

SYSTEMATIC REVIEW **OPEN ACCESS**

Resilience in Practice: A Systematic Review of Coping Factors for Therapists With Lived Experience of Mental Ill Health

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ABSTRACT

Therapists with lived experience of mental ill health (MIH) bring unique insights and empathy to their practice. However, this dual identity creates significant challenges as they balance personal wellbeing with professional responsibilities. This systematic review explores coping strategies and resilience factors to support therapists with MIH. The review adhered to PRISMA guidelines and included studies using qualitative, quantitative, and mixed-methods approaches. Eligible studies focused on coping strategies and resilience mechanisms for therapists with MIH. Databases searched included Web of Science, MEDLINE, ASSIA, CINAHL, Embase, and APA PsycINFO, with additional forward and backward citation searches. Data synthesis employed a thematic narrative approach to identify recurring themes. The search and screening process resulted in 14 eligible studies of various designs. Key coping strategies identified were personal therapy, support systems, self-care practices, and reflective techniques. Personal therapy provided a safe space for therapists to process challenges and enhance their professional empathy. Support systems, including peer networks and nonjudgmental supervision, fostered resilience, although stigma and systemic barriers often reduced their accessibility. Reflective practices, such as journaling and supervision, were essential for promoting self-awareness and professional growth. Despite these strategies, therapists faced challenges in managing dual identities and navigating workplace stigma. The studies highlighted the professional value of lived experience in enhancing therapeutic relationships, but systemic support and organizational change were often lacking. This review emphasises the importance of systemic and institutional support in fostering resilience for therapists with MIH. Addressing stigma, providing resources for self-care and supervision, and integrating lived experiences into professional practice are critical. Future research should explore diverse populations and longitudinal perspectives to deepen understanding and inform inclusive practices. Enhancing support for therapists with MIH will ensure their sustained contributions to the mental health field.

1 | Introduction

Therapists with lived experience of mental ill health (MIH) hold a distinctive position within the landscape of mental health work, bringing a depth of insight and empathy to the therapy room. This dual identity, however, presents unique challenges as they

navigate the interplay between their professional responsibilities and personal wellbeing. Research so far indicates that a high proportion of therapists have experiences of MIH (Deutsch 1985; Gilroy et al. 2001; Grice et al. 2018). For instance, compared to the general population where depression is estimated to affect about 5% of the population (World Health Organization WHO 2023), a

Laura Wijnberg is the co-author and second reviewer.

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study looking at 1000 psychologists found that 62% experienced depression (Gilroy et al. 2002).

Given the increasing recognition of lived experience as an asset in mental health services (e.g., Williams and Haverkamp 2015; Boyd et al. 2016), understanding how therapists with MIH navigate their roles is vital. Identifying coping factors not only supports their resilience and professional longevity but also ensures the continued delivery of high-quality care to clients. The literature on therapist wellbeing has emphasized the importance of coping strategies such as self-care, supervision, and mindfulness in mitigating stress and burnout (e.g., Mahoney 1997; Dayal et al. 2014). However, research specific to therapists with lived experience of MIH remains limited, leaving critical gaps in understanding how these professionals manage their dual roles.

This systematic review aims to address the question: *What factors help therapists with lived experience of MIH cope in their professional role?* By synthesising evidence on coping strategies, resilience-building practices, and support mechanisms, this review seeks to identify pathways for promoting the wellbeing and professional sustainability of therapists with MIH.

2 | Methods

The systematic review adhered to PRISMA guidelines (Page et al. 2021), with a protocol registered on PROSPERO (CRD42024598173) outlining criteria, search strategies, and methodology.

2.1 | Eligibility Criteria

The inclusion and exclusion criteria for this systematic review were designed to ensure a focused examination of how therapists with lived experience of MIH manage their personal mental health while maintaining professional responsibilities. Studies were reviewed for relevance by comparing their characteristics—such as study design, participant details and findings—against predefined inclusion criteria. Focusing specifically on coping with MIH in therapists, rather than general workplace stress, for example, addresses the unique challenges faced by mental health professionals who navigate both personal mental health struggles and their professional roles. Including dissertations, first-person accounts and case studies enriches the review by capturing diverse, nuanced perspectives and experiences that may not be fully represented in traditional peer-reviewed studies. These sources provide valuable insights into the lived experiences of therapists, highlighting unique coping strategies and resilience-building approaches.

Inclusion criteria:

- Therapists with lived experience of MIH, including psychologists, psychotherapists and other mental health professionals providing psychological therapy.
- Must include coping mechanisms or resilience strategies for managing MIH in therapists, such as self-care, mindfulness, professional support, and emotional regulation.

- Studies or primary data sources that contribute original findings, such as peer-reviewed qualitative, quantitative or mixed-method studies, case studies or first-person accounts and dissertations.
- Published in the English language.

Exclusion criteria:

- Nontherapy mental health staff (e.g., nurses, social workers, psychiatrists, peer-support workers) or therapists without lived experience of MIH.
- Studies unrelated to coping with MIH in therapists (e.g., general workplace stress, vicarious trauma, or burnout prevention alone).
- Not original research studies, such as books, book chapters, reviews, editorials, and other reviews or meta-analyses.

2.2 | Information Sources

Web of Science, CINAHL, Applied Social Sciences Index and Abstracts (ASSIA), MEDLINE, Embase, and APA PsycINFO were the databases used to conduct the search. Given the limited literature in this area, “forward” searching (identifying articles that have cited papers identified through the database search) and “backward” searching (reviewing the reference list of identified papers) were employed to find additional articles for screening. Search dates included any publications from database inception until and inclusive of week 44 of 2024 (November 2, 2024).

2.3 | Search Strategy

The search strategy consisted of searching terms commonly found through preliminary examinations of relevant literature (e.g., scoping searches and other reviews such as Clement et al. 2014; Simionato and Simpson 2018; Vivolo et al. 2024) and using Boolean operators (“AND”/”OR”) and truncation symbols (“*”) to ensure all relevant studies could be captured. The search terms can be seen in Table 1. Filters were used where available to restrict the search to papers published in English and publication period. The development of the search strategy was informed by consultation with an academic librarian experienced in systematic reviews. Controlled vocabulary terms (e.g., MeSH terms for MEDLINE) and subject-specific headings were incorporated alongside free-text keywords to enhance comprehensiveness and precision. The strategy was iteratively refined through scoping searches and feedback from the review team.

2.4 | Selection and Data Collection Processes

All studies were imported to Covidence software (Covidence systematic review software 2025) for screening and extraction. Covidence is an online systematic review management platform that supports the review process by enabling independent screening of titles and abstracts, full-text review, data

TABLE 1 | Search terms.

