Let's tango! Integrating professionals' lived experience in the tranformation of mental health services

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Chapter 2

Use of experiential knowledge by mental health professionals and its contribution to recovery: literature review

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Abstract

Objective

This article explores the use of experiential knowledge by traditional mental health professionals and the possible contribution to the recovery of service users.

Design and Methods

The review identified scientific publications from a range of sources and disciplines. Initial searches were undertaken in databases PsycINFO, PubMed, and Cochrane using specific near operator search strategies and inclusion and exclusion criteria.

Results

Fifteen articles were selected. These were published in a broad range of mental health and psychology journals reporting research in western countries. In the selected articles, a varying conceptualization of experiential knowledge was found, differing from therapeutic self-disclosure embedded in psychotherapeutic contexts to a relational and destigmatizing use in recovery-oriented practices. Nurses and social workers especially are speaking out about their own experiences with mental health distress. Experiential knowledge stemming from lived experience affects the professional's identity and the system. Only a few studies explored the outcomes for service users' recovery.

Conclusion

A small body of literature reports about the use of experiential knowledge by mental health professionals. The mental health system is still in transformation to meaningfully incorporate the lived experience perspective from traditional professionals. There is little data available on the value for the recovery of service users. This data indicates positive outcomes, such as new understandings of recovery, feeling recognized and heard, and increased hope, trust, and motivation. More research about the meaning of experiential knowledge for the recovery of service users is desirable.

Introduction

This article explores the use and possible contribution of experiential expertise of mental health professionals to the recovery of users. It will present findings from a literature review on the use of experiential knowledge by mental health professionals.
It is part of a PhD research on the value of experiential knowledge for the recovery of users of mental health services. This review includes qualitative and quantitative studies published between 2015 and 2020.

Since the 90s, peer support workers (also referred to as 'experts by experience' and 'lived experience practitioners') in several western countries around the world started using their lived experiences as part of mental health services changing their focus to recovery-oriented care. This led to the further professionalization of peer support in general. Lived experiences of service users, often connected to stories of personal recovery, illustrated how people cope with severe psychiatric conditions or addiction (Weerman, 2016). Experiential expertise is based on a lived experience with a particular disease, disability, or other disruptive life event (Castro *et al.,* 2019). In 1976, sociologist Borkman became the first to clarify the concepts 'experiential knowledge' and 'experiential expertise. She defined experiential knowledge as "the truth learned from personal experience with a phenomenon rather than truth acquired by discursive reasoning, observation, or reflection on information provided by others" (Borkman, 1976).

It refers to wisdom and know-how gained from a personal experience with a phenomenon, such as a disease or disability. Experiential expertise, the second concept, was defined as "a competence or skill in handling or resolving a problem through the use of one's own experience" (Borkman, 1976). The most important difference between both concepts is that everyone with the same problem may have experiential knowledge, but the degree to which one has integrated and is competent to share the knowledge with others varies (Castro *et al.,* 2019). Experiential knowledge has been introduced as the 'third' source of knowledge, alongside academic and practice-based knowledge, stemming from intuitive knowledge focusing on the elaboration of existential and moral insights in view of practical questions and dilemmas (Boevink, 2009).

Roots can be found in the users' and survivor movement that arose out of the civil rights movement of the late 1960s and personal histories of psychiatric abuse by well-known activists like Judy Chamberlin in the US, Mary O'Hagan in New Zealand, and Wilma Boevink in the Netherlands. Since then, many former service users have developed into peer support workers, being employed in the field of addiction and mental health care (Doukas and Cullen, 2010). Generally, effect studies have compared the practice of peer support workers to treatment as usual and found no significant difference between peer and non-peer staff (Lloyd-Evans *et al.,* 2014; Chien *et al.,* 2019). Only one randomized control study that researched peer supported self-management for people discharged from a mental health crisis team suggests that peer-delivered self-management reduces readmission to acute care and feelings of loneliness, and enhances social networks (Johnson *et al.,* 2018). Despite these inconclusive results, investments have been done in the promotion and uptake of peer support internationally (Stratford *et al.,* 2019).

In the US, Canada, New Zealand, Australia, UK, and The Netherlands, peer support work is professionalizing fast, in terms of education, certification, function descriptions, and professional associations (Stratford *et al.,* 2019). While peer support workers form a growing part of the work force, there are still issues around the broader implementation and innovation. A number of these issues is related to the status in the organization concerning roles, responsibilities, and payment (Moran *et al.,* 2013). Other issues are related to an institutional culture, which, in most cases, is still dominated by the medical model (Kemp & Henderson, 2012; Faulkner, 2017).

The most recent development is that professionals from the traditional disciplines, like nurses, social workers, psychologists, and psychiatrists, also bring to the surface their personal lived experience, which so far had been hidden, because of professional standards precluding its use (Banks, 2012). However, all helping professions, from psychotherapy to social work, are known to attract individuals with a history of psychological troubles in general (Zerubavel and Wright, 2012; Reid and Poole, 2013). Research reveals that a considerable number of professionals in mental health care has been exposed to traumatic and disruptive experiences in their lives. Estimations fluctuate between 45% and 75% (Zerubavel and Wright, 2012; Weerman, 2016). Being aware of one's vulnerabilities is basic to the training of psychoanalysts, the Rogerian tradition, and other humanistic approaches (Ziv-Beiman and Shahar, 2016). To 'know oneself' was, in fact, crucial in a number of psychotherapeutic traditions (Amundson and Ross, 2016). Although clinicians have been encouraged to process their issues as part of their personal-professional development, the use of personal lived experiences in mental health care practice, so far, has been limited.

