and probably more seen. You know, than I had been previously and I think it just felt like all those jigsaw pieces like came together. So yeah, it overall it was very positive.	**Experiencing helpfulness in not only thinking about the past but also looking forwards** **Focusing on individual goals helped her feel seen** **Positive experience, a turning point in what had been her journey so far** **Describes feeling seen and understood as "jigsaw pieces" that "came together"** **A sense of hopefulness**

Appendix P - Example clustering of Experiential Statements (ES)



Initially unclear on the terminology and meaning of the BPD dx

She had heard of dx prior to it being given but was unsure what the wording (of borderline) meant

She thought that 'borderline' meant that she was experiencing a presentation somewhere in between something (on the borderline, between one thing or another)

Experiencing an added difficulty navigating the workplace in roles where lived experience is not explicit

She acknowledges that others in alternative roles such as nursing may face consequences risking registration

The benefits of a lived experience role are a 'hard to manage privilege'

She feels a sense of gratefulness that she is in a SU facing role at the moment that does not carry SU risk

When her previous job role had the title of lived experience in it was easier for her to be more explicit about it

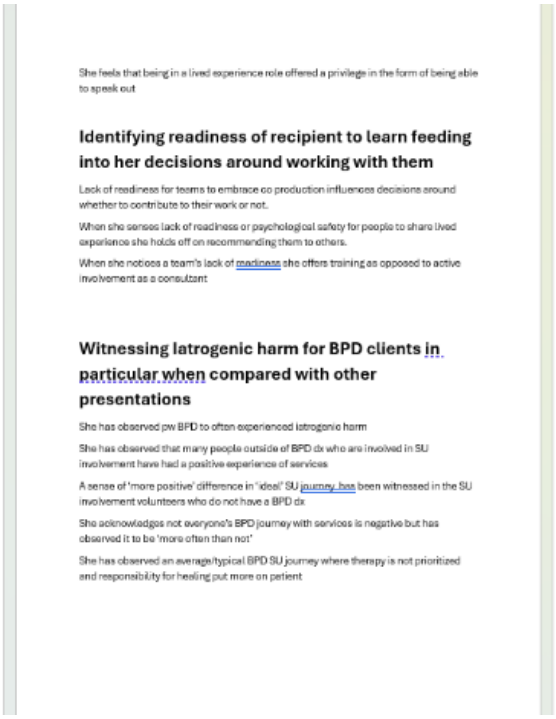
Having a lived experience job role took away some of the onus that comes with sharing the dx with people who may be unexpected

She has considered whether carrying diagnosis as lived experience practitioner is harder or easier than carrying lived experience in a non lived experience role.

Internal thought processes unique to non lived experience roles with more questioning on how much should be shared

She finds self disclosure experiences harder when not working in lived experience role specifically

The times she has spoken out as freely as she does now are only possible because she is in a named lived experience role



She feels that being in a lived experience role offered a privilege in the form of being able to speak out

Identifying readiness of recipient to learn feeding into her decisions around working with them

Lack of readiness for teams to embrace co production influences decisions around whether to contribute to their work or not.

When she senses lack of readiness or psychological safety for people to share lived experience she holds off on recommending them to others.

When she notices a team's lack of readiness she offers training as opposed to active involvement as a consultant

Witnessing Iatrogenic harm for BPD clients in particular when compared with other presentations

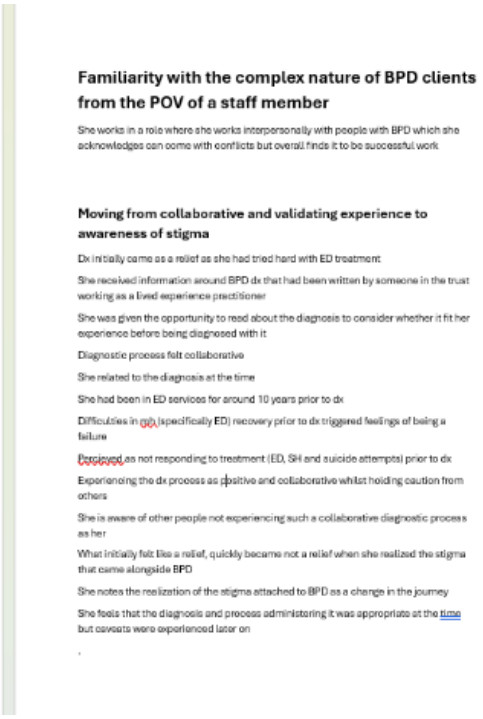
She has observed pw BPD to often experienced iatrogenic harm

She has observed that many people outside of BPD dx who are involved in SU involvement have had a positive experience of services

