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'Your experiences were your tools.' How personal experience of mental health problems informs mental health nursing practice.

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Abstract

Introduction: 'Expertise by experience' is a highly valued element of service delivery in recovery-oriented mental health care, but is unacknowledged within the mental health nursing literature.

Aim: To explore the extent and influence of mental health professionals' personal experience of mental ill health on clinical practice.

Method: Twenty seven mental health nurses with their own personal experience of mental ill health were interviewed about how their personal experience informed their mental health nursing practice, as part of a sequential mixed methods study.

Results: The influence of personal experience in nursing work was threefold: first, through overt disclosure; second, through the 'use of the self as a tool'; third, through the formation of professional nursing identity.

Discussion: Mental health nurses' experience of mental illness was contextualised by other life experiences and by particular therapeutic relationships and clinical settings. In previous empirical studies nurses have cited personal experience of mental illness as a motivator and an aspect of their identity. In this study there was also an association between personal experience and enhanced nursing expertise.

Implications for practice: If drawing on personal experience is commonplace, then we must address the taboo of disclosure and debate the extent to which personal and professional boundaries are negotiated during clinical encounters.

Relevance statement

This study is relevant to mental health nursing practice, recruitment and training because it identifies ways in which nurses' 'expertise by experience' of mental health problems informs their practice, in both overt and subtle ways. Recognising the impact of personal experience on mental health nursing practice is vital to recovery oriented and collaborative working with service users. This study should lead to a debate within the profession on disclosure, openness and use of self within mental health nursing work.

Accessible summary

- What is known on the subject

- 'Expertise by experience' has become an increasingly valued element of service design and delivery by mental health service providers.

- The extent and influence of mental health professionals' personal experience of mental ill health on clinical practice has seldom been interrogated in depth

- What this paper adds to existing knowledge

- We investigate how mental health nurses' own personal experience of mental ill health informs their mental health nursing practice with particular reference to direct work with service users.

- Participants said that personal experience could impact on work in three positive ways: to develop their relationship with service users, to enhance their understanding of service users and as a motivation for potential mental health nurses to join the profession.

- This study moves the discussion of the state of mental health nurses' mental health further towards the recovery and wellbeing focus of contemporary mental health care, where 'expertise by experience' is highly valued.

- **What are the implications for practice**

- We must address the taboo of disclosure within clinical nursing practice and debate the extent to which personal and professional boundaries are negotiated during clinical encounters.

Main body

Introduction

The incorporation of 'expertise by experience' has become an increasingly valued aspect of service design and delivery by mental health service providers (Perkins, Rinaldi and Hardisty, 2010; Gillard and Holley, 2014). It has usually been sought from mental health service users who either offer consultation to mental health service providers or, latterly, through the creation of specific 'peer support worker' roles, in which expert service users will explicitly refer to their own experiences of mental ill health in their work with other service users in accordance with a 'recovery-oriented' approach (Gillard et al, 2013; Gillard and Holley, 2014). Whilst the growth of peer support and use of experts by experience reflects an acknowledgement of the worth of the lived experience in mental health, the extent of unacknowledged or un-called-for 'expertise by experience' among health care professionals has not been identified, although it is being increasingly written about in first person accounts (MacCulloch and Shattell, 2009) and qualitative studies (Goldberg et al, 2015; Richards, 2016). In this study, mental health nurses (MHNs) with personal experience of mental ill health were asked about the ways in which their own experiences of mental ill health has influenced and affected their mental health work.

What nurses with experience of mental ill health may bring to their role: the wounded healer and the impaired professional

When the impact of a person's own mental ill health on mental health work has been examined in previous studies , common images are either of the 'impaired professional' or the 'wounded healer'. Where the 'wounded healer' is an archetypal image of a helper whose own experiences give them curative powers and motivate them to heal others (Zerubavel and Wright, 2011; Conchar and Repper, 2014; MacCulloch and Shattell, 2009),

'impaired professionals' are perceived as presenting potential risk to service users and clients (Telepak, 2010). They draw negatively on their experiences, adversely affecting engagement and causing stigma and censure from their colleagues and managers (Telepak, 2010). Gärtner et al's (2010), systematic review of the evidence on the impact of nurses and allied professionals' mental ill health on their work frames health professionals' mental ill health in terms of service user safety and quality of service user experience. The 'wounded healer' image has some positive connotations though, because the wounded healer is seen as drawing on wisdom and insight from their experiences. The 'impaired professional' image does not have such positive connotations.

