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

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Chapter 4

Professionals harnessing experiential knowledge in Dutch mental health settings

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Abstract

Purpose

This study aims to explore the perspectives of mental health professionals who are in a process of integrating their own experiential knowledge in their professional role. This study considers implications for identity, dilemmas and challenges within the broader organization, when bringing experiential knowledge to practice.

Design/methodology/approach

As part of a participatory action research approach, qualitative methods have been used, such as in-depth interviews, discussions and observations during training and project team.

Findings

The actual use of experiential knowledge by mental health care professionals in their work affected four levels: their personal–professional development; the relation with service users; the relation with colleagues; and their position in the organization.

Research limitations/implications

Because of its limited context, this study may lack generalizability and further research with regard to psychologists and psychiatrists, as well as perceptions from users, is desirable.

Social implications

According to this study, social change starts from a bottom-up movement and synchronously should be facilitated by top-down policy. A dialogue with academic mental health professionals seems crucial to integrate this source of knowledge. Active collaboration with peer workers and supervisors is desired as well.

Originality/value

Professionals with lived experiences play an important role in working recovery- oriented, demonstrating bravery and resilience. Having dealt with mental health distress, they risked stigma and rejections when introducing this as a type of knowledge in current mental health service culture. Next to trainings to facilitate the personal–professional process, investments in the entire organization are needed to transform governance, policy and ethics.

Introduction

Over the past decades in The Netherlands, like in other countries, the traditional problem-oriented approaches in mental health care shifted to a more recovery-oriented perspective (Delespaul, e.a., 2016). At the same time evidence-based practices became dominant in clinical mental health care, which led to a standardization of mental health treatment. The latter led to a growing criticism on evidence-based practice, because of underrating the variety of users and the context of health care (The Council for Public Health and Society, 2017). Especially the past decade the evidence based model and clinical relevance of bio-markers for Mental Health practice are increasingly under pressure (van Os and Kohne, 2021).

In The Netherlands and abroad, this led to discussions about the hierarchy of knowledge, which places randomized controlled trials (RCTs) and systematic reviews of RCTs at the top and the views of clinicians and patients at the bottom, marginalizing both professionals and users voices (Faulkner, 2017). As professional and private life have oftentimes been separate areas in mental health practice and experiential knowledge is generally not incorporated nor validated, these developments evidently influence one another. Traditionally, mental health professionals, were expected to stay distant, which led to the marginalization of a group that has seen the other side of the table (Fox, 2016). Professionals have split their identity in a personal part kept secret to themselves and a professional part. Banks (2012) states that this separation is not only meant for the protection of the professional but also exists for the benefit of the user, who should not be burdened with personal troubles – even when conquered – of the person counselling him or her. However, refraining from personal experiences entirely may also lead to alienation and a distant relationship (Byrne *et al.,* 2017). The construction of a mental health professional incorporating lived experiences implies a shift of taking this “new” source of knowledge into account. This means more than a coming-out with a disorder or a disruptive life event and can be challenging in a mental health care setting that is oftentimes still dominated by a positivistic, empirical-analytical culture (Weerman, 2016).

The medical model is known for its deficit orientation, prioritizing the system needs for standardized, measurable, outcomes over the individual priorities of service users (Byrne *et al.,* 2015; Slade, 2012).

Novel policy attempts to reform the mental health field, show several interesting developments and innovations in which the experiential knowledge of mental health professionals is (re)discovered. Besides peer support workers, a wider movement across traditional disciplines, from social workers, nurses to psychologists and psychiatrists became interested in acknowledging experiential knowledge. Both the Division of Clinical Psychology and the Royal Australian and New Zealand College of Psychiatrists value lived experiences of, respectively, psychologists and psychiatrists, as it can provide a vital contribution to stigma reduction (British Psychological Society, 2020; Royal Australian and New Zealand College of Psychiatrists, 2016).

Even though it is considered a personal choice to transform personal (such as emotional and intuitive) lived experience into experiential knowledge (Grundman *et al.,* 2020), the professionalization of experiential knowledge in The Netherlands currently rises and several universities integrated experiential knowledge in their Social Work curricula (Weerman and Abma, 2018). Professionals started to actively use this "new" (re)source during encounters with service users, colleagues and managers. As little is known about how professionals with lived experiences reflect on the process learning to use experiential knowledge in their work, in this article we will focus on the personal–professional process of transforming lived experiences to experiential knowledge. What dilemmas and challenges do professionals face?