A sense of 'more positive' difference in "ideal" SU journey has been witnessed in the SU involvement volunteers who do not have a BPD dx

She acknowledges not everyone's BPD journey with services is negative but has observed it to be 'more often than not'

She has observed an average/typical BPD SU journey where therapy is not prioritized and responsibility for healing put more on patient



Familiarity with the complex nature of BPD clients from the POV of a staff member

She works in a role where she works interpersonally with people with BPD which she acknowledges can come with conflicts but overall finds it to be successful work

Moving from collaborative and validating experience to awareness of stigma

Dx initially came as a relief as she had tried hard with ED treatment

She received information around BPD dx that had been written by someone in the trust working as a lived experience practitioner

She was given the opportunity to read about the diagnosis to consider whether it fit her experience before being diagnosed with it

Diagnostic process felt collaborative

She related to the diagnosis at the time

She had been in ED services for around 10 years prior to dx

Difficulties in mh (specifically ED) recovery prior to dx triggered feelings of being a failure

Perceived as not responding to treatment (ED, SH and suicide attempts) prior to dx

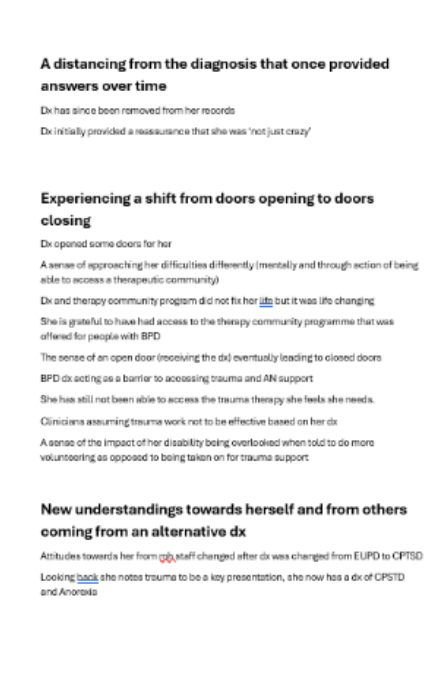
Experiencing the dx process as positive and collaborative whilst holding caution from others

She is aware of other people not experiencing such a collaborative diagnostic process as her

What initially felt like a relief, quickly became not a relief when she realized the stigma that came alongside BPD

She notes the realization of the stigma attached to BPD as a change in the journey

She feels that the diagnosis and process administering it was appropriate at the time but caveats were experienced later on



A distancing from the diagnosis that once provided answers over time

Dx has since been removed from her records

Dx initially provided a reassurance that she was 'not just crazy'

Experiencing a shift from doors opening to doors closing

Dx opened some doors for her

A sense of approaching her difficulties differently (mentally and through action of being able to access a therapeutic community)

Dx and therapy community program did not fix her life but it was life changing

She is grateful to have had access to the therapy community programme that was offered for people with BPD

The sense of an open door (receiving the dx) eventually leading to closed doors

BPD dx acting as a barrier to accessing trauma and AN support

She has still not been able to access the trauma therapy she feels she needs.

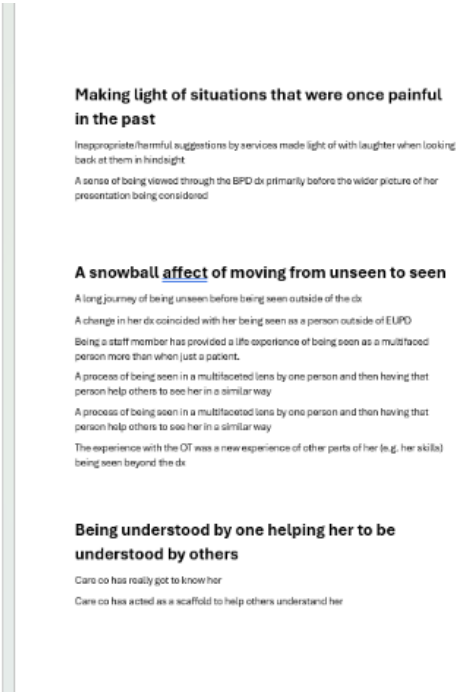
Clinicians assuming trauma work not to be effective based on her dx

A sense of the impact of her disability being overlooked when told to do more volunteering as opposed to being taken on for trauma support

New understandings towards herself and from others coming from an alternative dx

Attitudes towards her from mh staff changed after dx was changed from EUPD to CPTSD

Looking back she notes trauma to be a key presentation, she now has a dx of CPSTD and Anorexia



Making light of situations that were once painful in the past

Inappropriate/harmful suggestions by services made light of with laughter when looking back at them in hindsight

A sense of being viewed through the BPD dx primarily before the wider picture of her presentation being considered

A snowball affect of moving from unseen to seen

A long journey of being unseen before being seen outside of the dx

A change in her dx coincided with her being seen as a person outside of EUPD

Being a staff member has provided a life experience of being seen as a multifaced person more than when just a patient.