Therapist		Lived experience		Mental ill health		Coping
“therapist*” OR “psychological therapist*” OR “psychotherapist*” OR “psychoanalyst*” OR “clinical psychologist*” OR “counseling psychologist*” OR “counselor*” OR “mental health professional*” OR “mental health practitioner*” OR “mental health clinician*” OR “psychological practitioner*” OR “practitioner*” OR “psychological professional*” OR “therapeutic professional*” OR “mental health care provider*” OR “psychoanalytic therapist*” OR “CBT therapist*” OR “mental health worker*” OR “psychological clinician*”	And	“lived experience” OR “personal experience” OR “firsthand experience” OR “experiential knowledge” OR “subjective experience” OR “personal encounter*” OR “individual experience” OR “personal history” OR “lived perspective” OR “life experience” OR “expert* by experience” OR “personal background”	And	“mental illness” OR “mental health issue*” OR “psychological distress” OR “mental disorder*” OR “emotional distress” OR “depression” OR “anxiety” OR “bipolar disorder” OR “schizophrenia” OR “PTSD” OR “severe mental illness” OR “personality disorder*” OR “OCD” OR “panic disorder*” OR “eating disorder*” OR “trauma” OR “psychosis” OR “mood disorder*” OR “mental health challenge*” OR “adjustment disorder*” OR “trauma-related disorder*” OR “psychological condition*” OR “psychiatric condition*” OR “emotional disorder*” OR “psychological problem*” OR “mental health problem*” OR “mental health disturbance*” OR “dysthymia” OR “disorder*” OR “psychiatric illness*”	And	“coping mechanism*” OR “resilience” OR “self-care” OR “support system*” OR “stress management” OR “emotional regulation” OR “mindfulness” OR “therapeutic practice*” OR “wellbeing” OR “peer support” OR “professional support” OR “adaptation” OR “stress reduction technique*” OR “self- help technique*” OR “self-management” OR “support network*” OR “organizational support” OR “clinical supervision” OR “mentorship” OR “professional guidance” OR “colleague support” OR “meditation” OR “relaxation technique*” OR “wellness practice*” OR “preventive strateg*” OR “burnout prevention” OR “health promotion” OR “personal development” OR “emotional support”

extraction, and resolution of conflicts between reviewers. The study selection was conducted through screening of titles and abstracts, then a full-text review, carried out by two reviewers (A. D. and L. W.) to determine eligibility according to the inclusion and exclusion criteria. A PRISMA flow diagram documents the selection process (Figure 1). Full-text data extraction was conducted by a single reviewer (A. D.) and checked by a second reviewer (L. W.) for accuracy. Data extraction covered study characteristics (e.g., aim, design, location, sample size), population details (e.g., age, gender, ethnicity, role), coping strategies (e.g., self-care, peer support, supervision). A summary table was then created to display key study characteristics and main findings related to coping with MIH (see Table 2). Although agreement rate between reviewers was high (98%; Cohen’s κ : 0.96), any discrepancies were resolved through discussion, with the option of consulting a third reviewer; however, including a third reviewer was not needed.

2.5 | Study Risk of Bias Assessment

The Mixed Methods Appraisal Tool, MMAT (Hong et al. 2018), was chosen for this systematic review because it is specifically designed to evaluate studies across diverse methodological designs, including qualitative, quantitative, and mixed-methods research. This flexibility was particularly important given the high heterogeneity among the included studies, with variation in their designs, methodologies, populations, settings, and outcomes. Using MMAT supported the systematic and equitable evaluation of all included studies, regardless of their methodology, enhancing the reliability and validity of the review’s findings. One nonempirical paper was assessed using the JBI Critical Appraisal Checklist for Text and Opinion Papers (McArthur et al. 2015) instead of the MMAT. The risk of bias assessment was conducted by two independent reviewers (A. D. and L. W.) and summarized in Table 3. The agreement rate between reviewers was 96% (Cohen’s κ : 0.95), with any

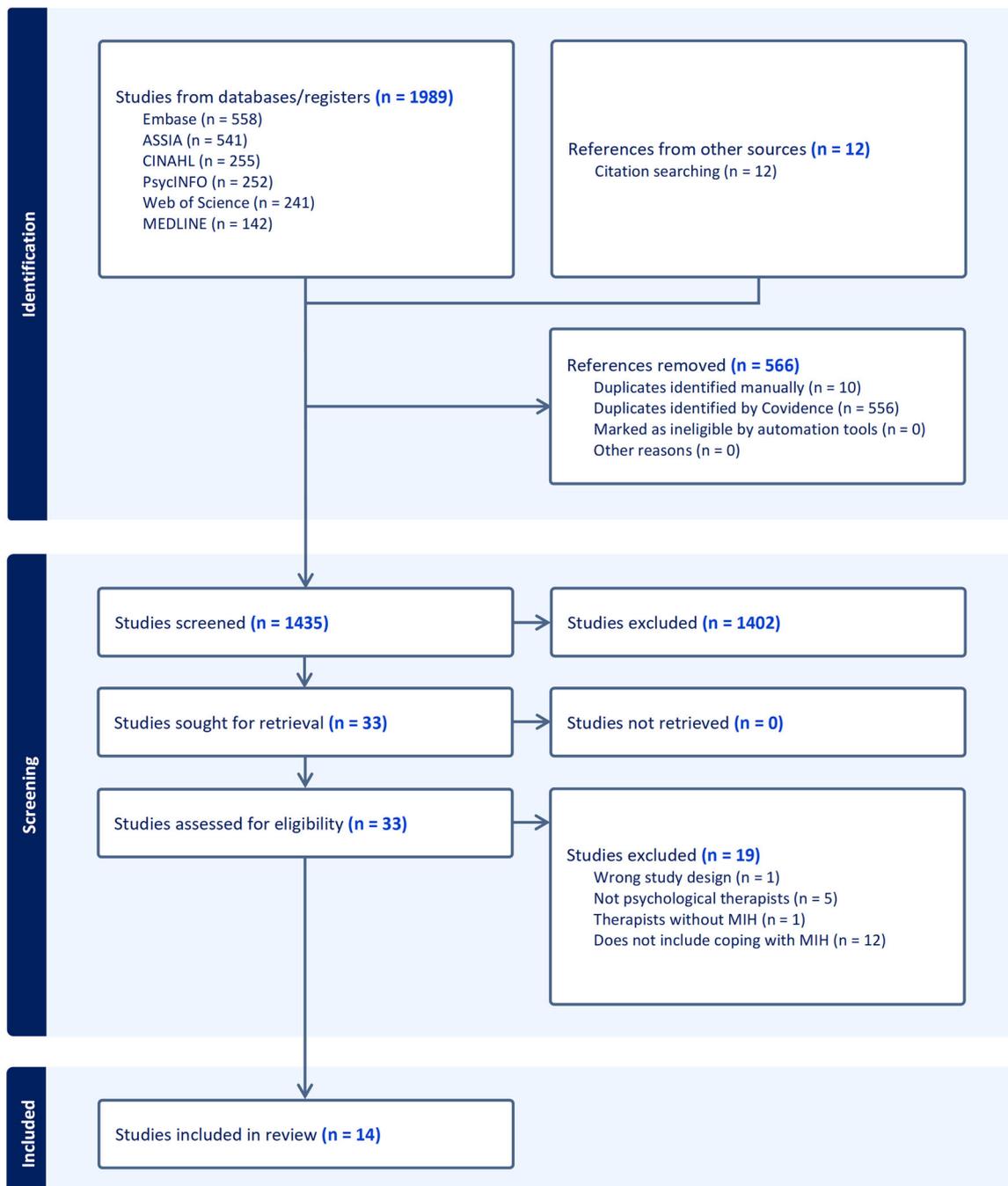


FIGURE 1 | PRISMA flow diagram.

discrepancies resolved through discussion, with the option of consulting a third reviewer, which was not needed ultimately.

2.6 | Synthesis Methods

Given the methodological diversity among the studies included in this review, a thematic narrative synthesis approach (Popay 2006; Mays et al. 2005; Boland et al. 2020) was employed to integrate the findings. This approach is well-suited to exploring and synthesising data from diverse studies, allowing for the identification of recurring themes and patterns relevant to the coping and resilience strategies of psychological therapists with lived experience of MIH. The synthesis began with a

preliminary analysis to develop initial thematic descriptions summarized from relevant study results, which were then grouped into thematic areas such as the importance of self-care, personal therapy, or support systems, listed in table form (Table 4).