Design and methods

This study took place in three Mental Health (MH) organisations in the North-Eastern part of The Netherlands from 2017 to 2020. A participatory action research approach (Abma *et al.,* 2019) was used to contribute to the implementation of experiential knowledge in the practice of psychiatry by an action–reflection–learning cycle. Responsive evaluation is a particular version of participatory action approach; one that values the multiple perspectives of stakeholders and dialogue to come to mutual understanding (Abma *et al.,* 2016; Abma *et al.,* 2020). In this participatory study, we worked with professionals from all three MH organizations who were invited to explore the professionalization of experiential knowledge and took part in the project as "co-researchers". Additionally academic researchers collaborated as "participating actors" in the learning communities. See Table 1 for their roles in the various phases of the study.

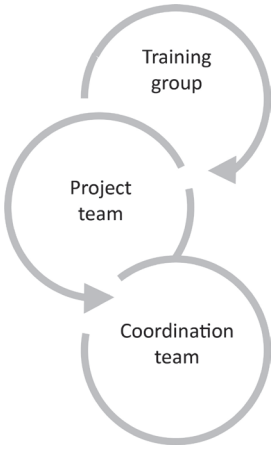
Table 1. *Participation matrix*

	Academic researchers in their role as 'participating actors'	**Participants in their role as 'co-researchers'**
Phase 1 Initiation and planning	Formulating and developing design and topic list interviews	Setting up teams in own organisations and creating action plans
Phase 2 Execution	Completing interviews Support social actions	Bring social experiments and actions to practice Discuss first findings in training and project teams
Phase 3 Evaluation	Facilitating learning, reflection and social change in the broader context	Evaluation and redefining action plan based upon reflections
Phase 4 Closing	Dissemination of project results in professional and scientific publications, policy and conferences	Contributing to professional publications, policy and conferences

Procedures

The set-up of the research was emergent, covering four iterative phases (initiation and planning, execution, evaluation and closing) accordingly to the participatory process. First of all, professionals participated in a post-bachelor training targeting the professionals to use lived experiences at work. Three researchers were part of the training group (Figure 1) to stimulate the "action-, reflection-, and learning-cycle." The participants practiced a core profession of nurse, social worker or humanistic counsellor. During the training sessions, the researchers worked in an interactive and collaborative way on the professionalization and implementation of experiential knowledge in participants' organizations. Next to the training-sessions, all professionals joined project-teams that were set up locally in the three concerned MH organizations. These joint collaborations consisted of professionals with lived experiences and their colleagues, i.e. peer workers, human resource-colleagues, managers and policy makers. Thirdly, in the coordination team the coordinating professionals with lived experiences from each organization participated to inspire and exchange upon the setup of plans. This led to specific strategies that targeted again the local organization, such as an authorized role-description for "Professionals with lived experiences" and actions to improve visibility and open up the debate in the participating organizations.

Figure 1. *Action-, reflection-, and learning-cycle in three contexts*



Subsequently, in-depth interviews were held in 2017, 2018 and 2019, using a topic list with topics held relevant within the context of the project (included in Appendix). Each interview had a duration of 60–75min which took place at the workplace. All interviews were first transcribed, then summarized and returned to the individual participant for first a first validation (member check).

Braun and Clarke's (2006) thematic analysis approach was used to identify, analyse and reflect on possible patterns or themes that emerged during the interviews and during discussions in the training and project team. This approach involves familiarization, coding and generating initial themes, reviewing and eventually defining them.

Participants collectively reflected and discussed findings while being part of the broader learning community (training group), which helped in the process of sense-making and analysis. Themes that emerged repeatedly were discussed and reflected on with the participants and consequently captured as relevant.

The majority of the participants also actively contributed to annual conferences as part of the research project. These were organized in collaboration with two other health organizations, as part of a larger consortium, aiming to exchange practices and build on (creative) co-constructions of this "new" type of knowledge. Participants of the conference were able to exchange good practices and collaboratively set an agenda for the future action-plan of the concerned consortium.