A process of being seen in a multifaceted lens by one person and then having that person help others to see her in a similar way

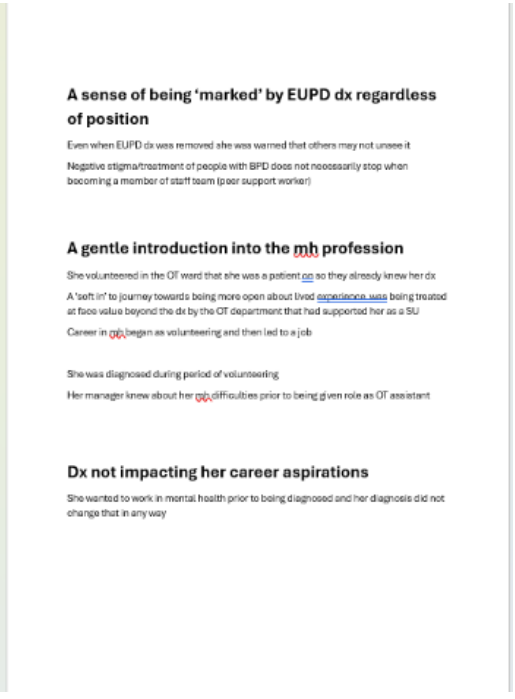
A process of being seen in a multifaceted lens by one person and then having that person help others to see her in a similar way

The experience with the OT was a new experience of other parts of her (e.g. her skills) being seen beyond the dx

Being understood by one helping her to be understood by others

Care co has really got to know her

Care co has acted as a scaffold to help others understand her



A sense of being 'marked' by EUPD dx regardless of position

Even when EUPD dx was removed she was warned that others may not unsee it

Negative stigma/treatment of people with BPD does not necessarily stop when becoming a member of staff team (peer support worker)

A gentle introduction into the mh profession

She volunteered in the OT ward that she was a patient on so they already knew her dx

A 'soft in' to journey towards being more open about lived experience was being treated at face value beyond the dx by the OT department that had supported her as a SU

Career in mh began as volunteering and then led to a job

She was diagnosed during period of volunteering

Her manager knew about her mh difficulties prior to being given role as OT assistant

Dx not impacting her career aspirations

She wanted to work in mental health prior to being diagnosed and her diagnosis did not change that in any way

Appendix Q - Showing the process from participant subthemes for participant 'Gabriella' and all remaining participant PETs (overarching cluster title) to Participant Experiential Themes (PETs) naming (in bold text)

Participant 'Bella'	
PET	**Subtheme (cluster)**
PET 1: A mixture of feeling reassured, shocked and attacked by the EUPD dx	lack of involvement when being diagnosed Feeling insulted by the EUPD diagnosis Learning about the stigma attached to the dx initiated a shift from feeling reassured to feeling attacked
PET2: A shift to distance self from dx related to a lack of faith in the construct	Identifiable stages that led to the distancing from the dx Experiencing barriers to being understood from a new perspective Importance placed on the variation of presentations within the EUPD diagnostic criteria Barriers she experienced as a SU contributing to scepticism towards the dx as a professional
PET 3: Breaking free from the hold of the dx whilst simultaneously using it as a source of insight	Experiencing the diagnosis as double-edged sword – a source of insight to fight against stigma whilst carrying a negative load Professional journey helping to break free from the 'hold' of the diagnosis and make purpose from pain
PET 4: Own research and professional training contributing to new understandings	Professional training and doing her own research helping her to work in trauma informed way Coming to understand people diagnosed with EUPD from a neurodivergent lens
PET 5: Carrying the emotional weight of hearing 'people like me' discussed in a negative light	Feeling insulted, sad and frustrated from stigmatised views towards 'people like me' Frequent 'set' of terms and narratives repeatedly observed amongst staff

	Experiencing others wanting to distance themselves from those with the EUPD dx Hopelessness and lack of optimism observed amongst colleagues towards clients with EUPD A shared heaviness and admiration towards peer support workers with the dx Unexplicit ways in which stigma is acted on through clinical decision making processes
PET 6: Navigating powerlessness limits of influence but continuing to make ripple effects of change	Recognising limits of her influence within public health and advocating on a wider scale Tension between joy and heaviness and a void of powerlessness
PET 7: Making sense of the factors perpetuating stigma, service structures and lack of knowledge	Noticing influence on service model/resources in how they influence increased stigma Holding grace towards those where stigma comes from lack of education and brainwashing Noticing features of a team that make it feel easier to share
PET 8: Feeling in-between spaces and questioning legitimacy as a professional	Expressed identity confusion between professional and lived experience parts felt early on Processing identity through connecting and reflecting with other allies Feeling a pressure to 'pick a side
PET 9: The emotional labour of carrying lived experience and holding back on what she wishes she could say	Extra effort taken to monitor responses the emotional toll carrying her lived experience Experiencing secondary trauma when working with clients who have/are undertaking a similar journey