In Moll's (2010, 2013) recent ethnographic study of the experience of mental ill health of 32 participants from one Canadian health organisation the experience of mental ill health pervaded mental health work but staff were not encouraged to be open about it. Moll's subjects talked about how personal experiences were 'strategically disclosed' and 'actively concealed', at odds with the public messages within the organisation to be open and talk about their mental ill health. In ethnographic studies Kidd's (Kidd, 2008; Kidd and Finlayson, 2010) and Joyce et al's (2007, 2009) subjects talked about their experiences of having mental ill health and being nurses. For some of Kidd's 18 subjects nursing work was seen as triggering mental ill health or exacerbating preexisting vulnerabilities. For others the experience of mental ill health was separate from work but still informed their nursing practice. Joyce et al's (2007, 2009) 29 nurses with mental ill health 'crossed a boundary' when they became both a nurse and a service user. The focus of these studies was the impact of mental health workers' experience of mental ill health on their relationships with colleagues, and the nurses' perceptions of their work. In the present study we aimed to investigate how mental health nurses' own personal experience of mental ill health informs their mental health nursing practice with particular reference to direct work with service users.

Methods

This study has been conducted and reported with reference to the COREQ criteria for qualitative research (Tong et al, 2007). Data were collected as part of a sequential mixed method study on subjective wellbeing and mental health in UK MHNs. The first phase was an online survey of 237 MHN members of two national professional associations. In the second phase of the study, a purposive sample of 27 MHNs who reported both high subjective wellbeing and personal experience of mental ill health in the survey took part in semi structured interviews between July 2013 and February 2014. They were transcribed and analysed between February 2014 and September 2015. The number of interviews undertaken was determined by by the number of survey respondents who met the sample criteria (history of mental health problems and high subjective wellbeing) and who were willing to take part in an interview.

Research participants

Of the 27 participants 22 were female. They had worked as MHNs for between a few months and 26 years. Several had more than one type of personal experience of mental ill health, both in the past or present, either of their own or of close family members. The MHNs worked in a range of mental health settings and roles.

Face to face interviews were undertaken with 12 nurses, and 15 interviews were undertaken via Skype. Recorded verbal consent was given by each participant at the start of each interview. No incentives were given to take part. The data collection methodology has been discussed elsewhere (Oates, 2015). Interviews were undertaken by JO.

Interview guide and data analysis

The interviews were semi-structured, following a topic guide (Tong et al, 2007; Holloway and Wheeler, 2013). The topic guide was piloted with three respondents to a pilot survey,

and was reviewed by a Service User Representative Panel. The interviews were between 36 and 82 minutes in length. Transcripts of the interviews were analysed and coded using NVivo software following a phased thematic analysis approach, as advocated by Braun and Clarke (2006). Coding and thematic analysis were primarily undertaken by JO, under the supervision of JJ and ND. The reliability and validity of the coding was assured through an exercise in comparative coding between JO and JJ for a sample of the interview transcripts.

Braun and Clarke's (2006) thematic analysis approach derives findings in structured way, moving analysis from the descriptive to the abstract systematically. The approach involves first, data management (familiarisation, labelling and sorting), with a 'systematic and comprehensive coverage' of each unit of analysis. From this, and from data summary and display (meaning an ordering an summarising of the data) comes analysis, which begins with devising analytical building blocks by deriving themes from the data. Braun and Clarke (2006) differentiate between passive and active thematic analysis, with passive analysis being when themes 'emerge' or 'are discovered' from the data. Rather, an active analysis acknowledges the researcher's role in identifying patterns, selecting those of interest and choosing how to report them. In this instance the analysis was active as well as 'grounded' in what emerged from the data. It was driven by the core research question of 'how do nurses with personal experience of mental health problems and high subjective wellbeing negotiate, use and manage their own mental health and wellbeing?' and fell into three areas (subjective wellbeing, subjective experience of mental health problems and mental health nursing work). This paper presents findings for one of the three major themes: mental health nurses' experience of mental ill health in relation to their work.