To assess the robustness of the synthesis, sensitivity analyses were conducted (quality-driven and thematic sensitivity analysis). First, a quality-driven sensitivity analysis was performed by comparing the thematic synthesis with the results of the risk of bias appraisal. This involved checking whether excluding lower-quality studies, or those with particularly unique designs or narrow participant groups (e.g., single narrative accounts such as Vierthaler and Elliott 2020), would alter the key

TABLE 2 | Characteristics of included studies.

References	Location	Design	Aim	Participant characteristics	Main findings related to coping/resilience
Williams and Haverkamp (2015)	Canada	Qualitative: Interpretive description (ID)	To explore ethical implications of therapists' eating disorder (ED) history	N = 11 ED therapists (100% female, 28–61 years) with ED history	Self-knowledge of own ED history, self-disclosure, authenticity, training and supervision, personal therapy, self-reflection, maintaining own health, enhanced therapeutic relationship (empathy, connection, diminished power imbalance, compassion), maintaining healthy boundaries.
Cain (2000)	United States	Qualitative: Thematic analysis	Examine the impact of countertransference on therapeutic practices, the management of personal and professional challenges, and the stigma faced by therapists with psychiatric histories	N = 10 MH professionals incl. psychologists (70% female and 30% male; 32–57 years; White) with major depression, bipolar disorder, schizoaffective disorder, borderline personality disorder, and others	Use of self-awareness techniques and reflective practices, setting professional boundaries and prioritizing self-care, seeking support from supervisors and peers, although stigma often hindered open discussions, advocacy for reducing stigma to foster more inclusive professional environments.
Vierthaler and Elliott (2020)	United States	Combined first person narrative case study	To illustrate the lived experience of a psychologist with bipolar disorder	N = 1 psychologist (100% female; White) with bipolar disorder	Visibility of lived experience promotes recovery and destigmatisation, self-disclosure, transparency, strong support system, medication, personal therapy supportive work environments are crucial.
Elliott and Ragsdale (2020)	United States	Qualitative: Thematic analysis	To explore how therapists with self-identified mental illnesses perceive stigma, make decisions about disclosure, and understand the impact of their mental illness on their professional roles	N = 12 MH professionals incl. psychologists (75% female and 25% male; 36–63 years; White) with depression, PTSD, bipolar disorder, and borderline personality disorder (66% reported multiple diagnose)	Emphasis on self-care, including mindfulness, therapy, and professional peer support. Some participants found the act of helping others therapeutic, shifting focus away from their own struggles. Lived experiences enhanced participants' ability to connect with clients and understand their struggles.
Gilroy et al. (2002)	United States	Quantitative: Survey, χ^2 analyses	To examine the prevalence of depressive symptoms among psychologists, explore their	N = 425 psychologists (55% female and 45% male; 31–80 years; predominantly	Personal therapy was valued for providing insight, skill development, and emotional support. 31% of

(Continues)

TABLE 2 | (Continued)

References	Location	Design	Aim	Participant characteristics	Main findings related to coping/resilience
Mahoney (1997)	United States	Quantitative: Survey	To examine self-care patterns and the role of personal therapy in therapists reporting “personal problems”	N = 155 therapists (54.5% female and 45.5% male; mean 45.1 years; ethnicity not explicitly stated) with self-reported problems such as anxiety and depression	respondents used psychotropic medication, with psychiatrists prescribing most treatments. Increased empathy and therapeutic effectiveness resulting from depression. Suggestions for organizations promoting self-care activities, such as personal therapy, peer supervision, meditation. High levels of personal therapy use and positive evaluations of its impact; self-care activities incl. exercise, hobbies such as reading, leisure activities like vacations, peer supervision, reflective practices like keeping a personal diary or prayer or meditation, volunteering, attending church, receiving massages or chiropractic care; personal therapy.
Jost (2014)	United States	Qualitative: IPA	To understand how therapists with mental illness view their personal and professional experiences	N = 3 therapists (66.7% female and 33.3% male; 55–70 years; White) with psychiatric conditions	Psychotherapy, medication, sharing personal struggles in safe and confidential settings, lived experience as positively impacting practice (enhanced empathy, feeling connected), self-disclosure as a path to self-acceptance and healing.
Verbeek (2016)	United Kingdom	Qualitative: IPA	To explore experiences of therapists recovered from eating disorders	N = 9 therapists (100% female; 35–65 years, White) with personal history of ED/body image concerns	Empathic resonance, authenticity and self-disclosure, self-acceptance and respect, relaxation and reflection, supervision and personal therapy.
Gough (2016)	United Kingdom	Qualitative: IPA	To explore how mental health professionals with lived experience of mental illness perceive its influence on their roles, identities, and practices	N = 9 MH professionals incl. psychologists (100% female; 20–60 years; White)	Openness among colleagues reduces shame and promotes help-seeking. Positive impact of lived experience on relationship with the self. Positive impact of lived experience on the therapeutic relationship (enriched by

(Continues)

TABLE 2 | (Continued)

References	Location	Design	Aim	Participant characteristics	Main findings related to coping/resilience
Cleary and Armour (2022)	United Kingdom	Qualitative: IPA	Investigate the role of lived experience of mental health issues in shaping the practice of counselors and psychotherapists and their support in disclosing and valuing these experiences	N = 3 (66.7% female and 33.3% male; 32–58 years; White) counselors and psychotherapists with lived experience of mental health issues	<p>increased empathy, which makes people cope better in their role).</p> <p>Supervisory relationships provided essential support and a safe space for reflection. Nonjudgmental supervisors facilitated learning from mistakes and helped manage countertransference.</p> <p>personal therapy was transformative, fostering resilience and professional growth. Training programs and theoretical knowledge contributed to a deeper understanding of self and others, enhancing both personal and professional identity. Enhanced therapeutic relationships by fostering connectivity and trust.</p> <p>Careful disclosure created relational bonds and provided hope.</p>
Curry (2024)	United States	Qualitative: IPA	To explore the lived experiences of counseling graduate students diagnosed with chronic mental illness (CMI), focusing on stigma, support systems, self-efficacy, and the impact of their condition on their education and clinical practice	N = 8 counseling graduate students (gender not explicitly stated; 25–45 years; predominantly White) with CMI, incl. major depression, bipolar disorder, and generalized anxiety disorder	<p>Empathy, reliability, and a deeper understanding of client experiences were highlighted. Importance of external support systems, such as family, friends, and professional mentors. Institutional support (e.g., disability services) was inconsistently helpful. Use of personal therapy and mental health services was widespread.</p> <p>Participants relied on self-care practices, including mindfulness, exercise, and structured time management. A single supportive faculty member could positively influence resilience and success.</p>

(Continues)

TABLE 2 | (Continued)

