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

Karbouniaris, S.

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Chapter 5

Explorations on the use of lived experiences by psychiatrists: facilitators and barriers

Karbouniaris, Simona
Boomsma-van Holten, Marjolein
Oostindiër, Antoinet
Raats, Pascal
Prins-Aardema, Cecil
Weerman, Alie
Wilken, Jean Pierre
Abma, Tineke

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Abstract

Purpose
This study aims to explore the perspectives of psychiatrists with lived experiences and what their considerations are upon integrating the personal into the professional realm.

Design/methodology/approach
As part of a qualitative participatory research approach, participant observations during two years in peer supervision sessions (15 sessions with 8 psychiatrists with lived experiences), additional interviews as part of member feedback and a focus group were thematically analysed.

Findings
Although the decision to become a psychiatrist was often related to personal experiences with mental distress and some feel the need to integrate the personal into the professional, the actual use of lived experiences appears still in its early stages of development. Findings reveal three main considerations related to the personal, professionality and clinical relevance comprising 11 facilitators and 9 barriers to harness lived experiences.

Research limitations/implications
This study was conducted locally and there are no similar comparable studies known. It was small in its size due to its qualitative nature and with a homogeneous group and therefore may lack generalisability.

Practical implications
Future directions to further overcome shame and stigma and discover the potential of lived experiences are directed to practice, education and research.

Originality/value
Psychiatrists with lived experiences valued the integration of experiential knowledge into the professional realm, even though being still under development. The peer supervision setting in this study was experienced as a safe space to share personal experiences with vulnerability and suffering rather than a technical disclosure. It re-sensitised participants to their personal narratives, unleashing its demystifying, destigmatising and humanising potential.

Background

Like all physicians, psychiatrists have a privileged position in society and in the context of mental health care: they have status, expertise, considerable power and are granted access to the most intimate parts of patients' lives. But with these privileges come "darker" consequences (Gerada *et al.,* 2018). Entrance to medical school is determined by selection procedures and typically starts off with homogenising influences to neutralise the impact of social differences among medical students (Beagan, 2000). For some students this socialisation entails letting go of prior conceptions that do not match the medical professional identity (Beagan, 2000).

Specifically, the relational dimension of the work is strongly mediated: during pre-clinical years there is rarely any patient contact while being immersed into a largely biologically oriented medical framework. Then, during residencies, patient contact is thoroughly controlled by protocolised clinical procedures (Brincat, 2006). Few components of the current curricula focus on the emotional landscape of medical students, leaving those struggling with personal issues, isolated (Shapiro, 2011). In learning therapy emotions –one's own and others' – ought to play an important role in the personal–professional development. However, medical trainees are known to avoid professional help for their own struggles (Hankir *et al.,* 2017) even though they suffer from higher rates of psychological distress and suicide attempts than the general population (Beyond blue, 2013).

Historically, reservations on self-disclosure date back to the earliest years of traditional psychoanalysis in which the therapist was supposed to be impenetrable to the patient, acting like a mirror (Peterson, 2002). Thereafter, psychodynamic theories considered selfdisclosures as possibly harmful for patients. In spite of that the rise of the humanist movement in the 1960s advanced the argument that self-disclosure could be therapeutic, as also emphasised by feminist and self-help movements. In addition, Jung (1963) introduced the concept of the wounded healer and the ability to draw from wounds appropriately in therapy and warning for possible splitting of the helping professionals.

Surprisingly, there are few detailed reports about what it means for a therapist to process, resolve or recover from a wound in such a way that it might enhance, rather than interfere with, providing effective psychotherapy. Psychotherapists are often wary about the recovery status of the wounded healer: "at worst, we judge, and at best, we worry" (Zerubavel and Wright, 2012). Nowadays narrative, humanistic and existential orientations all have different takes on the effect of therapeutic self-disclosures (Zur, 2007). Perceived benefits vary from a strong therapeutic alliance to the decrease of feelings of shame and stigma (Karbouniaris *et al.,* 2020). Several new approaches to therapeutic self-disclosure surfaced towards the end of the 20th century and reframed it as boundary-crossing rather than violating, referring to its possible benefits (Psychopathology Committee of the Group for the Advanced of Psychiatry, 2001).

Even though lived experiences are often part of the decision to pursue psychiatry, medical trainees often feel insecure to disclose and worry about ramifications from educators and colleagues (Adame, 2011).

Shapiro (2011) states that medical education overall is characterised by its persistent ignoring, detaching and distancing from emotions. In recent years much has been written on the exposure to stress in medical school and the risk of burnout due to mental distress (Swensen and Shanafelt, 2020; Yang and Hayes, 2020). Tacit rules of the so called "hidden curriculum" in the Dutch professional culture concern hard working norms and trainees are expected to meet high quality physician performance achievements (Van den Goor, 2020) prioritising professional career above private life in a period in which age peers developmentally focus on different aspects of life. Next to general stressors of residencies (e.g. fatigue and sleep disruption, frustrations from working with demanding patients, facing unresolved outcomes, poor peer support), psychiatry training in particular has its own relatively unique set of challenges, including adversities such as suicides (Brenner *et al.,* 2018; Duarte *et al.,* 2020). In addition to the high achievement culture in many mental health services there is the pressing problem of being understaffed (Brittlebank *et al.,* 2016). Heavy workloads and reorganisations, as part of the marketisation of health care, hamper a humanistic practice and negatively affect the calling as a doctor (Van den Goor, 2020). As a head of the team or organisation, they face end-responsibilities and are legally governed by disciplinary regulations. Such responsibilities permeate indeed all aspects of life, as one may be constantly occupied. Over time psychiatrists develop a deep-rooted sense of professional identity "the medical self" which allows them to do the work as demanded, but becomes dominant and one is never "off-duty" (Gerada, 2022).