Whereas the introduction of peer support workers in mental health services contributed to the transformation in the direction of a recovery-oriented landscape in general, it also consequently led to a division between professionals. Traditional professionals felt unseen and disadvantaged (Weerman *et al.,* 2019). Weerman et al. explain how working alongside a peer support worker eventually facilitated the coming out of mental health professionals in The Netherlands (Weerman *et al.,* 2019). This led to further acknowledgement of the worth of lived experience in mental health settings. Yet, many other professionals felt urged to keep their personal experiences at bay (Weerman and Abma, 2018). To date, there is very little scientific evidence on the professional use of this type of knowledge in mental health care. Therefore, this review explores the international context on the use of experiential knowledge by professionals in mental health settings and searches for possible contributions to the recovery of service users.

Methods

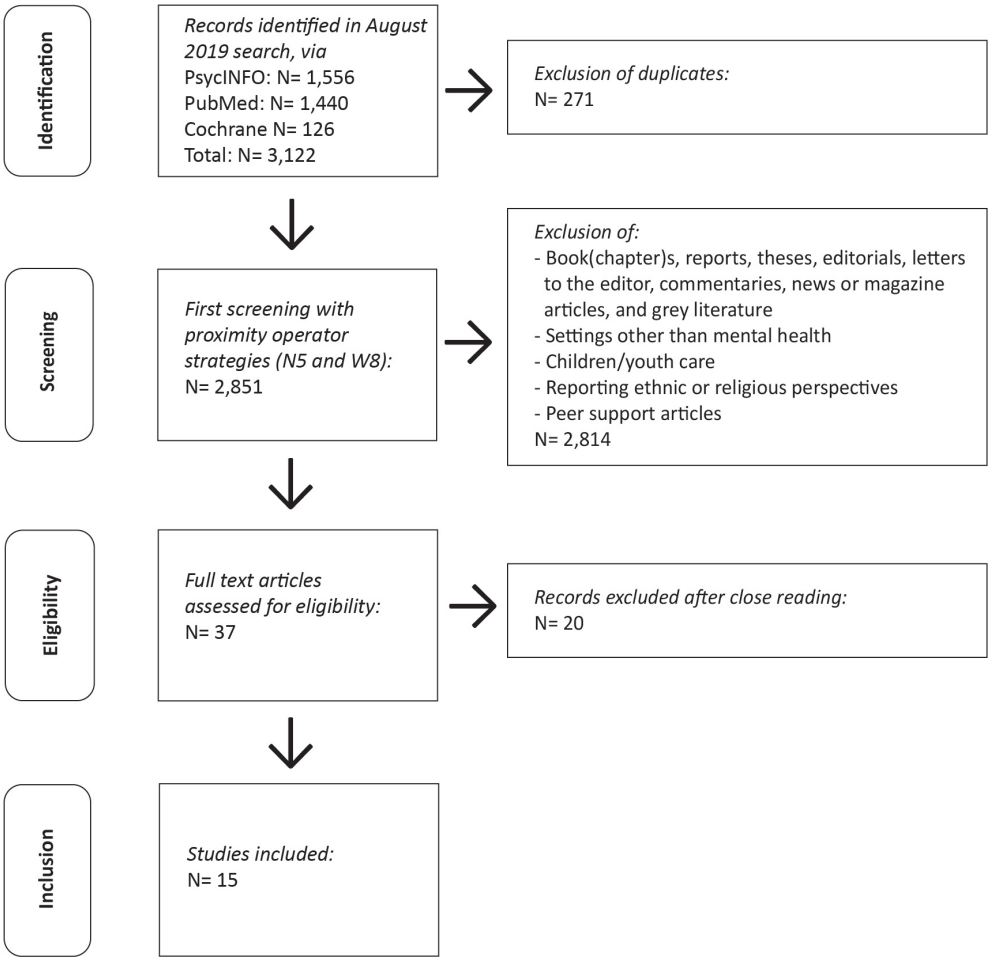
A literature review was conducted including qualitative and quantitative studies from 2015 to 2019, consulting the following databases: PsycINFO, PubMed, and Cochrane Library. The research question highlighted what the value and impact of experiential knowledge of professionals for mental health services is, which led to a further operationalization and a refined search string combining the following terms: mental health personnel, psychiatric nurses, social workers, psychiatrists, (psycho)therapists, counsellors, psychologists, practitioners and self-disclosure, posttraumatic growth and/or lived experiences and/or wounded healer and/or experiential knowledge and/or recovered.

The literature search was conducted by the first author and two information specialists. A preliminary check with three different search strings resulted in more than 3,000 publications. Duplicates were excluded. By using a 'near operators' search strategy[ii]. This number was reduced to 2,851 articles in the aforementioned databases. A set of inclusion and exclusion criteria was used to ensure that the publications selected captured the research question. The focus of the literature study was on journal articles published in English-language, peer-reviewed journals.
The articles had to be available online, identifiable through an electronic database, and published between January 2015 and June 2019, focusing on recent developments. The end date was the time when the search commenced. Books, book chapters, published reports, theses, editorials, letters to the editor, commentaries, news or magazine articles, and grey literature (e.g., unpublished reports) were excluded. The articles included are research and empirical findings, systematic reviews, scoping reviews, critical interpretive reviews, and narrative reviews.