References	Location	Design	Aim	Participant characteristics	Main findings related to coping/resilience
Murata (2010)	United States	Mixed methods: survey and qualitative interviews	To explore depression prevalence among psychologists and its impact on competency	N = 325 (survey) psychologists (59.1% female and 40.9% men; 28–85 years; predominantly White), N = 9 (interview) psychologists (55.6% female and 44.4% male, 50–70 years; predominantly White)	Unsupportive or judgmental interactions with peers and instructors increased stress and self-doubt. Enhanced understanding of clients' and own issues (empathy, compassion, flexibility), coping skills (e.g., exercise, meditation), medication, reducing caseload, lived experience as meaningful/valuable, importance of psychotherapy/treatment, normalizing depression, deeper insight into self, increased mindfulness, importance of support system.
Warren et al. (2013)	United States	Qualitative: Thematic analysis	To examine how personal eating pathology affects treatment of patients	N = 139 ED professionals incl. psychologists (96.4% female, 3.6% male; 25–65 years, predominantly White) with histories of ED	Increased empathy/relational understanding, importance of personal recovery through personal therapy, self-awareness, understanding and respecting own limits, self-disclosure, support system, continuing education and improving knowledge, managing personal and professional boundaries.
Boyd et al. (2016)	United States	Mixed methods: Quantitative (descriptive analysis) and qualitative data (thematic analysis) collected via survey	Document the existence and contributions of competently functioning mental health providers with lived experience to understand their challenges and strengths and provide insights for creating an inclusive and supportive work environment	N = 77 MH professionals incl. psychologists (age, gender and ethnicity not collected to preserve anonymity) with lived experience of MIH incl. PTSD, depression, anxiety disorders, and bipolar disorder	Enhanced empathy, therapeutic understanding, and hope for clients and therapists. Prioritized self-care as essential to professional readiness. Emphasis on personal wellness practices, connecting with peer networks, and using support systems.

TABLE 3 | Quality assessment of included studies.

Tool	Study designs	Quality criteria	Williams and Haverkamp (2015)		Vierthaler and Elliott (2020)		Elliott and Ragsdale (2020)		Gilroy et al. (2002)		Mahoney (1997)		Jost (2014)		Verbeek (2016)		Gough (2016)		Cleary and Armour (2022)		Curry (2024)		Murata (2010)		Warren et al. (2013)		Boyd et al. (2016)	
			Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
MMAT	Screening questions	S1. Are there clear research questions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		S2. Do the collected data allow to address the research questions?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		1.2. Are the qualitative data collection methods adequate to address the research question?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		1.3. Are the findings adequately derived from the data?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		1.4. Is the interpretation of results sufficiently substantiated by data?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
		1.5. Is there coherence between qualitative data sources, collection, analysis, and interpretation?	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
	Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?							Y																			

(Continues)

TABLE 3 | (Continued)

Tool	Study designs	Quality criteria	Williams and Haverkamp (2015)	Cain (2000)	Vierthaler and Elliott (2020)	Elliott and Ragsdale (2020)	Gilroy et al. (2002)	Mahoney (1997)	Jost (2014)	Verbeek (2016)	Gough (2016)	Cleary and Armour (2022)	Curry (2024)	Murata (2010)	Warren et al. (2013)	Boyd et al. (2016)	
		4.2. Is the sample representative of the target population?				Y	Y	Y									
		4.3. Are the measurements appropriate?				Y	Y	Y									
		4.4. Is the risk of nonresponse bias low?				Y	Y	Y									
		4.5. Is the statistical analysis appropriate to answer the research question?				Y	Y	Y									
Mixed methods		5.1. Is there an adequate rationale for using a mixed methods design to address the research question?												Y			Y
		5.2. Are the different components of the study effectively integrated to answer the research question?												Y			Y
		5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?												Y			Y
		5.4. Are divergences and inconsistencies between												Y			Y

(Continues)

TABLE 3 | (Continued)

Tool	Study designs	Quality criteria	Williams and Haverkamp (2015)	Cain (2000)	Vierthaler and Elliott (2020)	Elliott and Ragsdale (2020)	Gilroy et al. (2002)	Mahoney (1997)	Jost (2014)	Verbeek (2016)	Gough (2016)	Armour (2022)	Curry (2024)	Murata (2010)	Warren et al. (2013)	Boyd et al. (2016)
		quantitative and qualitative results adequately addressed?														
		5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?														
JB1		1. Is the source of the opinion clearly identified?			Y											
CACTO		2. Does the source of the opinion have standing in the field of expertise?			Y											
		3. Are the interests of the relevant population the central focus of the opinion?			Y											
		4. Is the stated position the result of an analytical process, and is there logic in the opinion expressed?			Y											
		5. Is there reference to the extant literature?			Y											
		6. Is any incongruence with the literature/sources logically defended?			N/A											

Note: N, no; N/A, not applicable; Y, yes.

TABLE 4 | Themes identified within included studies.

References	Self-care	Personal therapy	Support systems	Enhanced empathy and connection	Boundaries and dual identity	Self-disclosure, advocacy, destigmatisation	Reflective practices
Williams and Haverkamp (2015)	Y	Y	Y	Y	Y	Y	Y
Cain (2000)	Y	N	Y	N	Y	Y	Y
Vierthaler and Elliott (2020)	N	Y	Y	N	N	Y	N
Elliott and Ragsdale (2020)	Y	Y	Y	Y	N	Y	Y
Gilroy et al. (2002)	Y	Y	Y	N	N	N	Y
Mahoney (1997)	Y	Y	Y	N	N	N	Y
Jost (2014)	N	Y	N	Y	N	Y	N
Verbeek (2016)	Y	Y	Y	Y	N	Y	Y
Gough (2016)	N	N	Y	Y	N	Y	N
Cleary and Armour (2022)	N	Y	Y	Y	Y	Y	Y
Curry (2024)	Y	Y	Y	Y	N	N	Y
Murata (2010)	Y	Y	Y	Y	Y	Y	Y
Warren et al. (2013)	N	Y	Y	Y	Y	Y	Y
Boyd et al. (2016)	Y	N	Y	Y	N	N	Y

Note: N, no; Y, yes.

findings. Second, a thematic sensitivity analysis was conducted by re-examining the data according to study type (qualitative, quantitative, or mixed methods), participant characteristics (such as therapist role, gender, or mental health condition), and geographic context. This process allowed us to test whether particular themes were driven by specific subgroups or methodological approaches. Together, these sensitivity analyses support the robustness of the synthesis and provide reassurance that the findings reflect broad and recurring patterns rather than artefacts of individual study designs or samples.

Risk of reporting bias was performed by reviewing discrepancies between stated aims and reported results, and potential limitations were noted. Themes identified were assessed for certainty using a modified Grading of Recommendations, Assessment, Development, and Evaluation (GRADE) approach (Kavanagh 2009; Higgins et al. 2019). This thorough and systematic approach ensured that the findings are both credible and relevant to the context of therapists with lived experience of MIH. Both the synthesis and sensitivity analyses were conducted by A. D. only.

3 | Results

3.1 | Study Selection, Characteristics, and Quality Appraisal

In total, 14 studies were included in the review following the screening and review process. Figure 1 summarises the study selection process, while Table 2 includes the identified studies with their characteristics. Of the 14 studies, 9 studies used qualitative methods to explore topics around therapist mental health (Cain 2000; Warren et al. 2013; Jost 2014; Williams and Haverkamp 2015; Gough 2016; Verbeek 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022; Curry 2024), 2 employed a mixed-methods design (Murata 2010; Boyd et al. 2016), 2 were quantitative studies (Mahoney 1997; Gilroy et al. 2002), and 1 was a first-person narrative account (Vierthaler and Elliott 2020). Three studies focused on eating disorders (ED) therapists with ED histories (Warren et al. 2013; Williams and Haverkamp 2015; Verbeek 2016), one study looked at graduate counseling students with chronic MIH conditions (Curry 2024), while the others had a focus on psychotherapists experiencing mood disorders, personality disorders, and trauma-related disorders such as PTSD (Mahoney 1997; Cain 2000; Murata 2010; Jost 2014; Boyd et al. 2016; Gough 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022; Vierthaler and Elliott 2020). Table 3 summarises the quality assessment for each study.