Ethics

A study protocol, including participant information and an interview topic guide were approved by the local University Research Ethics Committee. This study was focused on a sensitive topic: personal experience of mental ill health and work. The principal investigator was also a MHN. Confidentiality and anonymity of participants was maintained through the use of pseudonyms throughout the analysis and reporting. All participants were given information about the scope of the study and gave recorded consent to take part. In the reporting of these interviews, all participants have been anonymised. Participants were advised that confidentiality would be maintained unless they disclosed to the interviewer about themselves or another person being at immediate risk of harm. Participants were also given information about how to access help for their own mental health problems as a means of addressing the potential risks of taking part in the study.

Findings

In this study we aimed to explore the effect of personal experience of mental ill health on MHNs' own mental health work. Participants said that personal experience could impact on work in positive ways, when MHNs drew on that experience to develop their relationship with service users, to enhance their understanding of service users or as a motivation for potential MHNs to join the profession. 'Bringing experiences to work' emerged as a core theme during the analysis: with sub themes of disclosure and boundary crossing; use of self; and nursing identity. These were the three ways in which MHNs 'brought experiences to work'. 'Disclosure and crossing boundaries' was the most overt and least frequent way of bringing experiences into work, encompassed within more subtle ways in which mental ill health experiences were brought to work, 'use of self', whereby MHNs drew on their life experiences (not just of mental ill health) to understand and empathise with service users. This was encompassed by the broader way in which personal experi-

ences were brought to work, through the MHNs' identity as a nurse and motivation to practise, where the personal mental health history was a part of who they were as a nurse.

Disclosure and boundary crossing

Overt disclosure to service users about experience of mental ill health was a rare occurrence. It was seen as taboo, a crossing of the boundary between the professional and the service user. Verbal interaction between MHNs and service users should be 'a conversation with a purpose'(Norman), where disclosure could be used as a means of explaining or evidencing understanding, meaning that self disclosure only happened in the context of an intended benefit to the service user. Boundaries may be negotiated or crossed, but it was important for a number of participants to know that boundaries were there, to keep and to know 'a line'. For Diana, not talking about herself was a means of 'self protection', whereas for Ryan it was about putting the service user's best interests first:

> 'You know, you need to be careful how much information you're giving to patients about your own experiences, and you need to make sure that you're doing that in a way that's in the best interest of the patient and it doesn't just become a sort of... a type of extra therapy for the staff member.'

Some participants set specific rules around their self disclosure, Rob said anything referring to his own life would only be relayed in the 'third person.'

> 'I will try to help patients reflect on things by using my experiences but not in a direct way, like in a third person type of way, say I knew somebody who suffered too. Do you know what I mean? If I wanted to have a conversation with the patient about something that happened in my life I would put it in a third person.'(Rob)

Carrie had a technique for sharing her experiences as a means of relationship building, which contrasted with Rob's only disclosing in the third person. She used 'we' rather than 'I' or 'you' or 'they':

> 'I use we, and us, and I'll always use the plural. I don't like to say, you know, when you're feeling like that. I'll always say, when we're feeling like this…'

Likelihood of self disclosure was affected by the mental health setting, for example, it was deemed 'you can't go there' in forensic settings because of perceived risks of service users using personal information against the nurse. In settings with young people or people with Asperger's or Autistic Spectrum Disorders, self disclosure was also seen as risky, because service users:

> 'don't have the cognitive judgement to work out what is appropriate. So if I told them that I'd had depression they might want to speak about that every single session. Cos the social cues are not there.' *(Diana)*