All potentially relevant articles were screened upon title and abstract. The publications varied considerably in size, scope, and profundity. Articles from professional areas other than mental health (e.g., somatic care) were excluded, as well as publications focusing on children/youth care. Furthermore, articles that focused on ethnic and/or religious perspectives were also excluded.
A second screening upon relevance resulted in 37 relevant articles. Articles describing contributions of non-traditional mental health professionals exclusively, such as those of peer support workers, were excluded. Close reading of the 20 remaining articles upon relevance concerning the actual use of experiential knowledge amongst traditional professionals reduced the number of included articles to 15 publications.

ii Proximity operators yield more precise search results.

Figure 1. *Flow chart*



Results

The 15 selected articles were published in a broad range of mental health and psychology journals. Most of the studies involved qualitative research, using different methods like grounded theory, discourse analysis, auto-ethnography, narrative analysis, and a consensual analysis. Five studies were found using a quantitative design. Characteristics of the included publications are listed at the end of the article.

We describe findings related to the use of experiential knowledge by traditional professionals and possible contributions to the recovery of service users. In the selected articles a varying conceptualization of experiential knowledge is identified, differing from use of personal knowledge in traditional psychotherapeutic contexts to recovery-oriented practices. These conceptual differences partly depend on the paradigm, either being medical-clinical or recovery-oriented.

Findings

A scarce body of literature reports about the use of experiential knowledge by mental health professionals. Mainly professionals practising applied professions, e.g., social workers and nurses, are increasingly speaking out about their own experiences of using mental health services (Richards, Holttum and Springham, 2016). Some studies report that traditional professionals became inspired after working alongside peer support workers (Oates, Drey and Jones, 2017; Von Peter & Schulz, 2018). Byrne, Happell & Reid-Searl state that mental health nurses tend to enjoy closer relationships with consumers than other professionals (Byrne, Happell and Reid-Searl, 2017). We differentiate the use of experiential expertise affecting the personal-professional identity, system-related changes, and the recovery of service users.

Personal-professional transformation

Professionals who started using their experiential knowledge believe that their service user experiences enhance their current work, such as an adequate use of self-disclosure, increased emotional empathy and insight, and the ability to hold hope for service users (Richards, Holttum and Springham, 2016). Levitt et al. and De Vos et al. both point out that therapists with lived experiences use disclosures in a more relational and responsive manner by demonstrating humanity and sincere care for service users (Levitt *et al.,* 2016; Vos, Netten and Noordenbos, 2016). Some professionals undergo training to be able to use their lived experiences as actual experiential knowledge. Training and supervision is considered particularly helpful to reflect on the interaction between experiential knowledge and the profession, since conflicts in values, attitudes, and actions pose a challenge at the meeting point between the service user and professional part within one individual (Goldberg, Hadas-Lidor and Karnieli-Miller, 2015). Oates et al. describe how crossing the boundary between the professional and the service user was at first seen as a taboo, and possible reoccurring self-stigma should be addressed (Oates, Drey and Jones, 2017; Peter and Schulz, 2018). Goldberg et al. identified the transformation process ‘from patient to therapatient’ (here, clinical social workers) in Israel (Goldberg, Hadas-Lidor and Karnieli-Miller, 2015).

This process included four stages starting with an initial exploration of themselves as potential help providers and not merely as receivers, questioning the possibility of a service user being a therapist, feeling incompetent to identifying their ability to be professional, and finally integrating service user and therapist parts in one identity. Richards et al. describe how professionals face dilemmas in integrating both identities, depending on the discursive resources most salient in relation to the contexts (Richards, Holttum and Springham, 2016).

Goldberg et al. argue that, by making professionals familiar and comfortable with a hybrid identity, they make extensive use of their lived experience in ways that contribute to service users (Goldberg, Hadas-Lidor and Karnieli-Miller, 2015). New identity constructions incorporate positive identities of "wounded healer," "personhood," and "insider activist," in which mental distress is normalized as human experience, and recovery is "of life" rather than from illness. In this way, professional and service user identities can complement one another and enable empathy with and access by other service users, as well as fulfilling a destigmatizing role within mental health services (Richards, Holttum and Springham, 2016). Levitt et al. also stress that using one's own experiences might also be influenced by personality styles and work preferences (Levitt *et al.,* 2016). Lebel et al. refer to Riessman's introduced Helper Therapy Principle in 1965, which suggests that when an individual (the "helper") provides assistance to another person, the helper may benefit himself (LeBel, Richie and Maruna, 2015). Giving help can be reintegrative for the professional himself.

Contributions to the system

Research illustrates the mental health system in mainly the western countries (Australia, UK, USA, The Netherlands, and Israel) is struggling to meaningfully incorporate the lived experiences of professionals (Richards, Holttum and Springham, 2016; Byrne, Happell and Reid-Searl, 2017).