3.2 | Results of Syntheses

A thematic narrative synthesis revealed 7 common themes among the 14 studies (Table 4).

3.2.1 | Self-Care

In the nine studies covering this theme, self-care practices were viewed as essential for managing stress, promoting well-being,

and fostering resilience. Mindfulness, physical exercise, meditation, hobbies, personal therapy, and structured time management were commonly emphasized as self-care practices. These strategies helped therapists maintain mental health and professional readiness. However, the effectiveness of self-care practices appeared to vary depending on the availability of time, resources, and institutional support. For instance, Boyd et al. (2016) found that therapists within structured organizations like the Veterans Association (VA) had more access to resources for self-care, whereas Curry (2024) noted that graduate students often struggled to implement self-care amidst academic pressures. Cain (2000) noted that stigma and fear of being perceived as less competent often discouraged therapists from openly prioritizing or discussing self-care needs.

Out of the nine studies contributing to this theme, two were quantitative (Mahoney 1997; Gilroy et al. 2002), two were mixed methods (Murata 2010; Boyd et al. 2016), and five were qualitative (Cain 2000; Williams and Haverkamp 2015; Verbeek 2016; Elliott and Ragsdale 2020; Curry 2024). Contributions to the theme of self-care emerged from both qualitative and mixed methods studies, consistently describing self-care as a foundational coping strategy for therapists with lived experience of mental ill health (MIH). For example, Curry (2024) found that counseling graduate students used structured routines and physical exercise to manage academic and personal demands. Elliott and Ragsdale (2020) identified mindfulness and peer support as essential elements of self-care, often integrated into their clinical identities. Verbeek (2016) similarly highlighted the importance of relaxation, reflection, and maintaining personal boundaries as key practices in sustaining recovery. Murata (2010) and Boyd et al. (2016) contributed qualitatively to this theme through participants' descriptions of coping and resilience strategies. However, their quantitative components did not include formal measurement or statistical analysis of self-care behaviors.

Quantitative findings from Mahoney (1997) and Gilroy et al. (2002) provided insight into the prevalence of self-care practices and perceived benefits. Mahoney (1997) surveyed 155 psychotherapists at a professional conference using a self-report questionnaire with 4-point Likert scale items. Nearly 90% reported having engaged in personal therapy and endorsed additional self-care strategies such as exercise, journaling, spiritual activities, and taking time off work. Most participants strongly agreed that these practices improved both their personal resilience and clinical performance, although the study did not conduct inferential statistical analyses to test significance. Gilroy et al. (2002) conducted a national survey of 425 counseling psychologists, primarily focused on experiences of depression. While the primary emphasis was on personal therapy and use of psychotropic medication (31% reported using the latter) as forms of self-care, the authors also discussed the importance of broader organizational support for self-care. They advocated for systemic efforts to promote activities such as peer consultation and mindfulness, although these practices were not directly measured in the survey.

3.2.2 | Personal Therapy

Personal therapy was highly valued across 11 studies for its ability to foster self-awareness, emotional regulation, and

personal recovery. It provided a safe space for therapists to reflect on their struggles, develop coping strategies, and enhance their professional skills. While most studies emphasized the benefits of therapy, Mahoney (1997) and Curry (2024) highlighted potential barriers such as cost, time, and stigma, particularly among early-career therapists and students. Despite its widespread endorsement, the extent to which organizations supported therapists' access to therapy was underexplored, representing a gap in the literature.

Of the 11 studies, 1 was mixed methods (Murata 2010), 2 were quantitative (Mahoney 1997; Gilroy et al. 2002), 1 was a first-person narrative account (Vierthaler and Elliott 2020), and 7 were qualitative (Warren et al. 2013; Jost 2014; Williams and Haverkamp 2015; Verbeek 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022; Curry 2024). Across qualitative and mixed-methods studies, personal therapy was consistently described as a transformative process supporting emotional regulation, reflective practice, professional identity development, and enhanced therapeutic effectiveness. Therapy helped therapists manage MIH symptoms, establish healthy boundaries, and build resilience. Graduate students in particular highlighted therapy as a tool for navigating academic and clinical pressures (Curry 2024). The quantitative studies by Mahoney (1997) and Gilroy et al. (2002) indicated high uptake of personal therapy among therapists (e.g., 84.7% in Mahoney 1997 study and 72% in Gilroy et al. 2002 study), with respondents reporting positive outcomes such as increased insight and professional preparedness. While they described the frequency and subjective benefits of personal therapy (e.g. 74% found therapy helpful in Mahoney [1997]), they did not report statistically significant associations between therapy use and specific resilience outcomes. However, all indicated a positive direction of association, with personal therapy perceived as beneficial for coping, self-awareness, and professional development. These findings, alongside Murata (2010) mixed-methods data (e.g., 2/3 of psychologists who experienced depression sought formal treatment and most found it beneficial), suggest a positive but not statistically quantified association between personal therapy and therapist well-being. Overall, personal therapy was widely endorsed as a valuable support mechanism contributing to both personal resilience and professional functioning among therapists with lived experience of MIH.

3.2.3 | Support Systems

Support systems were identified across 13 studies. Of the 13 studies, 2 were quantitative (Mahoney 1997; Gilroy et al. 2002), 2 were mixed methods (Murata 2010; Boyd et al. 2016), 1 was a first-person narrative account (Vierthaler and Elliott 2020), and 8 were qualitative (Cain 2000; Warren et al. 2013; Williams and Haverkamp 2015; Gough 2016; Verbeek 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022; Curry 2024). Each study described the use or value of supervisory, peer, collegial, or other, noninstitutional support. The qualitative and narrative account highlighted supervisory relationships, peer networks, and institutional support (when effective) as crucial for coping and resilience. Nonjudgmental supervisors and peer supervision provided safe spaces for reflection and growth, and supervision

consistently stood out as an essential space for therapists to reflect and learn. Personal networks comprising of family, friends, partners, and mentors were key sources of encouragement and stability as well. From the quantitative side, Mahoney (1997) reported that over 60% of respondents engaged in peer supervision as a form of self-care, while Boyd et al. (2016) highlighted the role of peer networks and inclusive organizational culture in supporting mental health professionals within the VA. Murata (2010) and Gilroy et al. (2002) also noted the role of collegial and informal supports in recovery from depression. However, none of the studies tested for statistically significant associations between support system use and psychological or professional outcomes such as resilience, burnout, or clinical effectiveness. While no quantitative studies tested for statistical associations, both qualitative data and descriptive trends suggest support systems are consistently perceived as protective and enabling factors. However, stigma within professional environments sometimes hindered therapists from seeking support, as noted by Cain (2000) and Elliott and Ragsdale (2020). Organizational culture played a critical role in determining the efficacy of support systems, with Boyd et al. (2016) identifying institutional support as a resilience-enhancing factor within the VA system. Conversely, Curry (2024) reported that graduate students often faced a lack of understanding from faculty, which negatively impacted their resilience. These findings suggest that systemic factors significantly influence the accessibility and utility of support systems.