Some MHNs had worked in therapeutic communities or with borderline personality disorder clients where the MHN's personality and experience were very much part of the therapeutic approach. Participants talked about times where they might disclose their experiences, when developing rapport, validating experiences and developing the nurse-service user relationship. Tracy said that she used disclosure to 'turn the conversation around' to where she wanted it to go. Ellen said:

> 'I definitely feel that, for my working qualities, and the experiences that I have, it's been very beneficial to be able to talk to patients and their families about some of the difficulties that people may have. So I do share the fact that I have had depression and a period of great difficulty, just because I think I have a little bit more un-

derstanding than I did, whereas before I was all, kind of, like, let's do it, you know, let's set some goals.'

'…more early in my career I might have been less open as my training would have said do not tell people. But working with older people who openly ask you things out of friendship and kindness and they only want to be normal- asking have you any family and that sort of thing. I don't have any problem with that…' (Trevor)

Those MHNs who had worked or were working with older people said that talking about home and family was part of being 'normal' with their client group, as described by Trevor. Ruth had chosen to talk more about herself when working alongside a peer support worker as a group co-facilitator. Working out how to negotiate boundaries came with years of mental health nursing experience; over time MHNs may become more relaxed and comfortable to negotiate boundaries rather than being rigid. This was in part due to changing client group (from working in a forensic locked setting to an older adults community team for example) and due to the MHN becoming more confident in their practice:

Using my own experience to inform my work with service users

Whilst overt disclosure was rare, 'use of self', drawing on experience to inform practice, was familiar to most participants. Indeed it was viewed as being fundamental to their nursing approach, as highlighted by Ruth:

'…one of the important things about nursing is that you are using your personality and you're using your experiences. At the same time I do feel like, you know, I have to have a role. I have to be professional. I have to be boundaried …'(Ruth)

Life experience and 'being real' meant being credible to service users but also being able to understand and empathise with them. Having some shared experience (of mental ill health) was a point of connection. This mental health experience was in the context of a

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broader range of relevant aspects of the self that were shared in their work. Several MHNs described the importance of wider 'life experience' to mental health nursing. They talked about how it gave MHNs credibility and insight. Neil said that his life experiences as a carer of someone with mental ill health and his life experiences of working in manual labour both gave him credibility with service users and insights that some of his younger colleagues who had gone into mental health nursing straight from school lacked. In these instances use of one's own experience was not necessarily a deliberate overt disclosure of personal mental ill health, rather it was an element of relationship building and making connections.

When an episode of MHNs' mental ill health had taken place whilst the MHN was nursing (rather than before joining the profession), this affected how they interacted with and understood their service users. For most participants, the experience increased their empathy, and deepened their understanding of anxiety, low mood or suicidal thoughts; as well as increasing empathy the experience enabled the MHNs to see the possibility of recovery for others. Ellen said:

> 'I think some of the things that I thought would be helpful to people now make me cringe. You know, things that came up in books, or groups that we would do, and the way that we would talk to people about, you know, wow, you know, you should be doing this, this would be really helpful. And when they would say, but I can't do that, and we was like, oh, maybe they're just not trying. And now just really appreciating that it's just, they're here, they're doing so much just by being here, and just, I don't know, yes. I think I'm such a better practitioner for having experienced it.'

Conversely, two MHNs said that being in the midst of their mental ill health whilst nursing made them less able to work well with service users and less able to access their emotions, as well as being less able to manage their workload. Monica described herself as

'emotionally blunted', and Patty described herself as 'frustrated and angry'. Being mentally ill made nursing harder because the MHNs did not have the same control of and fluency with their emotions as usual.