Even though traditional professionals with lived experiences might want to open up, this is not a common practice. Professionals with lived experiences who work in an environment where the served population has been stigmatized may want to fulfil a role as social change-maker, albeit often without the consent of academic colleagues. Clinicians and therapists seem most reserved in this development since academic socialization holds expectations to keep own needs, aspirations, and weaknesses out of the clinical practice (Peter and Schulz, 2018). They are trained to be self-effacing (Peter and Schulz, 2018). While the concepts of 'professional self-disclosure' and 'wounded healer' are familiar for psychotherapists and host meaningful principles to strengthen the therapeutic alliance, there is a threat that the focus of therapy will shift from user to therapist (Levitt *et al.,* 2016; Berg, Antonsen and Binder, 2017; Simonds and Spokes, 2017; Pinto-Coelho *et al.*, 2018). The risk to be portrayed as an impaired professional and the negative connotation thereof have hindered these practitioners (Tay, Alcock and Scior, 2018). Oates et al. address the taboo of disclosure and debate the extent to which personal and professional boundaries are negotiated during clinical encounters (Oates, Drey and Jones, 2017). It takes effort and self-reflection to critically bring these taboo and power differentials to the foreground (Peter and Schulz, 2018). The introduced new hybrids and ambivalences are considered undesirable or even dangerous because they threaten the status quo and the apparent logic of the system (Peter and Schulz, 2018). This can lead to significant risks to the mental health and well-being of the concerned activists. Byrne et al. state that mental health professionals in general tend to have pessimistic views about the capacity of people

diagnosed with mental illness to recover, so supportive colleagues may not be available (Byrne, Happell and Reid-Searl, 2017). The risk of being encapsulated or being ignored in the system seems realistic, leading to both internal and external conflicts. Others warn for the appearance of a new and separate group, since professionals with lived experiences might present different and superior than peer support workers and other professionals (Richards, Holttum and Springham, 2016). Self-care techniques seem important mediators against these identified risks (Byrne, Happell and Reid-Searl, 2017). Other possible beneficial factors in this regard include therapist self-insight, adequate training and guidance, and a safe work environment (Vos, Netten and Noordenbos, 2016).

Contribution to recovery of users

Few scientific studies report about the actual contribution to the recovery of service users. Whereas therapeutic disclosures are pursued to evoke favourable changes in clinical symptoms, there are few insights on the use of experiential knowledge and outcomes in broader terms of recovery and quality of life (Levitt *et al.,* 2016; Noyce and Simpson, 2018; Pinto-Coelho *et al.,* 2018; McCormic *et al.,* 2019).

Some professionals use their experiential knowledge for specific therapeutic purposes, such as providing new insights into the recovery process, modelling, and enhancing hope (Vos, Netten and Noordenbos, 2016; Berg, Antonsen and Binder, 2017). De Vos et al. argue that users with eating disorders benefit from being treated by a recovered therapist (Vos, Netten and Noordenbos, 2016). The most important changes reported were feeling recognized and heard, diminished levels of shame, increased feelings of hope, increased sense of trust, more openness/honesty, and a stronger motivation to change (Vos, Netten and Noordenbos, 2016). Another study shows how the lived experience instantly increased empathy and deepened the understanding of anxiety, low mood, or suicidal thoughts (Oates, Drey and Jones, 2017). When recovered from certain distress, these experiences enable the professional to see openings of recovery for others (Vos, Netten and Noordenbos, 2016). Identification, as an underlying dynamic, is associated with increased commonality and helps to normalize mental distress (Richards, Holttum and Springham, 2016).

Conclusion

We found a scarce body of literature from research in western countries concerning the use and value of experiential knowledge by traditional mental health professionals. Nurses and social workers especially are speaking out about their own experiences with mental health distress, and some became inspired by working alongside peer support workers or lived experience practitioners, which facilitated coming outs about hidden personal histories with mental health distress (Richards, Holttum and Springham, 2016; Oates, Drey and Jones, 2017; Peter and Schulz, 2018). The use of experiential expertise affects the personal-professional identity, the mental health care system, and the recovery of service users.

Firstly, professionals who use experiential knowledge want to enhance their practice with adequate self-disclosure, more empathy and insight, and the ability to hold hope for service users.

Experiential knowledge is used in a relational and responsive manner, and the decision to use personal experiences might be related to personality styles (Levitt *et al.,* 2016; Vos, Netten and Noordenbos, 2016). Several authors describe the transformative process professionals undergo in order to integrate the professional and personal identity into a new identity construction, in which professional and service user identities can complement one another and mental distress is normalized as human experience (Goldberg, Hadas-Lidor and Karnieli-Miller, 2015; Richards, Holttum and Springham, 2016; Oates, Drey and Jones, 2017). Giving help can also be beneficial for professionals themselves (LeBel, Richie and Maruna, 2015).

Secondly, research illustrates the mental health system is struggling to meaningfully incorporate lived experiences of professionals (Richards, Holttum and Springham, 2016; Byrne, Happell and Reid-Searl, 2017). The use of experiential knowledge by traditional professionals is not a common practice. Clinicians and therapists seem most reserved in this development. Even while historically academic professionals developed interesting concepts such as 'the wounded healer' and 'therapeutic self-disclosure,' using personal experiences for professional purposes remained controversial, putting emphasis on the therapist's possible vulnerability. It takes effort and self-reflection to critically bring these taboo and power differentials to the foreground, affecting the well-being of the concerned activists. Self-care techniques seem important mediators besides self-insight, adequate training and guidance, and a safe work environment (Vos, Netten and Noordenbos, 2016; Byrne, Happell and Reid-Searl, 2017).

Lastly, few scientific studies report how experiential expertise might affect recovery of service users and quality of life in broader terms. Some studies indicate positive findings, such as providing new insights into the recovery process, feeling recognized and heard, diminished levels of shame, increased feelings of hope, increased sense of trust, more openness/honesty, and a stronger motivation to change (Vos, Netten and Noordenbos, 2016). The lived experience may increase empathy and deepen understanding of anxiety, low mood, or suicidal thoughts (Oates, Drey and Jones, 2017).