Participants

The participants (co-researchers) were working in a variety of recovery oriented in- and outpatient settings, as displayed in Table 2. Their ages varied from 27 to 60 year, amongst whom 12 female and 3 male. As part of the research, all participants followed a 1 year post-bachelor training in working with experiential knowledge. This one-year training consists of 16 trainings focusing on theory, narrating recovery stories, collective discussions and reflections on key themes, such as shame, stigma, vulnerability, resilience and exchanging about action plans (Table 3).

Table 2. *Participant characteristics (N = 15)*

Participant	Gender	Age-category	Professional	Mental health setting
1	M	46-55	Nurse	High Intensive Care (inpatient) and Intensive Home treatment (outpatient)
2	F	36-45	Social worker	Supported living
3	M	56-65	Humanistic counsellor	Both inpatient and ambulatory
4	F	56-65	Humanistic counsellor	Both inpatient and ambulatory
5	F	36-45	Social worker	Supported living
6	F	46-55	Nurse	Supported living and treatment
7	F	36-45	Nurse	High Intensive Care (inpatient)
8	F	36-45	Social worker	Daycare program
9	F	56-65	Social worker	Daycare program
10	F	26-35	Social worker	Supported living
11	F	26-35	Social worker	Supported living
12	F	36-45	Social worker	Daycare program

Participant	Gender	Age-category	Professional	Mental health setting
13	M	56-65	Nurse	Supported living and treatment
14	F	26-35	Nurse	High and medium intensive care (inpatient)
15	F	46-55	Nurse	FACT team

Table 3. *Post-bachelor training programme (1 year)*

Session 1-2	Session 3-4	Session 5-6	Session 7-8	Session 9-10	Session 11-12	Session 13-14	Session 15-16
Writing and presenting personal recovery story	Writing and presenting personal recovery story	Body of knowledge on experiential expertise	Body of knowledge on experiential expertise	Exchanging about actions, impact and evaluation	Exchanging about actions, impact and evaluation	Creating of products Dissemination activities	Creating of products Dissemination activities
Theory of change	Create action plans	Finishing action plans	Discussion and reflection	Discussion and reflection	Discussion and reflection	Discussion and evaluation	Discussion and evaluation

The training offers directions to benefit from lived experience in a professional context by transforming lived experiences to experiential knowledge and bringing this knowledge to practice (Weerman and Abma, 2018). After the termination of the training, the group continued in a follow up group to further exchange upon actions, reflections and learned lessons.

Quality procedures

A number of different approaches to the critical appraisal of qualitative research have been described over the years. During the interviewing and analysis, the criteria of Lincoln and Guba (1985) were taken into account: “credibility”, “authenticity”, “transferability”, “dependability” and “confirmability” (Lincoln and Guba, 1989). The researchers met these criteria by joining professionals in their daily work-setting, in order to gain a deepened understanding of the context and work (prolonged engagement). Participants received a summary of the interview with the question if they recognized the script and had any additional reflections (member check). Triangulation (capturing and respecting multiple perspectives using various methods and sources) contributed to the dependability and confirmability of the study. As part of transferability findings were discussed in the learning community. Findings were also presented in two Applied Universities and its meaning for other organizations and contexts was further explored. The first three researchers kept a log of field notes in which important steps and changes were reported, as part of an audit trail.

Ethical considerations

According to the Medical Ethics Review Committee of VU University Medical Center (registered with the US Office for Human Research Protections as IRB00002991; FWA number: FWA00017598) the Medical Research Involving Human Subjects Act did not apply to our research.

In addition to the informed consent and confidentiality, various additional ethical principles were taken into consideration during this project: Working on mutual respect, participation, active learning, making a positive change, contributing to collective action, and personal integrity (Abma *et al.,* 2019; Banks and Brydon-Miller, 2018). All participating organizations and involved professionals were selected according to their intention and willingness to be part of a larger project striving to further develop experiential knowledge. Approval was obtained for the activities and the publication of findings. Ethical guidelines as well as dedicated time within our research team meetings and conversations with critical friends and peers were helpful to discuss issues of power, ethics, and responsibilities.
The Dutch code of conduct for research integrity (VSNU, 2018) as well the research code of VUmc have be taken into account. In conformity to European privacy regulations (General Data Protection Regulation) all data has been stored in a protected environment. Sensitive data (such as the written summaries) amongst participant and researcher have been transferred by email with encryption.