3.2.4 | Enhanced Empathy and Connection

Lived experience was seen as a professional asset, enhancing empathy, compassion, and the ability to connect with clients. Therapists reported that their experiences allowed them to better understand and relate to their clients' struggles, fostering stronger therapeutic relationships. These factors, in turn, provided therapists with an enhanced sense of resilience and wellbeing, as well as a deeper insight into their own identities. Of the 14 papers included, 10 identified this sense of enhanced empathy and connection resulting from therapists' lived experience of MIH—two were mixed methods (Boyd et al. 2016; Murata 2010) and eight were qualitative (Warren et al. 2013; Jost 2014; Williams and Haverkamp 2015; Gough 2016; Verbeek 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022; Curry 2024). Across the data, therapists reported that their own struggles enabled them to approach clients with greater humility, nonjudgment, and emotional attunement. Lived experience was often seen as a resource that fostered therapeutic authenticity and deepened the client-therapist alliance. Several studies described how therapists were able to “sit with” difficult emotions, tolerate silence, and validate client pain without resorting to premature problem-solving. Therapists often saw this as increasing the safety and effectiveness of the therapeutic space. However, some also recognized potential risks, including over-identification and blurred emotional boundaries, particularly in early career stages or when supervision was insufficient. No studies within this theme used quantitative methods to measure empathy or therapeutic connection, and no statistical associations were reported. Nonetheless, the qualitative and mixed methods findings consistently indicated a positive direction of effect, with lived experience

perceived as strengthening therapeutic presence and relational capacity when well-integrated.

3.2.5 | Boundaries and Dual Identity

Five studies found that therapists need to create clear boundaries between their personal and professional lives. This included managing caseloads, respecting personal limits, and practicing careful self-disclosure while navigating this dual identity as therapists with MIH. While these strategies were effective, Cleary and Armour (2022) noted that organizational cultures often failed to support boundary-setting, leaving therapists to navigate these challenges independently. This highlighted a need for systemic changes to foster environments that respect and encourage healthy professional boundaries.

Of the five studies included in this theme, one was mixed methods (Murata 2010) and four were qualitative (Cain 2000; Warren et al. 2013; Williams and Haverkamp 2015; Cleary and Armour 2022). Across the findings, participants commonly described a heightened awareness of boundary challenges because of lived experience, including emotional over-involvement, difficulties separating personal and professional experiences, and uncertainty around self-disclosure. No quantitative studies reported on professional boundary management, nor were any statistical associations tested. However, qualitative evidence consistently indicated that lived experience prompted both greater boundary challenges and deeper boundary insight, with effective regulation dependent on self-awareness and organizational supports.

3.2.6 | Self-Disclosure, Advocacy, and Destigmatisation

Ten studies highlighted how careful, strategic self-disclosure can normalize mental health struggles, foster trust, and be a powerful tool for advocacy and destigmatisation. Out of the 10 studies, 1 was mixed methods (Murata 2010), 1 was a combined first-person narrative (Vierthaler and Elliott 2020), and 8 were qualitative (Cain 2000; Warren et al. 2013; Jost 2014; Williams and Haverkamp 2015; Gough 2016; Verbeek 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022). Together, these sources explored the nuanced decisions therapists made about whether, when, and how to disclose their lived experience of mental ill health. Most participants described a careful and often minimal approach to disclosure, shaped by context, supervision, and therapeutic purpose. While disclosure to clients was rare and typically symbolic, it was sometimes used to build alliance or normalize distress. Disclosure in professional spaces (e.g., with peers, supervisors, or trainees) was more common and occasionally took the form of advocacy. Several therapists described reclaiming their narrative as a form of empowerment and destigmatisation, particularly when embedded within supportive systems. Stigma remained a major barrier across studies. Participants expressed concern about being seen as unfit or impaired, particularly in hierarchical settings such as clinical training or institutional mental health systems. Supervision played a key role in helping therapists process these concerns and arrive at disclosure decisions that

aligned with their ethical and emotional boundaries. No quantitative studies assessed disclosure or advocacy, and no statistical associations were reported. However, the direction of evidence was consistently positive: self-disclosure, when used reflectively and in safe contexts, was associated with increased authenticity, professional empowerment, and systemic destigmatisation.

3.2.7 | Reflective Practices

Reflective practices, such as journaling, meditation or mindfulness, supervision, and continued education and enhanced training, were central to building resilience. These activities helped therapists process their experiences, learn from challenges, and develop a deeper understanding of themselves and their clients. However, the studies varied in the extent to which they explored systemic support for reflective practices, leaving questions about how organizations could better facilitate these activities.

For this theme, 11 studies made contributions—2 were mixed methods (Murata 2010; Boyd et al. 2016), 2 were quantitative (Mahoney 1997; Gilroy et al. 2002), and 7 were qualitative (Cain 2000; Warren et al. 2013; Williams and Haverkamp 2015; Verbeek 2016; Elliott and Ragsdale 2020; Cleary and Armour 2022; Curry 2024). Across these studies, reflective practice was described as a central process that enabled therapists to ethically and emotionally integrate their lived experience of MIH into clinical work. Qualitative findings revealed that therapists engaged in supervision, journaling, and self-reflection to track internal responses, manage counter-transference, and maintain therapeutic boundaries. Reflection was used to process identity concerns, manage shame, and consider when and how lived experience could be used ethically in practice. Several studies described how reflective practice contributed to professional growth and resilience, helping therapists reframe their personal histories as assets. The mixed-methods studies supported these findings, particularly through participants' descriptions of reflective peer networks and recovery-oriented supervision models. While Mahoney (1997) and Gilroy et al. (2002) reported on related practices such as therapy, journaling, and supervision in descriptive terms, no quantitative study directly measured reflective practice as a construct, and no inferential statistical tests were conducted linking reflection to outcomes. Nonetheless, across all studies, there was a consistently positive direction of effect: reflective practice was experienced as both a protective factor and a growth mechanism for therapists with lived experience of MIH.

3.3 | Sensitivity Analyses

Quality-driven sensitivity analysis was based on the quality assessment tool results. Due to the high quality of the studies included, no studies could be excluded. However, excluding studies with unique designs or narrow participant groups (e.g., Vierthaler and Elliott 2020) did not significantly alter the synthesis, indicating that the core findings are robust and not overly reliant on any one study.

Thematic sensitivity analysis revealed relatively consistent themes across various designs and participant characteristics. Some differences emerged based on study design and participant demographics, though. For example, IPA provided deeper insights into experiences of authenticity and self-acceptance, while quantitative studies focused on prevalence and patterns in MIH issues and coping strategies. Gender-specific themes, such as self-disclosure and authenticity, were more prevalent in female-focused studies, although the majority of studies included predominantly female participants. Participants with mood disorders highlighted the critical roles of therapy and medication.

3.4 | Certainty of Evidence

The GRADE (Grading of Recommendations, Assessment, Development, and Evaluation) approach is a systematic framework for assessing the quality of evidence across studies (Kavanagh 2009; Higgins et al. 2019). The identified themes in this systematic review were evaluated for their strength of evidence, resulting in moderate or high ratings (see Table 5). The modifications to the traditional GRADE framework allowed for the inclusion of qualitative and mixed-methods studies, focusing on thematic synthesis and the quality of underlying evidence rather than statistical metrics. This approach ensures a fair assessment of the diverse methodologies used in the studies while maintaining rigor in evaluating their contributions to the review (Prasad 2024).