The limited number of articles found indicates a lack of scientific knowledge about professionals working with their experiential knowledge and its meaning for the recovery of service users. This is not surprising, since the notion of the value of lived experiences and its use in recovery-based mental health services is still in its early stages of development. More research is desirable. Therefore, the empirical part of the first author's PhD research focuses on the lived experiences and experiential knowledge of traditional mental health professionals and its possible meaning for the recovery of service users.

Limitations

Because of the limited number of studies, evidence about possible contributions of the use of experiential knowledge for the recovery of service users is still scarce. Most of the included articles concerned qualitative studies with limited sample sizes. Also, some articles were written from a specific area, like eating disorders or psychotherapy. Furthermore, two articles that were selected for the review came from one PhD study, which may have limited its scope.

Authors	Title	Journal	Year of publication	Sample	
Berg, H., Antonsen, P., & Binder, P.-E.	'Sincerely speaking: Why do psychotherapists self-disclose in therapy? A qualitative hermeneutic phenomenological study'	Nordic psychology	2017	A qualitative hermeneutic phenomeno-logical study (n=10 therapists)	
Byrne, L., Happell, B., & Reid-Searl, K.	'Recovery as a lived experience discipline: A grounded theory study'	Issues in Mental Health Nursing	2015	Grounded theory study amongst 13 lived experience practitioners (LEP) in Australia	
Byrne, L., Happell, B., & Reid-Searl, K.	'Risky business: Lived experience mental health practice, nurses as potential allies'	International Journal of Mental Health Nursing	2017	Grounded theory study amongst 13 LEP in Australia	
De Vos, J. A., Netten, C., & Noordenbos, G.	*'Recovered eating disorder therapists using their experiential knowledge in therapy: A qualitative examination of the therapists' and the patients' view'*	Eating Disorders: The Journal of Treatment & Prevention	2016	Qualitative cross-sectional design incl. questionnaire amongst 205 users and 24 practitioners with lived experience	
Goldberg, M. Hadas-Lidor, N. & Karnieli-Miller, O.	*'From patient to therapatient: Social work students coping with mental illness'*	Qualitative Health Research SAGE	2015	Qualitative narrative analysis (n=12)	

	Site	Objectives	Findings
	Norway	Study on the rationale of self-disclosure of therapists	Therapists understood self-disclosures as a way of normalizing experiences, humanizing the therapeutic interaction and underlining the importance of emotional self-acceptance. However, self-disclosures were considered insignificant or potentially harmful if they resulted in a change of focus from therapist to service user.
	Australia	To explore the existing and potential role for lived experience practitioners in the ongoing implementation of recovery principles within the mental health sector	The findings suggest that lived experience practitioners experienced significant barriers to the implementation of recovery-focused practice with three main issues: 1) Recovery co-opted, 2) Recovery uptake, and 3) Recovery denial. Lived experience practitioners are the logical leaders of recovery implementation due to their own internal experience and understandings of recovery but must be enabled to take on their role as recovery experts and leaders.
	Australia	To generate a theory to explain experiences of LEP in the implementation and development of their roles	Participants described the unique vulnerabilities of their mental health challenges being known, and while there were many positives about disclosing, there was also apprehension about personal information being so publicly known. Self-care techniques were important mediators against these identified risks. The success of lived experience roles requires support and nurses can play an important role, given the size of the nursing workforce in mental health, the close relationships nurses enjoy with consumers, and the contribution they have made to the development of lived experience roles within academia.
	The Netherlands	To examine recovered eating disorder therapists using their experiential knowledge and how this influences therapy and the service users they treat	Results showed that to be effective experiential knowledge and self-disclosure need to be shared thoughtfully and should not include specific details about ED symptoms. Other factors noted that enhanced the benefits of experiential knowledge included therapist self-insight and self-care, adequate training and guidance, and a safe work environment. Service users stated that being treated by a recovered therapist had a positive effect on their recovery process.
	Israel	To explore the experiences of social work students with psychiatric difficulties and their challenges as they went through the different stages of development as health care professionals	Findings reveal the developmental process students underwent from being patients to being ‘therapatients’. This process included four stages: 1) exploration of the health care world, 2) questioning the possibility of a service user being a therapist and feeling incompetent, 3) identifying their ability to be professionals, and 4) integrating between their user and therapist parts.

Authors	Title	Journal	Year of publication	Sample	
LeBel, T. P., Richie, M., & Maruna, S.	'Helping others as a response to reconcile a criminal past: The role of the wounded healer in prisoner reentry programs'	Criminal Justice and Behavior	2015	Quantitative survey (n= 258) formerly incarcerated persons completed a survey; 229 users and 29 staff members)	
Levitt, H. M., Minami, T., Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S.	'How therapist self-disclosure relates to alliance and outcomes: A naturalistic study'	Counselling psychology quarterly	2016	Naturalistic study of 52 therapy dyads (n=16 therapists and 52 users) quantitative analysis	
McCormic, R. W., Pomerantz, A. M., Ro, E., & Segrist, D. J.	*'The 'me too' decision: An analog study of therapist self-disclosure of psychological problems'*	Journal of Clinical Psychology	2019	Quantitative Vignette study (n= 104)	
Noyce, R., & Simpson, J.	'The experience of forming a therapeutic relationship from the user's perspective: A metasynthesis'	Psychotherapy research	2018	Review (meta-ethnographic study of 13 studies)	