Findings

All participants are familiar with mental health distress in their background, having suffered from depression, suicidality, eating disorder, dissociation, burn-out, post-traumatic stress disorder, psychosis, bipolar disorder and/or addiction. Some of the participants have roots in families where trauma or emotional neglect took place, sometimes as a Child of Parents with a Mental Illness (COPMI). This contributed to their motivation to work in a mental health care setting. Some of the participants decided to make a career change after a relapse and started the training as part of their reintegration. Others were determined to work as a mental health care professional with lived experiences from the beginning.
The actual use of experiential knowledge by professionals affected four levels: their personal-professional development; the relation with service users; colleagues and; the broader organization.

Personal–professional development

First of all participants report that the training formed a solid base and led to increased awareness and insights on how to work with personal experiences in a professional context. Participants positively evaluated being part of a group where there is space for sharing their personal recovery journey. Although some expected to receive concrete guidelines during the training, in how to work with lived experiences, participants say they benefitted from the reflective practice at the heart of the training. Joint reflections contributed to the transfer from lived experiences to experiential knowledge.

Participants faced the following struggles when bringing this type of knowledge to their mental health work-context: (fear of) rejection, stigma and shame, imbalance and fatigue, uncertainty and confusion about professional identity.

The first struggle in using experiential knowledge concerned the fear of rejection, shame and stigma. They faced a paradox between feeling proud on being a survivor, versus feeling ashamed because of their background:

> *I have the feeling that they look different at me, which is why I avoid certain colleagues. When someone asked me to open up it at first provoked a sense of shame in me. [P11]*

The fear of rejection became so intense for some, that it became difficult to manage feelings of shame and self-stigma. The appearing social stigma in the context of mental health was often topic of discussion in the trainings:

> *It's as if Mental Health contexts carry a double layer of stigma, while it should be the opposite. I used to think it would be a resort where I would find ultimate understanding. How can we care for people while holding on to distorted images? [P3]*

Secondly half of the professionals were confronted with imbalance and fatigue at the start of the training:

> *It's a very intense process and I will need to work through my own issues a bit further, which evokes a lot of emotions. [P6]*

> *I really had to learn how to divide my energy and not become too much emotionally involved. It's a process, but it definitely improves over time. [P7]*

Thirdly, working with experiential knowledge in some cases interfered with complex trauma and adverse childhood experiences, that became reactivated. In some cases, working in Mental Health contexts functioned as a coping mechanism, because professionals learned to dissociate and refrain from personal experiences in the past:

> *I wasn't aware of the impact of the relationship with my father until I started this training and I am feeling really triggered by it right now. [P2]*

Even though three participants (P2, P5, P6] dropped out of work during or after the training, others reported signs associated with "post-traumatic growth", referring to the joint crisis and resilience they relived when reflecting on their personal-professional pathway.

Despite these struggles that came to the fore, the growing awareness of an existential, embodied, intuitive source of knowledge was helpful in sense-making processes with users:

I feel the space to concentrate on deep human suffering such as the loss of a parent who was abusive. [P4]

Some reflected on it as part of an ongoing process of personal recovery and professional development, while others report about an actual integration of the personal-professional identity. This ultimately led to increased self-compassion and self-acceptance:

I've come a long way but it definitely made me stronger, I feel so much more secure in my working practice. [P6]

Even though many report this process to be non-linear, the majority experienced feelings of pride, respect and being able to break the stigma and taboo at work:

This is who I am, it's completely me and I finally don't feel the urge anymore to hide that specific side of my Self. It's a birthright of freedom. [P7]

Relation with service users

Participants gave examples of how their experiential knowledge affected the relationship with service users. This concerns four pros: mutual recognition, embodied knowledge as an important resource, feeling less stigmatized and feeling hopeful towards recovery, which will also be further explored in a separate study upon the perspectives of service users. Few examples also indicated that some users prefer the traditional professional role, considering the professional as an "expert".