Being and becoming a nurse

'I always say to people, look, this is me; I'm being genuine. Yes, I have a professional qualification but what you see with me isn't my nurse role; this is me, this is …, and I'm interacting with you in a very genuine way.' (Joanna)

The third way in which experiences of mental ill health influenced mental health nursing practice was as motivation to join the profession and as an aspect of participants' nursing identity. Nursing was seen as being 'part of my personality' (Sylvia) and a vocation. Being a nurse was associated with the MHN's personal values and beliefs. Participants talked about nursing identity changing over time, for them as individual nurses, but also for the profession as whole. Some participants' own experience of mental ill health called into question their nursing role. Being a nurse certainly affected how their own mental ill health and wellbeing was managed. Diana talked about how she had 'put up with a lot or behaviour' from a boyfriend with mental ill health because:

'in your role as a mental health nurse one of the things you do is you stick in there.'

She behaved in her personal life in a way that was expected of her in her professional role. For Sylvia personal values (of compassion and authenticity) were aligned with nursing values. For Ruth, working as a nurse in the NHS was aligned with her political views. She had a sense, though, that these values were being eroded and that nursing in the NHS held a different meaning to some years ago. She said:

'I think when I was doing my degree I used to go on a lot of demos and there were a lot of nurses and I thought how cool that was and I thought how cool nurses must

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be and working at the NHS must be because they were all, you know, quite political and all the rest of it, and I think up until a couple of years ago it felt like we were being paid better for what we were doing. It felt like you could say there was pride in being a nurse and it's definitely been eroded definitely feels like that.'

Many participants described how the job of nursing had changed, with increased paperwork and administration, less service user contact time and lower job security. Some MHNs had the experience of their service being moved out of the NHS and into the social care and voluntary sector. Nursing was seen a less secure profession with lower public standing than in the past. Talking about what it meant to be a nurse with a mental health history led participants to talk about what it meant to be a nurse. They provided a shared account of a profession subject to external social and political forces, where individual members were trying to conduct their nursing work in accordance with the values and beliefs that had led them to identify with 'nursing' at the start of their careers.

Having one's own experience of mental ill health influenced motivation and career choice:

'People are drawn to mental health because of our personalities and our experiences and things we've experienced in our childhoods.'(Diana)

When personal experience of mental ill health had happened prior to going into nursing it was commonly cited as a motivator for joining the profession. Experiences affected the choice of practice area as well as profession. For Tracy, personal experience dictated areas she did not want to work:

'I find it really difficult to work with alcoholic men, it's just something that I find hard. It makes me feel like a scared little eight-year-old, so I try and acknowledge that.'

Neil moved from adult to child mental health work partly due to his personal experiences. He said:

'I think the more I worked in adult mental health the more I wanted to make a difference at that earlier level - I suppose now I've got all of that experience that makes me a more effective practitioner and I think that is what drives me - that I've seen that I can make a difference'.

Trevor had moved from adult to older people's mental health services following his stress related depression. In contrast Alison and Eleanor had chosen to work in settings with higher stress and crisis demands because of a pleasure in 'being a little bit stressed.' (Eleanor).

Not everyone started out wanting to be a nurse though. For some, when choosing a career in health and social care, nursing offered the biggest financial incentive to train, others had different aspirations. One participant had wanted to teach, and some had originally trained as general nurses then gone into mental health at a later date. Despite comments regarding the challenges and changes in the way their services were delivered and the impact of those changes on their MHN roles, the MHNs talked about 'loving' their job. This love of the work was associated with an interest in the lives and wellbeing of other people and a desire to connect and play a part in changing lives for the better. In particular, as MHNs, they were connecting with people living outside of the main stream or at difficult points in their lives. This was described as a privilege:

'…what I like is working with people that need our help and you have got to see through the thing that most people would turn away from…those people in society who you would cross the street, you wouldn't want to sit next to them on a bus. I like working with those people in their acute phase, you know, seeing an improvement in that situation.' (Alison)

Discussion

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In this study we found that having personal experience of mental ill health influences mental health nursing work in three main ways. Most commonly, mental illness experiences informed MHNs' nursing identity and motivation to join the profession, although they were also informed by other values and beliefs. Experience of mental ill health was one form of experience that may have influenced the choice to nurse in mental health. Next, 'use of self' was a tool in the repertoire of nursing skills, with mental ill health experiences as one type of experience that was drawn upon within work. Having their own mental ill health had affected the MHN's ability to empathise with and respond to service users. In some cases this had had an adverse effect, when mental ill health had been experienced during their nursing career. Rarely, personal experience of mental ill health was disclosed during encounters with service users. Some nurses described infrequent disclosure of their experiences to service users whereby overt use of their experience developed or progressed specific relationships, but this was an infrequent and 'judicious' act.