The strongest evidence supports the role of personal therapy, support systems, and reflective practices in fostering resilience among therapists with lived experiences of MIH. Personal therapy (identified in 11/14 studies) consistently emerged as a cornerstone for promoting self-awareness, emotional regulation, and professional growth, as seen in studies like Gilroy et al. (2002), Mahoney (1997), and Curry (2024). These studies emphasise therapy's value in providing a safe space for therapists to process their struggles while enhancing their capacity to empathise with clients. The consistency across these studies and their direct alignment with the research question contribute to the high rating for this theme, despite some limitations in precision due to small sample sizes.

TABLE 5 | Modified GRADE approach for synthesized themes.

Theme	Modified GRADE rating
Self-care	Moderate
Personal therapy	High
Support systems	High
Enhanced empathy and connection	Moderate
Boundaries and dual identity	Moderate
Self-disclosure: Advocacy and destigmatisation	Moderate
Reflective practices	High

Similarly, support systems such as nonjudgmental supervisors, peer networks, and institutional backing were highly rated, with studies like Murata (2010) and Boyd et al. (2016) highlighting their role in providing stability and promoting resilience. These findings were consistent across varied settings, including institutional contexts like the VA and the NHS, bolstering confidence in this theme. The inclusion of reflective practices, such as journaling, supervision, and continuing education (Cain 2000; Williams and Haverkamp 2015), further underscores their importance in enhancing self-awareness and processing professional challenges. These themes received high ratings due to consistent findings across diverse studies and their clear relevance to the review question.

Other themes, including self-care, enhanced empathy, managing boundaries, and self-disclosure, were rated as moderate due to limitations in methodology and reporting. Self-care, while universally acknowledged as critical (e.g., Cain 2000; Boyd et al. 2016; Elliott and Ragsdale 2020), faced challenges in precision due to reliance on self-reported data and small sample sizes. Additionally, systemic barriers to implementing self-care, such as workload and organizational culture, were under-explored, leaving gaps in how these findings can be applied across broader contexts.

The theme of enhanced empathy and connection was well-supported by studies like Murata (2010) and Warren et al. (2013), which highlighted how lived experiences of mental illness deepen therapists' understanding of client struggles. However, findings were primarily derived from self-reported accounts, introducing potential biases. Additionally, the emphasis on positive outcomes may overshadow the emotional toll of lived experience on therapists, limiting the precision of the evidence.

Managing boundaries and professional identity was another moderately rated theme. Studies like Cleary and Armour (2022) and Williams and Haverkamp (2015) shed light on the balance therapists must maintain to protect their wellbeing while remaining effective in their roles. However, variability in approaches to boundary management across different contexts led to some inconsistency in findings. Similarly, the theme of self-disclosure showed high relevance for destigmatisation and advocacy, as noted in Jost (2014) and Elliott and Ragsdale (2020), but concerns about professional repercussions and selective reporting of positive experiences introduced bias, reducing the strength of this evidence.

4 | Discussion

4.1 | Interpretation of Results

The results of the synthesis reveal the complex and intricate nature of coping mechanisms in therapists with lived experience of MIH, combining personal, professional, and systemic factors. The findings indicate that self-care, personal therapy, managing boundaries and accessing support systems both in and outside of the workplace represent key elements in enhancing resilience in therapists with MIH. However, systemic

barriers such as cost, time constraints, and stigma might hinder therapists' accessibility to these strategies. Supportive relationships with supervisors, peers, and institutions can foster resilience, while stigma and organizational shortcomings often limit the effectiveness of these support structures. The value of lived experience in increasing empathy, therapeutic connections, and professional growth was also highlighted in most studies included. Nevertheless, this often was balancing against emotional toll and challenges of maintaining boundaries and managing dual identities as professionals with lived experience of MIH.

Findings on support systems as key resilience factors were consistent across qualitative and mixed-methods studies. The absence of longitudinal studies limits insights into how resilience strategies develop throughout therapists' careers. Including grey literature highlighted more systemic challenges, such as institutional barriers to self-care, which were more prominent in unpublished studies (e.g., Gough 2016; Curry 2024). Geographic analysis revealed consistent findings on support systems; however, institutional resources were more emphasized in US-based studies (e.g., Boyd et al. 2016), while peer supervision dominated UK contexts (e.g., Gough 2016). Excluding single-narrative studies (Vierthaler and Elliott 2020) did not alter the key themes, supporting the robustness of findings on self-disclosure and advocacy.

As noted by Cain (2000), therapists often face heavy caseloads and time constraints, leaving little opportunity for self-care or reflective practices. This systemic issue is compounded by the stigma surrounding mental health in many professional environments, which may deter therapists from seeking support or accessing necessary resources. Cleary and Armour (2022) found that the effectiveness of supervisory relationships depended heavily on the attitudes and training of the supervisors themselves. Nonjudgmental supervisors who provided a safe space for reflection were instrumental in fostering resilience. However, organizations often failed to train supervisors to recognize and address the unique challenges faced by therapists with MIH. The geographic concentration of studies in Western contexts, particularly the United States and the United Kingdom, further highlights systemic barriers that may differ in other cultural settings.

4.2 | Limitations of Evidence

The potential for reporting bias is evident in most studies, as they rely on self-reported data. Participants may underreport struggles or overemphasise positive outcomes to align with professional norms or personal comfort. For instance, studies like Warren et al. (2013) and Gough (2016) focus heavily on the advantages of lived experience, potentially underexploring its negative impacts. This bias requires caution in interpreting findings, as the perspectives of less forthcoming or more stigmatized individuals may be underrepresented.

Qualitative methods, particularly IPA, were commonly used to capture the nuanced experiences of therapists (e.g., Gough 2016; Cleary and Armour 2022). These approaches provided rich, in-depth insights but were often limited by

small, homogeneous samples that restricted generalizability. For example, Verbeek (2016) and Warren et al. (2013) focused exclusively on female therapists, which narrowed the applicability of findings. Mixed-methods studies, such as Boyd et al. (2016) and Murata (2010), offered a broader perspective but sometimes lacked integration between qualitative and quantitative components.

The limitations affecting the strength of evidence across the identified themes might primarily stem from methodological biases, small sample sizes, potential publication bias, and a lack of triangulation. Many of the included studies relied heavily on qualitative interviews and self-reported data, introducing risks such as social desirability bias or selective reporting, which could result in underrepresentation of challenges or negative experiences. Furthermore, the limited participant pools in many studies reduced the precision and generalizability of findings, particularly for themes like empathy and boundary management, which may vary significantly across different populations and contexts.

Regarding potential publication bias, reflective participants who volunteered for these studies were more likely to disproportionately emphasise positive outcomes of lived experience, potentially skewing the results toward more favorable interpretations, which would be more likely to be published in turn. This issue is compounded by the lack of triangulation in most studies, as few incorporated multiple data sources or validation methods to strengthen the credibility of their findings. The absence of triangulation means that conclusions are often drawn from a single perspective, limiting the robustness of the evidence.

Recruitment strategies varied widely in transparency and rigor, with many studies relying on convenience samples or professional networks (e.g., Mahoney 1997; Cain 2000). While these approaches facilitated participant access, they introduced potential biases, such as overrepresentation of therapists willing to disclose their experiences.