First of all, participants oftentimes received positive feedback from service users, after revealing their background and struggles with mental distress and/or addiction. This not only resulted in strong rapport, but also hope and felt understanding, because "the professional knows what he is talking about":

I oftentimes feel more connected to some of the users than to my colleagues and I can also give practical tips on how to cope with certain distress. [P10]

Secondly, participants explained that they developed an extra sensibility in relation to users, stating a professional with experiential knowledge can easily empathize with and attune to users' needs, feelings and conditions through the use of experiential knowledge:

I am much more aware of the intuitive and embodied knowledge I have and which helps me to resonate with users, a very powerful tool! [P13]

I can detect first signs of early psychosis, because I recognize things from personal experience. [P1]

Together with service users, participants search for ways to make sense of what has happened in the past. As part of this co-production, participants sensed they could contribute to the recovery process of users, especially when it comes to meaning making:

I enjoy working in a narrative fashion with users and frame things in meaningful ways. [P15]

Thirdly, the experiential knowledge that is derived from lived experiences brings in alternative perspectives and insights, that facilitate processes of destigmatization, normalization and humanization, e.g. taking voices seriously by exploring their meaning:

People tend to pathologize behaviors that I would consider as natural diversity. I often talk about the odds of my father, who suffered from bipolar disorder but from whom I learned most important lessons of life. [P15]

Fourthly, participants typically stimulated users' agency and empowerment and thereby their recovery-process. Oftentimes participants chose to postpone judgements, while facilitating learning processes and avoid decision-making without users' consent or active participation. Professionals who harness experiential knowledge serve as a positive role model, because they represent and model both vulnerability and resilience in one:

I want users to feel my confidence and hold hope for their future. [P5]

However, in a minority of the cases, participants were confronted with negative attitudes from service users who preferred to hold on to the perception of an 'unimpaired professional':

Some users don't appreciate all that much self-disclosure and really want you to be present as a professional, which should definitely be taken into account!. [P3]

Users need to be able to relate to me. If the gap is too large or too small, I cannot serve as a positive role model. [P10]

Participants underlined they continuously have to make estimations to what extent service users can identify themselves with the revealed living examples and what is helpful in this regard:

There is a group of users that feels even less confident about their personal chances when they see me working, living the life I have now. They get insecure about their capabilities because they tend to compare too much. [P12]

They indicate that the level of inter-relational proximity requires precision and that experiential knowledge has to be used in an adequate and professional way, in order not to trigger role-confusion.

Colleagues

Participants shared that they faced both positive as negative responses from colleagues. First of all, their coming out stimulated colleagues in the team to open up as well and became more responsive to a users' perspective and showing solidarity:

> *After I started talking openly, a few colleagues individually shared details from their personal lives, which I appreciate because if we want to realize a broader climate-change, more openness and safety are vital. [P9]*

These responses were marked as conditional to feel supported and mandated to work with this "new" source of knowledge:

> *One of the psychiatrists in my team particularly values my input and asks my opinion from a service users perspective. This active support of an authority was what we really needed. [P14]*

Participants believe that working with one's personal narrative and lived experiences requires a lot of reflexivity. The use of experiential knowledge in this regard became an important topic in some of the teams, during team-meetings, moral case deliberations and evaluations.

However, participants also faced negative responses and the following topics were distilled: devaluation, unfamiliarity with experiential knowledge and negative experiences with peer workers.

First of all, a coming out about a mental health and/or addiction background in their team several times led to further silencing rather than openings in the concerned teams, which participants attributed to unfamiliarity and taboos. Not being part of one home-team (due to flex-contracts) appeared to be a double complexity in this regard:

> *I don't always feel confident enough to expose my experiential expertise, because I am not part of the team and not sure how colleagues receive my input. [P7]*

Secondly, another recurring theme appeared to be the disqualification and devaluation when sharing one's vulnerability. Some colleagues looked down on professionals who presented their former status as a user and devaluated their current competency.

Colleagues were wary of possible risks or adverse side-effects, such as too much personal involvement:

Thirdly, some peer support workers felt intimidated by traditional professionals entering 'their' field of expertise.