Like the participants in this study, Moll's (2013) subjects' disclosure of personal mental ill health to service users was 'exceptional'. Participants in our study did not describe being silenced about their own mental health, rather disclosure was used 'with a purpose' in the context of their nursing work. This use of disclosure was more akin to what Welch (2005) described as 'pivotal moments' in therapeutic relationships, from his interviews with six experienced MHNs. For his interviewees, self disclosure, for example of the suicide of one of the nurse's relatives, took place in the context of developing trust and rapport. Gardner (2010) explored professional boundaries in the context of developing therapeutic relationships in a study of 15 MHNs. He conceptualised the nurse patient relationship in terms of 'levels of engagement' from 'therapeutic friendliness' to 'therapeutic alliance.' It was up to the MHN to artfully lever the relationship and rapport from stage to stage, navigating boundaries. Similarly, in O'Brien's (1999) focus group study, MHNs saw their expertise in mental health practice as being founded on how they managed that nurse- patient rela-

tionship. Whilst 'disclosure' was not mentioned specifically, the MHNs talked about individualised care which may incorporate 'bending the rules' and 'minimising the visibility' (of the therapeutic nurse-service user element) of the relationship, which entailed 'being natural' with the person. Our study shows that when MHNs consider the nurse-service user relationship as a therapeutic tool in their work, and also see their self as a tool in that relationship, which is highly individualised, self disclosure becomes one means of doing mental health nursing work.

Experience of mental ill health was incorporated into 'being real', making genuine connections with service users through revealing aspects of one's own history. McAllister et al's (2013) MHN leaders talked about making 'authentic connections'. Life experience, not just of mental ill health, was something that gave the MHNs credibility and insight. Authenticity or 'use of self' is a common theme in other studies looking at MHNs' perceptions of their role (Hurley, 2009; Holm and Severinsson, 2011). It is associated with notions of 'the wounded healer', whereby personal insight gives the 'healer' stronger powers to cure fellow sufferers (Zerubavel and Wright, 2012). None of the MHNs interviewed here declared themselves 'a wounded healer', although the notion that experience informed 'good' mental health practice was implied.

Personal experience of mental ill health influenced the formation and development of the MHNs' nursing identities. MHN identity has been the subject of substantial prior research and discourse (Clarke, 2006; Happell, 2006; Happell, 2014), often defined in relation to others: not just service users but also in relation to other mental health professionals (White and Kudless, 2008) and other nurses (Humble and Cross, 2010). It is not static, changing as the student MHN becomes the MHN (Rungipadiachy et al, 2006) and as the MHN takes on new educational roles and duties (Hurley and Lakeman, 2011; McCrae et al, 2014). Richards et al (2016) found that mental health professionals with personal expe-

rience of mental ill health constructed their identity in four ways: as either the patient, the professional, integrated or unintegrated, and moved between these four constructions throughout their interviews. In Goldberg et al's (2015) study of social work students with mental ill health, identity developed as their training progressed, leading to a final integration of patient and therapist identities. Whereas Goldberg et al (2015) saw a progression, Richards' et al's (2016) saw the different identities as being 'integrated' or 'unintegrated' to varying degrees. Similarly, where personal experience of mental ill health has been explored specifically in nurses, the primary image has been one of boundary crossing and boundary negotiation (Joyce et al, 2007; 2009; Kidd, 2008; Kidd and Finlayson, 2010). In our study, mental health nursing identity was conceived as being made up of several aspects, with an episode of mental ill health certainly being an important aspect of that identity. It is important to state, though, that these mental ill health experiences were but one element of what made up that MHN identity, and that the MHNs in this study had not all entered the profession as mental health service users. That part of their identity may have emerged subsequent to, and not prior to training.