	Internal candid dialogue of what she would like to say
PET 10: Sharing diagnosis feeling like a form of 'outting' herself - a risky and strategic experience, sometimes without choice	Feeling like an undercover mole Wondering how reactions would pan out if she did 'out' herself Worrying about rejection, judgement and being viewed as crazy Weighing up of pros and cons of sharing Coming prepared with a 'go to' 'party line' Pre-planning finer details of who when and where she will share Some 'sharing' taking place without choice Managing the urge to not spontaneously share in face of stigma to see how people would react
PET 11: Sharing feeling both relieving and vulnerable	A relief after sharing of not having to present as the 'perfect' clinician A weight feeling lifted after sharing Increased sense of vulnerability and regretful panic following sharing Surprise from staff following sharing feeling like a backhanded compliment Experiencing an initial positive response early on by a trusted other increasing her confidence and hope in being accepted by others Initial shock after sharing fading after colleagues reassure that they will treat her the same
PET 12: Using positive relationships with colleagues to help challenged negative perceptions around EUPD	Taking the risk to use herself as an example to help challenge unhopeful narratives towards those with the dx

	Challenging stigma, deepening connection, supporting decisions around client needs as reasons for sharing
PET 13: Finding the humour in heavy and high-pressure situations	Using humour as part of story telling for situations that feel serious and high pressure at the time
PET 14: Taking the positives from her own journey as a source of optimism, hope and curiosity towards clients	Professional value of remaining curious to the whole 'story' Experiencing the dx to be a barrier to understanding and meeting client needs adequately A relentless optimism and hope towards clients partly inspired by the successes of her own journey

Remaining participant PETs

'Grace'

PET 1: Experiencing the diagnosis as validating and a turning point in healing journey
Pet 2: Personal lived experience shaping career choice and strengthening relational connection with clients
PET 3: Managing multiple selves and the integration of identity
Pet 4: Sharing as a complex, relational and vulnerable process
PET 5: Sharing as a route to accessing support
PET 6: Navigating stigma and advocating for clients within the workplace

'Lucy'

PET 1: Diagnosis experienced as a double-edged, shaping understanding, identity and opportunities
Pet 2: Living with and coming to terms with pervasive stigma across time in varying contexts
PET 3: Striving to be seen as a whole and capable person beyond the diagnosis
PET 4: Stigma contributing to being singled out as a bad example to service users
PET 5: Developing a strong sense of self, capability and direction despite opposition

PET 6: Sharing in the workplace as an attempt to do the right thing but sometimes lacking control in the process
Pet 7: A shift from lived experience being undetectable to being used as a tool for advocacy and transparency, to challenge stigma
PET 8: Long lasting impact of workplace discrimination causing deep emotional harm and hopelessness
PET 9: Experiencing support inconsistently –being treated at others treated more like a patient
PET 10: Managing authenticity whilst also feeling the weight of concealment
PET 11: Tensions between work, care and wellbeing
PET 12: Hope, solidarity and adaptation over time
PET 13: Struggling to articulate the magnitude of what she has experienced

'Olivia'

PET 1: Beginning her journey with dx with awareness of negative perceptions surrounding it
PET 2: Experiencing the dx as a way to externalise, characterise and 'fight' difficulties
PET 3: Moving past initial negative impact of the dx and reframing as a positive asset
PET 4: Supportive relationships in the workplace
PET 5: Recognising own needs and ways of coping in the workplace
PET 6: Self acceptance
PET 7: Lived experience used to educate others

'Sammy'

PET 1: Lack of involvement in the diagnostic process
PET 2: Healing alongside helping others driven by core value of being useful
PET 3: Negotiating the conflict in values between the personal and professional identity
PET 4: Lived experience as expertise, qualification and relational skill
PET 5: Sharing as pragmatic, complex and emotionally uncertain
PET 6: Protecting wellbeing through pragmatism, distance and compartmentalisation

'Maria'

PET 1: A mix of doors opening and closing due to dx and an eventual distancing from it overtime
PET 2: A journey of working hard to be seen for her skills beyond service user identity
PET 3: Sharing as gradual, strategic and dependent on safety
PET 4: Witnessing, iatrogenic harm in varying contexts
PET 5: Growing confidence, assertiveness and advocacy through lived experience