> *There is still a lot of tension between me and the formal peer support workers here. It's like I have to prove my status and background as a former user to them! [P6]*

Lastly, some mental health workers associated the introduction of professionals using experiential knowledge, with previous struggles during the introduction of the peer workforce, sometimes resulting in a negative connotation:

We all have seen peer workers dropping out, derailing or malfunctioning because they get easily triggered on a personal and emotional level. [P12]

Impact in the organization

All participants shared a political mission to influence the working culture and the training offered back up in this regard. In each organization the mission and/or vision statement was reviewed specifically on the positioning of experiential knowledge. This resulted in a growing awareness that acknowledgement of this new source is needed by incorporating it in mission and/or vision documents. A positive of attitude of directors seemed crucial for a transition in this direction:

Once we thought that experiential knowledge was a welcome addition to care as usual, now we know that it's an essential source and I am very glad our director actually supports this mission. [P10]

This led to a further validation of the use of experiential knowledge, whilst other challenges came to the surface. These challenges were associated with the established hierarchic culture in which some values conflict with notions of emancipation, empowerment and inclusion. The identified challenges included: system and risk-management, operational policy and role of managers.

Participants report having minor chances to change the climate on an individual basis due to time and regulation restrictions, stemming from production-norms and standardization of care based upon evidence based and principles. They struggled with the rigidness of the medical model based upon avoiding risks, which often did not meet users' needs:

I need confidence. This role fits a jacket to me, but many colleagues still need time to adjust to the idea that lived experiences can nourish my professional work. [P6]

Collective actions that were organized bottom-up, such as disclosing one's personal background on a personal poster in public spaces in the organization, were not always fostered:

It's just all about the way I – and thereby also in general users here- am being perceived. One of my colleagues said it was exhibitionistic to expose myself in this manner. She believes it might burden users but I believe she feels endangered in her position! [P8]

For most participants however, the lack of safety and support from a close by manager was a more hindering factor in the professionalization and expansion of experiential knowledge. While in most teams the supervisors were well informed about the use of experiential knowledge, there was a lack of involvement of managers. This manifested in a lack of operational policy of experiential knowledge in the organization, despite apparent vision and mission statements:

I am glad that the board of directors of my organization supports this development, but I have to deal with the lack of knowledge and support from my direct manager. [P1]

Originality/value

In addition to peer support workers, professionals with lived experiences play an important role in working recovery oriented. The identified contributing factors match with those seen in peer workers: providing hope and inspiration and supporting users to make sense of and take control over their lives (Repper *et al.,* 2013). However, given that all involved professionals practiced a core profession of nursing, social work or humanistic counselling, they incorporated experiential knowledge in a broader body of knowledge. While the use of experiential knowledge by traditional professionals is scarcely accepted and the debate on how to corporate it in meaningful ways is still ongoing, the participants in this study came to the fore in their new role as professionals harnessing experiential knowledge, demonstrating bravery and strength. The training and follow up group not only facilitated personal–professional growth and extensive self-awareness about the use of experiential knowledge with regard to users, it also influenced the relationship with colleagues and the organization culture they were part of. Aiming for transformation on both micro and meso level seems a pivotal combination. Having dealt with mental health distress in their past, professionals risked stigma and rejections when introducing this as a type of knowledge in their mental health practice. They were challenged by ambivalent responses from colleagues and by a culture still mainly focusing on risk-management. Especially psychologists and psychiatrists seemed unfamiliar with this type of knowledge, sometimes devaluing it, despite positive statements on the contributions of lived experiences of several representative bodies (British Psychological Society, 2020; Royal Australian and New Zealand College of Psychiatrists, 2016). Also, in some teams former dissatisfying experiences with peer support workers impacted the current view on working with this type of knowledge.

Giving space to lived experiences not only implies a transformation of our understandings of mental health distress, but also affects policy, governance style and ethics of the entire organization. It takes a determined mind and a reflexive practice to work through this, with the back-up from open-minded colleagues and supervisors. Solely integrating experiential knowledge to policy has not been sufficient (Byrne *et al.,* 2017), but contributing to an open and safe work climate that supports dialogues, can make a difference and awakens social consciousness.

Social implications

After the rise of the recovery movement, its notions seems to be plateauing and the current model of recovery makes mental health distress an explicit problem of individualized identity, rather than an effect of structural inequality (Harper and Speed, 2013). Although the assumption had been that the employment of peer workers automatically contributed to a broader culture of change and disclosure for mental health professionals, this seems not to be sufficient (Byrne *et al.,* 2021). Whereas traditional professionals harnessing experiential knowledge built on to these efforts, they also faced challenges to further sensitize their environment while undergoing a personal-professional transformation.