	Site	Objectives	Findings
	U.K.	This study was designed to assess the professional-ex or wounded healer role of formerly incarcerated persons by examining potential differences between staff members and users in prisoner reentry programs	Findings support the notion that the wounded healer or professional-ex role is related to desistance and can potentially transform formerly incarcerated persons from being part of "the problem" into part of "the solution" to reduce crime and recidivism.
	U.S.A.	To examine types and functions of therapists' self- disclosure in relation to therapy alliance and outcomes	Findings indicated that the number of disclosures not significantly correlated with outcome or alliance scores, but disclosures that acted to humanize the therapist were associated with fewer clinical symptoms post-session than disclosures expressing appreciation or encouragement. Also, disclosures that conveyed similarity between the therapist and service user were associated with fewer post-session clinical symptoms and interpersonal problems when compared to disclosures that conveyed neither similarity nor dissimilarity. As well, neutral therapist self-disclosures were associated with better service user functioning than disclosures that relayed negative or positive information about the therapist.
	U.S.A.	To test the hypothesis that service user perceptions of therapists are most favourable when therapists self-disclose their own personal experience with the same psychological problem to a moderate extent	This study provides empirical data regarding the effect of the extent, rather than the mere presence or absence, of therapist self-disclosure regarding personal psychological experiences. The moderately extensive self-disclosure condition yielded the highest overall therapist perception.
	U.K.	To synthesize qualitative research exploring users' perspectives of forming a therapeutic relationship with their therapist or counsellor	The majority of service users voiced a preference for having similar personal characteristics to their therapist, believing that this would contribute to an implicit understanding of their difficulties and would make the therapist more effective. Additionally, they preferred their therapists to disclose information in order to facilitate the therapeutic relationship.

Authors	Title	Journal	Year of publication	Sample	
Oates, J., Drey, N., & Jones, J.	'Your experiences were your tools'. How personal experience of mental health problems informs mental health nursing practice'	Journal of psychiatric and mental health nursing	2017	Qualitative interviews with nurses with lived experiences (n=27)	
Pinto-Coelho, K., Hill, C. E., Kearney, M. S., Sarno, E. L., Sauber, E. S., Baker, S. M., Thompson, B. J.	'When in doubt, sit quietly: A qualitative investigation of experienced therapists' perceptions of self-disclosure'	Journal of Counseling Psychology	2018	Consensual qualitative research (n=13)	
Richards, J., Holttum, S., & Springham, N.	'How do "mental health professionals" who are also or have been "mental health service users" construct their identities?'	SAGE Open	2016	Discourse analysis (n=10)	
Simonds, L. M., & Spokes, N.	'Therapist self-disclosure and the therapeutic alliance in the treatment of eating problems'	Eating Disorders: The Journal of Treatment & Prevention	2017	Quantitative study (n=120 women with history of eating problems)	

	Site	Objectives	Findings
	U.K.	To explore the extent and influence of mental health professionals' personal experience of mental ill health on clinical practice	The influence of personal experience in nursing work was threefold: 1) through overt disclosure, 2) through the 'use of the self as a tool,' and 3) through the formation of professional nursing identity. Personal experience of mental illness in mental health nurses creates understanding of and empathy for mental health service users, and in certain circumstances, it is seen as giving mental health nurses 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 contextualized within the broader picture of nurses using themselves and their experiences in their work.
	U.S.A.	To learn from experienced therapists about the use of successful and unsuccessful therapeutic self-disclosure (TSD) over time	Therapist self-disclosure is a controversial intervention because of the concern about the focus shifting from the service user to the therapist. Experienced therapists suggested disclosure can be very helpful but that therapists should not disclose if it is not in user's best interest, if the therapist feels too vulnerable, and if the therapist's personal issues are strongly involved.
	U.K.	To explore how mental health professionals with mental health service user experience construct their identity	Participants constructed their identity variously, suggesting both "unintegrated" and "integrated" identities in relation to some professional contexts. Integrated identities can potentially be foregrounded to contribute the social value of service user and highlighting positive and hopeful perspectives on mental distress.
	U.K.	To model relationships between different types of therapist self-disclosure, therapeutic alliance, service user self- disclosure, shame, and severity of eating problems	The analyses presented provide support for the contention that therapist self-disclosure, if perceived as helpful, might strengthen the therapeutic alliance. A strong therapeutic alliance, in turn, has the potential to promote patient disclosure and reduce shame and eating problems.

Authors	Title	Journal	Year of publication	Sample	
Tay, S., Alcock, K., & Scior, K.	'Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help-seeking'	Journal of clinical psychology	2018	Quantitative online survey (n= 678 clinical psychologists)	
Von Peter, S., & Schulz, G.	''I-as-We' - Powerful boundaries within the field of mental health coproduction'	International journal of mental health nursing	2018	Auto-ethnography	

	Site	Objectives	Findings
	U.K.	To assess the prevalence of personal experiences of mental health problems among clinical psychologists, external, perceived, and self-stigma among them, and stigma-related concerns relating to disclosure and help-seeking	Personal experiences of mental health problems among clinical psychologists seem fairly common. Stigma, concerns about negative consequences of disclosure, and shame as barriers to disclosure and help-seeking merit further consideration. Within clinical psychology and across mental health professions more generally, there are unspoken beliefs that "experts" should be immune to human distress, which need to be challenged more openly.
	Germany	To explore some of the reasons for why self-disclosure is so difficult and how these difficulties may prevent productive forms of coproduction	Mental health professionals often revert to an "I-as-we", speaking of themselves as a collective and thereby reifying the boundaries between 'vulnerable users' and 'invulnerable professionals.' Ethnographic examples are given of how these boundaries are produced by a continuous, often invisible, and powerful category work. It is discussed how the dichotomous logic of these boundaries can cause people on both sides to feel reduced to a representation of a certain species, which can take on an existential dimension. Ways out are identified for mental health professionals to self-reflexively engage with their own crisis experience in co-productive and other relationships.