PET 6: Connection through 'finding a gang' of solidarity to foster belongingness
PET 7: one supportive 'other' having a positive ripple effect on others' misunderstanding of those dx with EUPD
PET 8: Holding dual perspectives as both a staff member and service user
PET 9: Developing, direction and standards for those she allows access to her

'Julia'

PET 1: A shift between confusion, anger and resentment towards the dx
PET 2: Finding positive ways to cope whilst others pathologise compartmentalisation as 'splitting
PET 3: Lived experience shaping entry into mental health work and guiding intuition when helping others
PET 4: A silent pain when witnessing stigma and lack of hope for EUPD clients
PET 5: Stigma persisting in those who should and do know better
PET 6: Managing secrecy, concealment and fear around sharing in relation to a hierarchy of acceptable difficulties
PET 7: Navigating stigmatising workplace cultures whilst trying not to blame colleagues who have different levels of awareness
PET 8: A wedge forced between work and home with advocacy feeling more safe outside of the workplace

'Rose'

PET 1: The impact of one hopeful professional as a turning point in her journey
PET 2: Moving from shame and diagnosis-first perceptions towards being valued as a whole person
PET 3: Upholding boundaries in who she allows access
PET 4: A hope to integrate and draw meaning to different parts of 'split' selves
PET 5: Carrying lived experience in the workplace feeling 'like a fruit salad' of good and bad
PET 6: Relational connection through both a verbal and felt sense
PET 7: Different approaches to sharing. for different audiences, with lingering doubt experienced after
PET 8: Stigma as a barrier to care and kindness and interfering with workplace opportunities
PET 9: Gratitude towards allies and finding connection with others like her to feel less alone

'Kste'

PET 1: Initial hope of seeking answers, validation and support through diagnosis
PET 2: Confusing, unsupported and anger-provoking experiences of receiving the diagnosis

PET 3: Being warned about the negative consequences that come with being diagnosed with BPD
PET 4: Gradual movement into mental health work shaped by lived experience and injustice
PET 5: An initial false sense of security entering the profession later followed by a growing awareness of stigma
PET 6: Testing the waters whilst feeling petrified of being found out
PET 7: Sharing feeling like a dream rather than a reality
PET 8: An invisible an unsuspected struggle to others
PET 9: Witnessing stigma, distancing and dehumanisation towards people with the diagnosis
PET 10: Positive experiences of safety, acceptance helpful but still not enough to overpower fear
PET 11: Balancing lived experience identity with professional identity and boundaries
PET 12: Lived experience as a source of empathy, insight and meaningful contribution
PET 13: Questioning being flawed because of the label
PET 14: Ongoing awareness of vulnerability, wellbeing and emotional limits

Appendix R - The process from individual PETs to initial draft GETs names, with final GETs and subthemes renamed since this point after an iterative process of revisiting transcripts, notes, statements and clusters

GETS	PETS
1. The diagnosis as simultaneously validating, understanding self distressing and shaped by stigma double edged..doors opening and closing	Participant 1 – Experiencing the diagnosis as validating and a turning point in understanding the self Participant 2 – Diagnosis experienced as a double-edged, shaping understanding, identity and opportunities Participant 3 – Beginning her journey with dx with awareness of negative perceptions surrounding it Participant 3 – Moving past initial negative impact of the dx and reframing as a positive asset Participant 4 – From a lack of involvement in the diagnostic process to now viewing the dx as a distressing reminder of adversity Participant 5 – A mix of doors opening and closing due to dx and an eventual distancing from it overtime Participant 6 – A shift between confusion and anger towards dx and resentment when compared to others' journey Participant 7 – A mixture of feeling reassured, shocked and attacked by the BPD dx Participant 7 – Breaking free from the hold of the dx whilst simultaneously using it as a source of insight Participant 9 – Initial hope of seeking answers, validation and support through diagnosis Participant 9 – Receiving the diagnosis as confusing, unsupported and instilling hopelessness Participant 9 – Confusing, unsupported and anger-provoking experiences of receiving the diagnosis