This transformation resembles novel thoughts on professionalism and uncovers existing paradoxes attached to experiential expertise: at times being an "upgrade", while other times considered a "downgrade".
A discussion about the distinctions between academic (psychologists, psychiatrists) and applied mental health professions (nurses, social workers) seems vital to overcome the possible risks that professionals with lived experiences are exposed to when opening up about their double identity. Miranda Fricker invigorates this debate through her concept of epistemic injustice, stemming from structural inequalities of power (Fricker, 2007). While professionals with lived experiences seem well positioned to be political advocates for service users, they also remain depended on those who have final decision power in mental health system, oftentimes managers, psychiatrists and psychologists. The latter seem less invested in using experiential knowledge, possibly because of conflicting interests or more inadvertently due to "a blind spot". This results in social exclusion and silencing of tacit knowledge, which also brings us to Foucault (1982), who introduced the concept of parrhesia, which means "freedom of speech". In line with parrhesia, truth is not related to objectivity and evidence but to morality. It imposes moral questions on power definitions: what or who is at stake when certain knowledge is in- or excluded? Even though all professionals may have "best" intentions, there is an evident division between those with a reputation as an expert and those who are not believed to have valid expertise. Professionals with lived experiences question this dynamic, by embodying a living example of "therapatients" (Goldberg *et al.,* 2015).

Organizations and individuals that aim to harness lived experiences in a professional manner, could benefit from a participatory action project (Abma *et al.,* 2019). The collective power of a project group of professionals with lived experiences helps to transform feelings of shame, blame, stigma into strengths and encourages participants to speak up and share testimonies from users perspective. This however is only a first investment and needs to be paired with collective changes targeting a change of culture. In our project we therefore creatively referred to "spicy" principles of Political-critical, Existential, Practical, Personal, Ethical and Relational, captured with the acronym "PEPPER" (Weerman *et al.,* 2019).

Through these principles one can build on a climate that supports varying perceptions and voices. Professionals with lived experiences may in fact contribute to the expansion of experiential knowledge in the broader organization by seeking collaboration with peer support workers, but also with supervisors, managers and policymakers. According to this study social change starts from a bottom up movement and synchronously should be facilitated by topdown policy.

Limitations

This study has made it evident that the use of experiential knowledge by traditional Mental Health professionals is considered a new but meaningful exploration, that contributes to a renewed recovery movement. However, the current study was conducted locally and there are only few similar comparable studies that focus on both the personal–professional process as well as changes in the broader organization. Also, the context where the professionals are working and to what extent it is recovery oriented, trauma and user informed should be taken in to account in follow up studies.

Even though all participants in this study claimed to work in a recovery oriented setting, existing processes of stigma and shame in the working culture seemed a hindering factor during the implementation of experiential knowledge by professionals.
Additionally, little is known about how users perceive the use of experiential knowledge by established professionals. It seems of value to further explore the perspectives of users this regard, since many of them also "grew up" in a traditional system with predefined user-practitioner roles, especially related to psychologists and psychiatrists. This will be subject to research in a subsequent study of the authors.

Declaration of interest statement

The authors report no conflict of interest.
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Appendix

Topic list interviews
Opening
Aim and estimated duration of the interview
Consent about audio recording
Member check procedures
Introduction
Could you please tell me something about yourself and with regard to current work, function, responsibilities, organization and previous work-experience
Education background
Professional use of experiential knowledge
Reason(s) to start training "experiential knowledge"
Implications of a professional use of experiential knowledge
Differences and commonalities between peer support workers and professionals using experiential knowledge
Actual use of experiential knowledge
First time explicitly using lived experiences and concerned motives
Use of this type of knowledge embedded in a role as nurse/social worker/humanistic counsellor
Personal values and mission as a professional
Lessons learned from the training and new insights, changes over time
Example on the use of experiential knowledge in current practice (considerations, when, how)
Complicating and facilitating factors
Possible outcomes for users
Collaboration with peer support and/or other professionals
Closure
Responsive evaluation procedure