

Disclosing the Clinician Within: Epistemic Injustice, Identity, and Lived Experience in Mental Health Practice

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Abstract

Background: Clinicians with lived and living experience (LLE) occupy contested spaces in mental health systems where a dominance of biomedical hierarchies and norms often marginalize experiential knowledge, leading to epistemological injustices which contribute to burnout, lack of safe disclosure and stymies growth in recovery orientated practice. This is perpetuated by interpersonal, intrapersonal and systemic stigma which directly needs to be challenged. As a burgeoning topic, notably over the past five years, the need for review, situated within a Mad Sciences paradigm is required to further legitimise lived and living experience knowledges in practice.

Aim: The aim of this narrative review is to synthesize how lived and living experience clinicians negotiate identity and disclosure, how their knowledge is legitimised in practice and policy, and which conditions enable safe, integration of dual identities in practice.

Design: This narrative review is positioned from a Mad Studies and a critical-realist stance with use of PRISMA processes for transparent searching and selection, and acknowledgment of bias as part of the authors own lived and living experience which informed design and synthesis of the project.

Findings: There is a persistent structural and internalised stigma within mental health practice identities which result in testimonial injustices, due to barriers to self-disclosure. and hermeneutical injustices by the lack of programs, policies and contention and role ambiguity that constrains disclosure and epistemic legitimacy. However, due to risks of co-option with survivor led challenges to dominant biomedical hierarchical systems, clinicians should include explicit recognition of survivorship knowledge as part of their professional identity emboldened by targeted training, reflective supervision, and recovery-oriented governance.

Limitations: Due to limited longitudinal evidence, inconsistent role definitions, scarce guidance for identified lived-experience clinician roles, and under-evaluation of organisational interventions, additional methodology, such as citation chaining was employed to broaden the scope of the review.

Conclusions: Embedding experiential expertise requires policies that enable safe disclosure, professional education that normalises dual identity, and co-designed frameworks that redistribute epistemic authority. The review provides a conceptual platform for future qualitative research and practice reforms to advance epistemic justice and workforce wellbeing. Genuine reform involves embedding LLE perspectives in education, supervision frameworks, and workforce policy, enabling clinicians to safely express and utilise their lived experience as an integral and credible dimension of professional practice.

Keywords: lived experience clinicians; Mad Studies; epistemic injustice; disclosure; stigma; recovery-oriented practice

Facilitators and Barriers to Disclosure of Lived Experience among Mental Health Clinicians

Overview: The integration of lived and living experience (LLE) within clinical practice presents both a challenge and an opportunity for identity reconstruction among mental health clinicians. For many practitioners, the coexistence of professional and lived experience identities is complex, shaped by personal recovery narratives, professional expectations, and institutional culture.

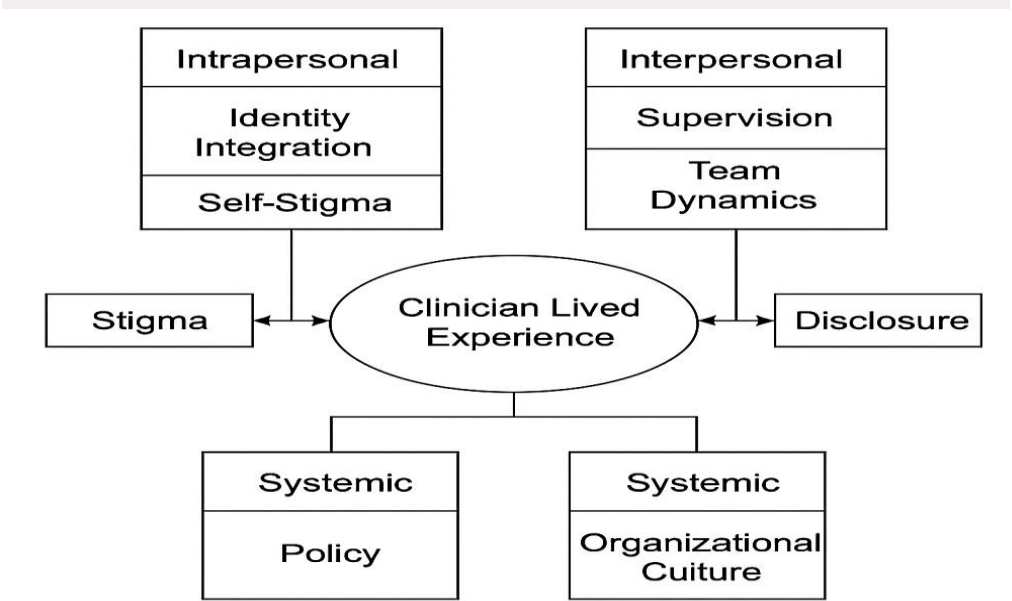


Figure 2: Barriers and Facilitators to Lived experience knowledge integration in practice

Background

- Clinicians with lived and living experience (LLE) often occupy contested spaces within biomedical hierarchies.
- Dominant biomedical models marginalize experiential knowledge, producing epistemic injustice and limiting safe disclosure.
- Stigma – interpersonal, intrapersonal, and systemic – constrains workforce wellbeing and authenticity.

Dual Identity Integration: Studies highlight benefits of accepting and integrating one’s dual LLE and Practitioner identity, enhancing empathy, authenticity, and therapeutic depth (Roots & Roses, 2024; Cleary & Armour, 2022).

Findings

- Persistent structural stigma and hierarchical systems reinforce testimonial injustice when someone’s knowledge or testimony is discredited because of prejudice, and hermeneutical injustice when a group lacks the *conceptual or interpretive resources* to make sense of their own experiences within the dominant social framework.
- Role ambiguity and risk-averse management hinder safe LLE integration.
- Recognition of survivorship knowledge can strengthen epistemic legitimacy when supported by supervision and policy.