	Participant 9 – Questioning being flawed because of the label Participant 9 – Being warned by others that the dx carries stigma and consequences
2. Navigating/contributing the integration and separation of different 'selves' with lived experience.. shaping professional identity as a skill and values when helping others…….professional growth..strength??. .being drawn to the work due to familiarity and understanding self	Participant 1 – Managing multiple selves and the integration of identity Participant 1 – Personal lived experience shaping career choice and strengthening relational connection with clients Participant 2 – Developing a strong sense of self, professional capability and direction despite obstacles Participant 2 – A shift from lived experience being undetectable to being used as a tool for Advocacy, transparency, to challenge stigma Participant 3 – Managing being authentic with professional boundaries Participant 4 – Negotiating the conflict in values between the personal and professional identity Participant 4 – Lived experience as expertise, qualification and relational skill Participant 5 – Growing confidence, assertiveness and advocacy through lived experience Participant 5 – Holding dual perspectives as both staff member and service user Participant 6 – Lived experience shaping entry into mental health work and guiding intuition when helping others Participant 6 – A wedge feeling forced between work and home with advocacy feeling more safe outside of the workplace Participant 7 – Own research and professional training contributing to new understandings of her lived experience Participant 7 – Identity confusion, in-between spaces and questioning legitimacy as a clinician

	Participant 7 – Her own success contributing to optimism, hope and curiosity as a key values to humanise service users Participant 8 – A hope to integrate and continue to make meaning different parts of 'split' selves Participant 8 – Carrying lived experience in the workplace 'like a fruit salad' of good and bad Participant 8 – Gradual movement into mental health work shaped by lived experience and passion Participant 9 – Lived experience and injustice shaping a gradual entry into mental health work Participant 9 – Gradual movement into mental health work shaped by lived experience and injustice Participant 9 – Balancing lived experience identity with professional identity and boundaries Participant 9 – Professional role shaping relationships, identity and ways of navigating the world Participant 9 – Lived experience as a source of empathy, insight and meaningful contribution
3. Witnessing and experiencing workplace stigma, discrimination and harm.. also trying to mitigate harm through advocacy???? A silent pain??.. 'people like me' discussed in negative light	Participant 1 – Navigating stigma and advocating for clients within the workplace Participant 2 – Flaws in the system and stigma contributing to being accused and singled out as a bad example to service users Participant 7 – Navigating powerlessness and limits of influence but continuing to make ripple effects of change Participant 2 – Long lasting impact of workplace discrimination causing deep emotional harm and hopelessness Participant 2 – Experiencing support inconsistently - at times recognized as staff, at others treated more like a patient

	Participant 2 – Struggling to articulate the magnitude of what she has experienced Participant 3 – Frustration toward negative remarks about the diagnosis and those unable to defend themselves Participant 4 – Unexpected revelations when discovering tensions between apparent compassion and stigmatizing discourse within staff culture Participant 5 – Witnessing, iatrogenic harm in varying contexts, often stemming from service users not being seen beyond the stereotype of the label Participant 6 – A silent pain when witnessing stigma and lack of hope for EUPD clients Participant 6 – Witnessing stigma persisting in those who should and do know better Participant 6 – Navigating stigmatizing workplace cultures whilst trying not to blame colleagues who haven't reached the same level of awareness of understanding Participant 7 – Carrying the emotional weight of hearing 'people like me' discussed in a negative light Participant 7 – Making sense of the factors perpetuating stigma, service structures and lack of knowledge Participant 7 – Using herself and her positive relationship with colleagues to help challenge negative perceptions around BPD Participant 8 – Stigma as a barrier to care and kindness and interfering with workplace opportunities Participant 9 – A false sense of safety entering the profession before recognizing stigma Participant 9 – An initial false sense of security entering the profession later followed by a growing awareness of stigma Participant 9 – Being hypervigilant around where stigma may be more likely to exist

	Participant 9 – Trying to spot patterns in where stigma may be worse but difficulties concluding this Participant 9 – Monitoring of responses and wondering if people can tell she has the dx Participant 9 – Witnessing stigma and dehumanization towards others with the diagnosis
4. **GET: Disclosure, concealment and authenticity as relational and an emotionally risky processes .. Testing the waters, strain of concealment and holding back.. self protection for both personal and professional self** 5.	Participant 9 – Being warned sharing her dx makes self-disclosure feel like a dream rather than a reality Participant 1 – Disclosure as a route to accessing support Participant 1 – Disclosure as a complex, relational and vulnerable process Participant 2 – Disclosure in the workplace as an attempt to do the right thing but sometimes lacking control in the process Participant 2 – Managing authenticity whilst also feeling the weight of concealment Participant 4 – Disclosure as pragmatic, complex and emotionally uncertain Participant 5 – Disclosure as gradual, strategic and dependent on safety Participant 5 – Developing direction for her career and the standards for those she allows access to her Participant 6 – Managing secrecy, concealment and fear around disclosure in relation to a hierarchy of acceptable difficulties Participant 7 – The emotional labour of carrying lived experience and holding back on what she wishes she could say Participant 7 – Disclosure feeling like a form of 'outing' herself as risky strategic experience, sometimes without choice Participant 7 – Disclosure bringing both relief and vulnerability