Most studies are geographically concentrated in the United States, with only a few offering perspectives from the United Kingdom or specific institutional settings like the NHS or the VA. This geographic homogeneity limits the generalizability of findings, as organizational cultures and attitudes toward mental health vary significantly across regions. An additional factor to consider is the structural difference between UK and US health systems, which likely shapes therapists' access to support. In the UK, NHS provision offers some access to funded therapy, albeit often limited by waiting times, whereas in the US, privatized healthcare means access is largely dependent on insurance coverage and personal resources. These differences may explain why UK studies emphasized peer supervision and collegial support, while US studies highlighted institutional programs or individual self-care. Such systemic contrasts underline the importance of interpreting resilience strategies within their wider healthcare context.

Many studies also focus on therapists in specialized roles, such as eating disorder treatment providers (e.g., Williams and Haverkamp 2015; Verbeek 2016) or those within specific

institutional contexts, such as Boyd et al. (2016) focus on VA professionals. Such specialization provides valuable insights into niche areas but limits the breadth of applicability for therapists in more generalized roles.

The lack of ethnic diversity among participants across all studies further limits the generalizability of findings. Participants across studies were predominantly or entirely from a White background, evidencing a startling underrepresentation of other ethnicities among this cohort. Therapists from minority ethnic backgrounds may face compounded stigma due to intersecting identities, as they navigate both the broader societal stigma surrounding mental illness and biases within professional or organizational contexts. It is also important to acknowledge that the lack of ethnic diversity observed in the included studies may not only reflect sampling limitations but also structural barriers within the profession itself. In the United Kingdom, for example, evidence shows that only around 7.4% of qualified clinical psychologists in England identify as being from minority ethnic backgrounds, a proportion that remains lower than the representation of these groups in the wider population (Griffith 2022). Broader reports also highlight ongoing sociocultural and economic barriers that continue to limit opportunities for aspiring psychologists from minoritised backgrounds (British Psychological Society 2021). These entrenched inequities in training access and professional pathways are likely mirrored in the research evidence base, underscoring the need for systemic efforts to ensure that the experiences of minority therapists are represented in both research and practice. By failing to account for ethnicity, these studies miss an opportunity to explore how therapists from diverse backgrounds might experience resilience, stigma, and support differently. Future research should prioritize including ethnically diverse samples and examining how cultural and racial identity intersect with lived experience to inform resilience strategies and professional practice. This inclusion would provide a more comprehensive and equitable understanding of the factors influencing therapists' lived experiences.

Another important limitation relates to gender representation. Across the included studies, participants were not only predominantly White but also predominantly female. This imbalance restricts the extent to which findings can be generalized to male or gender diverse therapists, whose experiences of stigma, disclosure, and coping may differ significantly. Future research should therefore seek to include more diverse gender identities and explore how gendered expectations intersect with lived experience to shape resilience and professional practice.

Across studies, resilience strategies commonly included supervision, personal therapy, selective self-disclosure, and fostering self-awareness. For instance, Verbeek (2016) and Gough (2016) highlight the importance of reflective practice and cautious self-disclosure, respectively, in managing countertransference and maintaining boundaries. Others, such as Curry (2024), emphasise the role of external support systems and mentorship in fostering resilience, particularly among students and early-career therapists. However, these strategies often vary in their effectiveness based on individual, organizational, and cultural

contexts, pointing to the need for tailored approaches to supporting therapists.

4.3 | Limitations of Review Process

One limitation of the review process involved the inclusion of methodologically diverse studies. While the inclusion of qualitative, quantitative, and mixed-methods studies enhances the breadth of the review, it also introduces challenges in synthesising findings. Qualitative studies often rely on small, homogeneous samples, limiting their generalizability, while quantitative studies may fail to capture the depth and complexity of lived experiences. Additionally, the integration of first-person narratives and case studies (e.g., Vierthaler and Elliott 2020) introduces highly subjective perspectives, which, while valuable, lack the methodological rigor of empirical research.

Although this review followed PRISMA guidelines, its focus on English-language studies and specific databases may have excluded relevant non-English research or studies published in less accessible journals. Additionally, while the inclusion of dissertations and case studies adds richness to the data, it increases the heterogeneity of the evidence base.

4.4 | Implications

The heterogeneity in study designs, populations, and contexts underscores the complexity of synthesising these findings into a cohesive framework. While the studies collectively highlight common resilience strategies and challenges, the variations in geographic focus, therapist characteristics and roles, and organizational settings suggest that findings must be interpreted contextually. For instance, resilience strategies effective in the United States may not translate directly to other cultural or institutional environments, such as the NHS in the United Kingdom. Findings might also differ among culturally or ethnically diverse populations.

Despite these limitations, the studies converge on the importance of fostering supportive environments that reduce stigma and encourage the integration of lived experience into therapeutic practice. Gaps in literature are also identified, including the need for more diverse geographic representation, longitudinal studies to explore resilience over time, and inclusion of underrepresented therapist populations (for instance, therapists from different ethnic minority backgrounds or different gender identities). Future research should seek broader diversity in their populations and geographic locations, as well as integrating different methodologies and utilizing a longitudinal model.

Moreover, significant systemic gaps were identified, leading to barriers and inequalities in therapists accessing organizational support. For instance, in the NHS, Gough (2016) observed that while therapists appreciated the systemic support available, organizational culture often failed to normalize discussions about MIH. Therapists from diverse ethnic or cultural

backgrounds may experience additional layers of stigma due to intersectionality, which are seldom addressed in workplace policies. Therapists working within the VA system benefited from access to resources, including peer support networks and wellness programs (Boyd et al. 2016). In contrast, Curry (2024) reported that graduate students often lacked access to comparable institutional resources, leaving them to rely solely on their personal coping strategies. This disparity underscores the need for organizations to create environments that actively support the wellbeing of therapists, especially those in early-career stages or in academic training programs.

The review emphasises the importance of systemic change to bridge these gaps. Creating organizational cultures that normalize mental health discussions can enable therapists to seek support without fear of judgment or professional repercussions. Elliott and Ragsdale (2020) highlighted the importance of peer networks in fostering a supportive environment but also noted that stigma often limited their effectiveness. Institutions should implement wellness programs, access to personal therapy, and structured time for self-care as part of professional roles. For instance, Mahoney (1997) emphasized the value of personal therapy and self-care activities like mindfulness and exercise, which could be institutionalized as preventative measures. Equipping supervisors with the skills to support therapists with MIH can enhance supervisory relationships, as demonstrated by Cleary and Armour (2022). Supervision was identified throughout the studies as vital to supporting therapists with MIH, and as such supervisors' attitudes and training will have a direct impact on therapist wellbeing. Training programs should focus on fostering nonjudgmental attitudes, recognizing signs of MIH difficulties and promoting resilience strategies tailored to therapists' needs.

To conclude, this review provides a nuanced understanding of the factors shaping the experiences of therapists with lived mental health challenges, offering valuable insights for future research and practice. It highlights the need for systemic and contextual approaches to supporting these professionals while leveraging their unique contributions to the field. It reveals that coping and resilience strategies for therapists with lived experience of MIH are multifaceted, combining personal self-care practices, professional support, and reflective techniques. Lived experience, when effectively managed, is seen as an asset, enriching therapeutic relationships and promoting personal growth. However, stigma and inadequate institutional support remain the most significant challenges that require further advocacy and systemic change.

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Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

All data relevant to this study are included in the manuscript.

Peer Review

The peer review history for this article is available at <https://www.webofscience.com/api/gateway/wos/peer-review/10.1002/mhs.2.70031>.

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Supporting Information

Additional supporting information can be found online in the Supporting Information section.
PRISMA checklist.