Barriers	Facilitators
Workplace stigma and pathologizing cultures	Supportive leadership & HR policy
Fear of discrimination or regulation	Peer-led reflective practice
Hierarchies silencing vulnerability	Recovery-oriented practice (ROP)
Internalized stigma and identity conflict	Authenticity and courageous disclosure
“Therapeutic abstinence” and role segregation	Intersectional and inclusive supervision

Implications: Non-disclosure of lived and living experience (LLE) among clinicians perpetuates a hidden culture of silence that can lead to professional isolation, emotional exhaustion, and unsafe clinical practice. When clinicians are unable to safely acknowledge their experiences, it reinforces stigma, erodes authenticity within therapeutic relationships, and increases vulnerability to burnout and attrition across the mental health workforce. This silence compromises reflective capacity and limits opportunities for professional growth, supervision, and peer support .

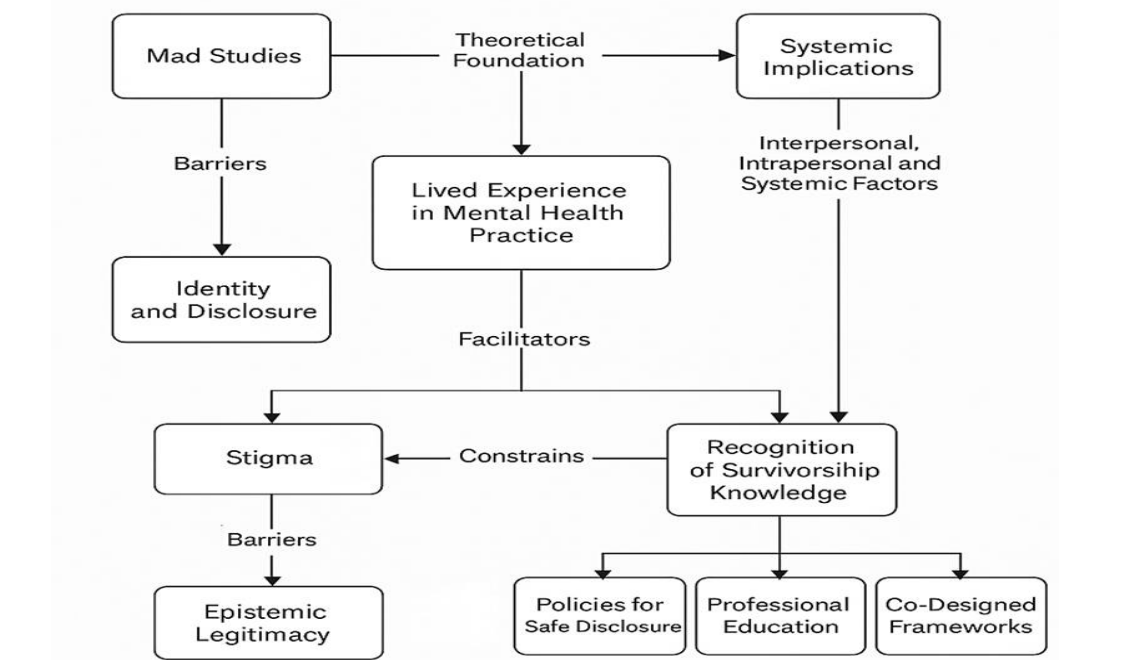


Figure 2: Thematic framework

Lived and Living Experience in Practice

Overview: Research on clinicians as a defined *lived experience (LLE)* workforce remains limited but is growing. Most studies since 2015 have focused on the issue however centred on peer work outside clinical roles, leaving a critical gap in understanding clinicians who integrate LLE into professional practice.

Identity and Legitimacy: Clinicians with LLE navigate complex intersections of professional identity, disclosure, and epistemic legitimacy within stigma-laden systems (Gupta et al., 2023). Building resilience alone is insufficient if structural stigma, risk-averse policies, and regulatory fears persist.

Intersectionality: Autoethnographic accounts show how embracing multiple identities promotes inclusivity, safety, and representation in therapeutic practice challenging systemic erasure of non-hegemonic identities (Khan, 2025).

Practice and Supervision: Safe, ethical integration of LLE requires non-judgmental supervision, reflective practice, and access to personal therapy to manage countertransference (Cleary & Armour, 2023).

LLE and Educational Pathways: LLE frequently motivates clinicians to enter the profession, yet disclosure in training or academia is often discouraged as professionally risky, sometimes described as a “kiss of death” (Devendorf, 2022; Davey, 2023).

Training and Systemic Change: Stigma and lack of specialised LLE training remain major structural barriers to professionalisation and workforce safety. A Dutch training program for psychotherapists with LLE demonstrated significant personal, relational, and organisational benefits, including increased empathy, trust, and self-awareness, while challenging biomedical and hierarchical models of mental health care (Karbouniaris et al., 2022).

Key Message: These findings affirm that valuing relational and emotional insight as legitimate professional knowledge fosters Recovery-Oriented Practice (ROP) and systemic reform. Recognising and supporting clinicians with lived and living experience enhances authenticity, resilience, and workforce sustainability. Addressing these issues requires systemic rather than individual solutions. When supported through inclusive leadership, reflective supervision, and recovery-oriented organizational cultures, disclosure can enhance empathy, authenticity, and mutual understanding between colleagues and consumers alike. It also repositions experiential knowledge as a legitimate and valued form of expertise, challenging traditional hierarchies of knowledge that privilege biomedical perspectives.