References

Amundson, J.K. & Ross, M.W. (2016). The Wounded Healer: From the Other Side of the Couch. *The American journal of clinical hypnosis, 59*(1), pp. 114–121.

Banks, S. (2012). *Ethics and values in social work*. Hampshire: Palgrave Macmillan.

Berg, H., Antonsen, P. & Binder, P.E. (2017). Sincerely speaking: Why do psychotherapists self-disclose in therapy?–A qualitative hermeneutic phenomenological study. *Nordic Psychology, 69*(3), pp. 143–159.

Boevink, W. (2009). *Lijfsbehoud, levenskunst en lessen om van te leren. HEE-gesch(r)ift.* Utrecht: Trimbos Instituut.

Borkman, T. (1976). Experiential Knowledge: A analysis of self-help groups. *Social Service Review*, *50*(3), pp. 445–456.

Byrne, L., Happell, B. & Reid-Searl, K. (2017). Risky business: Lived experience mental health practice, nurses as potential allies. *International Journal of Mental Health Nursing, 26*(3), pp. 285–292.

Byrne, L., Happell, B. & Reid-Searl, K., (2015). Recovery as a lived experience discipline: A grounded theory study. *Issues in mental health nursing, 36*(12), pp. 935-943.

Castro, E.M., Van Regenmortel, T., Sermeus, W. & Vanhaecht, K. (2019). Patients' experiential knowledge and expertise in health care: A hybrid concept analysis. *Social Theory and Health, 17,* pp. 307–330.

Chien, W.T., Clifton, A.V., Zhao, S., & Lui, S. (2019). Peer support for people with schizophrenia or other serious mental illness. *Cochrane Database of Systematic Reviews,* (4).

Corrigan, P.W. (2016). Lessons learned from unintended consequences about erasing the stigma of mental illness. *World Psychiatry, 15*(1), pp. 67–73.

Doukas, N. & Cullen, D. (2010). Recovered addicts working in the addiction field: Pitfalls to substance abuse relapse. *Drugs: Education, Prevention and Policy, 17,* pp. 216–231.

Faulkner, A. (2017). Survivor research and Mad Studies: the role and value of experiential knowledge in mental health research. *Disability & Society, 32*(4), pp. 500–520.

Goldberg, M., Hadas-Lidor, N. & Karnieli-Miller, O. (2015). From Patient to Therapatient: Social Work Students Coping With Mental Illness. *Qualitative Health Research, 25*(7), pp. 887–898.

Johnson, S., Lamb, D., Marston, L., Osborn, D., Mason, O., Henderson, C., ... & Lloyd-Evans, B. (2018). Peer-supported self-management for people discharged from a mental health crisis team: a randomised controlled trial. *The Lancet, 392*(10145), pp. 409–418.

Kemp, V. & Henderson, A.R. (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporters point of view. *Psychiatric Rehabilitation Journal, 35*(4), pp. 337–340.

LeBel, T.P., Richie, M. & Maruna, S. (2015). Helping others as a response to reconcile a criminal past:

The role of the wounded healer in prisoner reentry programs. *Criminal Justice and Behavior, 42*(1), pp. 108–120.

Levitt, H.M., Minami, T., Greenspan, S.B., Puckett, J.A., Henretty, J.R., Reich, C.M., & Berman, J.S. (2016). How therapist self-disclosure relates to alliance and outcomes: A naturalistic study. *Counselling Psychology Quarterly, 29*(1), pp. 7–28.

Lloyd-Evans, B., Mayo-Wilson, E., Harrison, B., Istead, H., Brown, E., Pilling, S., ... & Kendall, T. (2014). A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness. *BMC psychiatry, 14,* pp. 1-12.

McCormic, R.W., Pomerantz, A.M., Ro, E., & Segrist, D.J. (2019). The "me too" decision: An analog study of therapist self-disclosure of psychological problems. *Journal of Clinical Psychology, 75*(4), pp. 794–800.

Moran, GS., Russinova, Z., Gidugu, V., & Gagne, C. (2013). Challenges experienced by paid peer providers in mental health recovery: A qualitative study. *Community Ment Health J, 49,* pp. 281 – 291.

Noyce, R. and Simpson, J. (2018). The experience of forming a therapeutic relationship from the clients perspective: A metasynthesis. *Psychotherapy Research, 28*(2), pp. 281–296.

Oates, J., Drey, N. & Jones, J. (2017). 'Your experiences were your tools'. How personal experience of mental health problems informs mental health nursing practice. *Journal of Psychiatric and Mental Health Nursing, 24*(7), pp. 471–479.

Peter, von S. & Schulz, G. (2018). "I-as-We" – Powerful boundaries within the field of mental health coproduction. *International Journal of Mental Health Nursing, 27*(4), pp. 1292–1300.