The findings of this study offer a novel perspective on how the experience of mental ill health informs mental health nursing work, giving an insight into the influence that personal experience has on relationships and interactions with service users. The findings are supported by previous work on the use of self in nursing and on nurses' identities, where making connections and forming relationships are seen as the bedrock of mental health nursing practice. Where the nurses described the subtle and pervasive ways in which their practice was shaped by their personal experience, disclosure of the specifics of their mental ill health was not common. Self disclosure was selective and circumstantial. Whilst other researchers, such as Moll (2013) have conceptualised the lack of open discussion of mental ill health in mental health organisations as 'silencing', it is evident that the nurses in

this study made conscious individual decisions about disclosure on a relationship by relationship basis.

What the study adds to the international evidence

The findings of this study add to the international body of evidence by showing that deft use of self is part of the mental health nurses' clinical practice. Deliberate disclosure of experience was just one way in which the nurses in this study drew on their subjective experience in their work. This study moves the discussion of the state of mental health nurses' own mental health further towards the recovery and wellbeing focus of contemporary mental health care, bringing it in step with discussions of the possible benefits of lived experience on mental health work (Gillard et al, 2013).The perceived positive influence that personal experience had on the nursing practice of the participants in this study is in contrast to the 'largely negative' experience of the nurses in Joyce, Hazelton and Macmillan's study where participants saw becoming mentally ill as 'the antithesis of being a nurse' (2007, p375). For Kidd (2009) prior experience of mental illness individually and in the family was a motivating factor to join the profession. For her subjects, and for Moll's (2013), disclosure of mental illness was associated with vulnerability and bullying, and with concern about professional competence. It seems therefore that in previous empirical studies nurses have cited personal experience as a motivator but it has not always been associated with enhancing expertise. In the present study the participants made that explicit association. This aspect of being a nurse with mental health problems has not previously been explored. Contemporaneous research on social work students (Goldberg et al, 2015) and members of the multidisciplinary team (Richards et al, 2016) has also explored notions of identify formation and integration for people with lived experience who go into mental health professional practice; however this is the first study to address 'bringing experiences to work' in the specific context of mental health nursing.

Limitations, strengths and further work

The study is limited by its focus on MHN participants solely from the UK. The participants in this study had several common characteristics: all MHNs, all with personal experience of mental ill health but also with high subjective wellbeing. The participants were chosen because of a lack of prior research on nurses with these characteristics. It was possible to identify common themes and common threads within the interviews, and rather than there being 'deviant cases' within the group, a range of views has been presented in the results. Whilst there was a diversity of views reflected in each theme, there was sufficient commonality, derived from a robust analysis, that the representativeness of this group for other MHNs with their same defining characteristics may be argued for. The best way of testing this would be through a repeat study with a similar group. The extent to which participants' views may reflect those of nurses with no experience of mental ill health has not been gauged, and could only be done through further study.

Conclusion

We found that personal experience informs mental health nursing practice in numerous ways. Personal experience of mental illness in MHNs creates understanding of and empathy for mental health service users and, in certain circumstances, it is seen as giving MHNs credibility when talking to those in their care. The notion of mental ill health experience informing therapeutic contacts within mental health nursing practice should be contextualised within the broader picture of nurses using themselves and their experiences in their work. Perhaps surprisingly, the 'wounded healer' image was not referred to by the participants, although they did say that their experiences had motivated them to nurse and gave them enhanced understanding and credibility. Whilst the image has stayed pertinent in the theoretical and autobiographical literature on the helping professions, as evidenced by Conchar and Repper's (2014) review, it is not used by mental health nurses about

themselves. A revised conceptualisation of mental health professionals with mental ill health is needed, whereby experience of mental ill health is contextualised, both by the other personal influences on the professionals' working practice and by the situations and relationships where personal experience is overtly drawn on or disclosed.

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