	Participant 8 – Upholding boundaries in who she allows access Participant 8 – Different approaches to disclosure for different audiences and lingering doubt experienced after Participant 9 – Testing the waters whilst feeling petrified of being found out Participant 9 – Fear of judgement, rejection and being viewed as incapable or difficult underpinning concealment Participant 9 – PET 8: An invisible an unsuspected struggle to others Participant 9 – The emotional strain of concealment, self-monitoring and holding back
Change to reflect both positive and negative experience!! Support, safety and belonging within workplace relationships…impacting access to care outside of work	Participant 1 – A mix of supportive and boundary violating wellbeing interventions in the workplace Participant 1 – Variations in team culture and psychological safety impacting ability to be authentic in the workplace Participant 2 – Hope, solidarity and adaptation over time Participant 3 – Feeling greatly accepted and supported by colleagues Participant 9 – Positive experiences of safety, acceptance helpful but still not enough to overpower fear Participant 1 – Confidentiality concerns and insight into the system as a professional impacting care outside of work Participant 8 – Gratitude towards allies and finding connection with others like her to feel less alone Participant 3 – Current Positive experiences of supportive staff outweighing significance of negative memories in the workplace Participant 3 – rebuilding trust after experiencing being ‘burnt’

	Participant 3 – Experiencing positive changes in work culture Participant 5 – Connection through 'finding a gang' of solidarity to foster belongingness Participant 5 – The positive impact of scaffolding support from one person having a positive ripple effect on others' misunderstanding of those dx with EUPD
6. Emotional survival, coping and protecting wellbeing… **Career development facilitating journey from feeling unseen to seen and unheard to heard?**	Participant 3 – Experiencing the dx as a way to externalize, characterize and 'fight' difficulties Participant 2 – Tensions between work, care and wellbeing Participant 3 – Recognising own needs and ways of coping in the workplace Participant 4 – Protecting wellbeing through pragmatism, distance and compartmentalization Participant 4 – Using metaphor and reflection to make sense of experience Participant 5 – Using humour and emotional reframing to relate to past experiences Participant 6 – Compartmentalization as a way of coping becoming pathologized through the lens of 'splitting' Participant 7 – Finding the humour in heavy and high pressure situations Participant 9 – Ongoing vulnerability and awareness of emotional limits

Appendix S – IPA Recurrance of Themes Table

Themes		Participants								
GETS	**Subordinate themes**	**'Grace'**	**'Lucy'**	**'Sammy'**	**'Olivia'**	**'Maria'**	**'Julia'**	**'Bella'**	**'Rose'**	**'Kate'**
Early encounters with the diagnosis experienced as a 'double-edged sword'	The diagnosis opening some doors whilst closing others	X	X		X	X	X	X	X	
	Alternative explanations of distress and questioning the diagnosis as a construct	X	X	X	X	X	X	X	X	
The value and tension of integrating lived experience with professional identities	Lived experience as a source of connection and hope for others, despite its weight	X	X	X	X	X		X	X	

	Navigating shifts between identity parts and contexts	X	X	X		X	X	X	X	X
	Expectations of reduced vulnerability to distress when working in mental health		X					X		X
	Boundary violations when repositioned as a patient by the workplace	X	X						X	
Managing the emotional impact of stigma and discrimination towards 'people like me'	Hypervigilance whilst feeling a need to be undercover	X	X	X		X	X	X		X
	Heightened stigma and distancing from those diagnosed with EUPD compared to other more	X	X		X	X	X	X	X	X

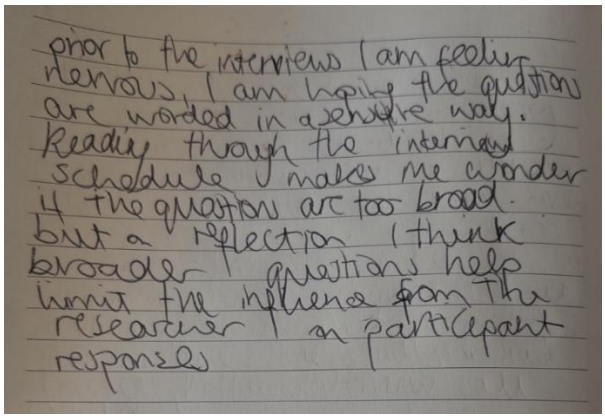
	‘socially acceptable’ difficulties									
	Inner dialogue of ‘what I wish I could say’	X			X	X	X	X	X	X
	Balancing hurt with understanding towards those who lack awareness	X			X	X	X	X	X	
	Systemic influences on stigma and discrimination	X	X	X		X		X		X