Pinto-Coelho, K.G. Hill, C.E., Kearney, M.S., Sarno, E.L., Sauber, E.S., Baker, S.M., ... & Thompson, B.J. (2018). When in doubt, sit quietly: A qualitative investigation of experienced therapists' perceptions of self-disclosure. *Journal of Counseling Psychology, 65*(4), pp. 440–452.

Reid, J. & Poole, J. (2013). Mad Students in the Social Work Classroom? Notes From the Beginnings of an Inquiry. *Journal of Progressive Human Services, 24*(3), pp. 209–222.

Richards, J., Holttum, S. & Springham, N. (2016). How Do "Mental Health Professionals" Who Are Also or Have Been "Mental Health Service Users" Construct Their Identities?. *SAGE Open, 6*(1).

Simonds, L.M. & Spokes, N. (2017). Therapist self-disclosure and the therapeutic alliance in the treatment of eating problems. *Eating Disorders: The Journal of Treatment & Prevention, 25*(2), pp. 151–164.

Stratford, A. C., Halpin, M., Phillips, K., Skerritt, F., Beales, A., Cheng, V., ... & Davidson, L. (2019). The growth of peer support: an international charter. *Journal of Mental Health, 28*(6), pp. 627-632.

Tay, S., Alcock, K. & Scior, K. (2018). Mental health problems among clinical psychologists: Stigma and its impact on disclosure and help seeking. *Journal of clinical psychology, 74*(9), pp. 1545–1555.

Vos, de J.A., Netten, C. and Noordenbos, G. (2016). Recovered eating disorder therapists using their experiential knowledge in therapy: A qualitative examination of the therapists and the patients view. *Eating Disorders: The Journal of Treatment & Prevention, 24*(3), pp. 207–223.

Weerman, A. (2016). *Ervaringsdeskundige zorg- en dienstverleners. Stigma, verslaving & existentiële transformatie.* [Doctoral Dissertation]. Vrije Universiteit Amsterdam.

Weerman, A. & Abma, T. (2018). Social work students learning to use their experiential knowledge of recovery. An existential and emancipatory perspective. *Social Work Education, 38*(4), pp. 453–469.

Zerubavel, N. & Wright, M.O.D. (2012). The dilemma of the wounded healer. *Psychotherapy, 49*(4), pp. 482–491.

Ziv-Beiman, S. & Shahar, G. (2016). Therapeutic self-disclosure in integrative psychotherapy: When is this a clinical error?. *Psychotherapy, 53*(3), pp. 273–277.

Reflection I: "Relational ethics?"

There is a personal angle to the writings of my dissertation, related to my own healing process. Parallel to the studies of this PhD research, I have been visiting a seasoned psychiatrist, who had quite a different take on the therapeutic relationship than my previous therapist. Although he worked trauma-focused and body-oriented, something was lacking. He was part of the dominant field, where the acknowledgement of experiential knowledge has been very scarce, and possibly also limited educated in normative professions.

For instance, even though therapy was already running for about a year, he did not talk about himself, nor share anything personal. This felt very unbalanced and unequal to me. While I was dreading intimacy but doing my best to open up, he'd stay in his 'safe' position and take the lead without really attuning to my needs. I remember he once asked me to stop masking my feelings, referring to my apparently visible defence mechanisms. This felt very uncomfortable and completely unsafe, pushing me towards vulnerability. It also made me mad in a way and perhaps primed me to further investigate his way of working. Obviously, relational ethics was not part of his framework, let alone was he trained in harnessing lived experiences, which is why I could not hold him to account for missing something. But what struck me most was the rationale behind his reservations. I deliberately started opening up discussions around it, in almost every session. Sometimes he'd discriminately say that he does reveal more to other clients depending on their illness and the relationship he had with them. Other times, he'd say that he did not expect any therapeutic profit out of self-disclosing or sharing personal matters and that the therapeutic relationship itself is overrated. I questioned the assumption of having processed all issues in learning therapy, in order to interact as a 'neutral' therapist. And I thought of the self-protective nature of this detached working style as I had experienced in earlier encounters with therapists, but I also decided to continue navigating this topic with him and I kept asking how he was doing and what he was occupied with. I needed more confidence in him as a person for the sake of my own process. Luckily, after a few confrontations new openings appeared.

He realised what was at stake and the next session he came back to me sharing his realisation of 'how uncommon' it actually is to expect openness from clients. They have to grant trustworthiness to a fairly unknown therapist so they are demanded to practice openness all the time. It also made him aware of how fast clients adjust to the situation and their position, as often being dependent on professional help.

After this period, he gradually started sharing more of himself, but this was clearly a search. Maybe I failed to bridge the gap between the differences of the cultural worlds we were part of. His work context could be characterised as a 'cure and short-term treatment setting', as well as his view on knowledge (positivistic) was obviously quite in conflict with the 'care and recovery' principles and the (social) constructivism paradigm highly esteemed in my work setting. This difference was like night and day.

I wondered, how this would work for other clients, would they accept a professional hiding self? Reciprocity can certainly not be enforced, but how do they obtain a sense of safety in the relationship with a relative stranger? I was also curious to find out what lived experiences could mean to those who resort to mental health care. How do clients reflect on professionals who integrate the personal with the

professional and what are their perceptions of helpful professional relationships? How do they reflect on intentional disclosures and sharing of their professional? How does that affect the power balance in the relationship? I wondered whether identification could contribute to the relationship. What could be the benefits and pitfalls of proximity in the relationship? How does that relate to the risk paradigm in mental health care? These were some of the topics that inspired me in my first study.