Navigating authenticity, sharing and relational safety in the workplace	Safe workplace relationships as a foundation for belonging	X		X	X	X		X	X	
	Weighing up the risks and benefits of sharing	X	X	X	X	X	X	X	X	X
	Testing the waters	X	X	X	X	X	X	X	X	X
	The mixed aftermath of sharing	X	X	X	X	X		X	X	
	The emotional cost when authenticity is suppressed	X	X				X	X		X

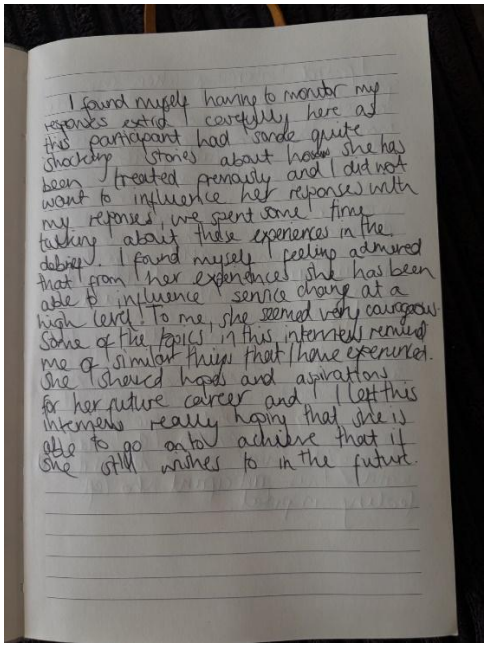
Moving beyond reductionist narratives associated with EUPD	The reward of contributing to positive shifts in workplace culture		X		X	X		X	X	
	Adaptive compartmentalisation versus 'EUPD splitting'						X		X	X
	'Turning lemons into lemonade' - healing alongside ‘giving back’ to others	X	X	X	X	X		X	X	

Appendix T – Primary researcher reflexive journal enties

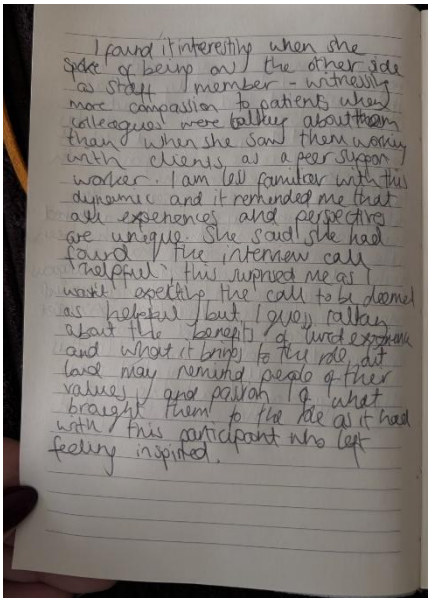
Journal entry example 1 - prior to participant interviews



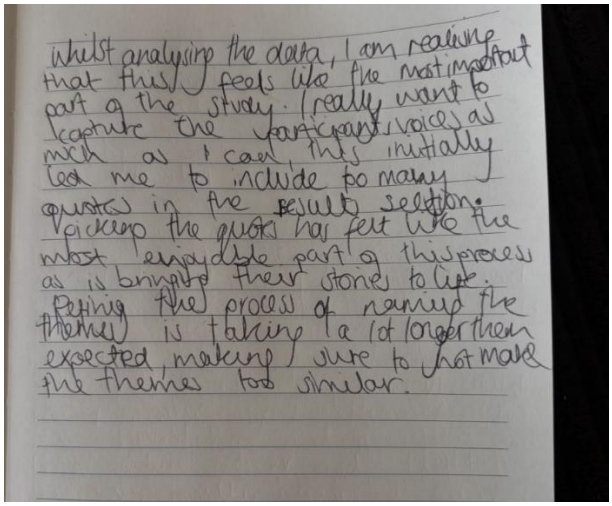
Journal entry example 2 – reflections following participant interview



Journal entry example 3 – reflections following participant interview


I found it interesting when she spoke of being on the other side as staff member - witnessing more compassion to patients when colleagues were talking about them than when she saw them working with clients as a peer support worker. I am all familiar with this dynamic and it reminded me that all experiences and perspectives are unique. She said she had found the interview call 'helpful' this surprised me as I would expect the call to be deemed as helpful but I guess talking about the benefits of lived experience and what it brings to the role, at least may remind people of their values / and passion / of what brought them to the role as it had with this participant who left feeling inspired.

Journal entry example 4 – example reflections from analysis process


whilst analysing the data, I am realising that this feels like the most important part of the study. I really want to capture the participants voices as much as I can, this initially led me to include so many quotes in the results section. Picking the quotes has felt like the most enjoyable part of this process as is bringing their stories to life. Refining the process of naming the themes is taking a lot longer than expected, making sure to not make the themes too similar.