Peer supervision settings form an acknowledged hallmark of the professional setting to facilitate learning and develop a balanced and healthy professional identity. Key is to establish an emotionally-safe environment which seems often not naturally established (Walkman and Williston, 2015). Hence, the exploration on how to use lived experiences may not be a matter of subject in these settings and thus may remain unacknowledged. Novel policy attempts to reform the mental health field show several interesting developments and innovations in which the value of lived experiences of nurses and social workers are discovered. The Division of Clinical Psychology and the Royal Australian and New Zealand College of Psychiatrists value the lived experiences of, respectively, psychologists and psychiatrists, stating "lived experiences can provide a vital contribution to stigma reduction" (British Psychological Society, 2020; Royal Australian and New Zealand College of Psychiatrists, 2016). Yet, psychiatrists are commonly not educated in recovery and resilience principles, neither in working with lived experiences professionally. In this study, we will focus on the perspectives of a group of Dutch psychiatrists with lived experiences: What are their considerations upon the use of lived experiences in their clinical practice? Which facilitators and barriers do they face?

Design and methods

Design

This study originated as part of a large ongoing participatory research project initiated in The Netherlands in 2017. The project aimed at the professionalisation of experiential knowledge by professionals working in mental health services, specifically targeted at the values and ethics from the perspective of patients. Therefore, the participating mental health organisations decided to further stimulate the reflective use and integration of experiential knowledge by psychiatrists in their clinical practice, as part of a collaborative

learning network. One of the goals was to involve lead professionals, which is why a group of psychiatrists was invited to form a peer supervision group. This group consisted of eight members, and was set up in the beginning of 2020.

The first and second author initiated the group, after which the first author guided the group, using a qualitative participatory approach (Abma *et al.,* 2017; Abma *et al.,* 2019). While the goal of the group was to exchange ideas on the use of lived experiences in a consultation setting with peers, it also promoted collective learning and integration of professional and personal knowledge. The first author, being an expert-by-experience herself, created a safe atmosphere and guided and structured the meetings by using a peer supervision method.

Next to the peer supervision group, the researchers additionally conducted three in-depth interviews with the participants to gain a rich and multi-layered understanding of the context, culture and complex process of the participants. Several qualitative methods (participant observations, interviews and a focus group) were used to collect and triangulate a wide variety of data. Data was collected during 15 peer supervision sessions. During the aforementioned activities, three psychiatrists became actively involved as co-researchers from this article (authors 3, 4 and 5). They helped to interpret data, co-presented at conferences and have co-written the manuscript.

Methods and data collection

Participant observations during the peer supervision sessions (1) from March 2020 to June 2022 (2), three interviews and a focus-group (3) were part of the data collection.

Open and active participant observations of in total 30 hours were held during 15 peer supervision group meetings. The first researcher immersed herself into the context of the psychiatrists. In the peer supervision group (n = 8), a supportive atmosphere was established. Each meeting, one of the members was invited to share a dilemma or struggle both work related and personally. Even while the themes discussed in this peer supervision group seemed not exceptional or different from regular peer supervision groups, they were thoroughly reflected in the context of one's background. After each meeting, a reflection was written by the facilitator and sent to the participant for validation/member check. This was often perceived as helpful in further processing and reflecting on the presented issue. Few meetings had been organised remotely because of the measures of the pandemic, after which the members expressed a strong preference to meet live, even if that could take up to 2 h travel time. Over time one member stopped attending, because one of the other members became her supervisor. Another member became long-term ill and was not able to work. The group decided to select and invite one new member.

In addition, three in-depth interviews with a duration of 60–75 min each took place at the workplace of the interviewee. These interviews were used to thoroughly gather additional insights and reflect on the personal background of and with the participants. Purposeful sampling was used to value the multiple perspectives of these participants and as a form of dialogue to come to mutual understanding (Abma *et al.,* 2016; Abma, 2020).

All interviews were transcribed, then summarised and returned to the individual participant for a first validation ("member check").

Lastly, a focus group of 2 h with psychiatrists and the researchers was organised to check findings with representatives of the group. All psychiatrists were invited for this meeting and four actually attended the meeting. The strategies developed for research purposes were part of an action and reflection cycle which involved brainstorming/ thinking, planning, doing and reflecting. Rather than being a static, linear process, these phases were intertwined and generated a cyclical process of praxis (action and reflection) that provided opportunities for change. Table 1 provides definitions for each phase and example strategies used in each of these phases.

Table 1. *Action Reflection Process and Related Strategies*

Action Reflection process phase	**Strategies**	**Whom involved?**
Brainstorming/thinking 1. Identify who we want to reach (lead professionals) 2. Identify how to reach	1. Set up of peer supervision group for psychiatrists with lived experiences 2. Top down mailing and warm recruitment at conference	1. Authors 1, 2, 4, 6 2. Directors of the involved mental health care organizations + authors 1, 2
Planning 1. Planning of meetings 2. Determining whom will facilitate 3. Determining method used for peer supervision meetings 4. Planning of interviews 5. Planning focusgroup	1. Collaboratively establishing group 2. Proposal to let group be facilitated by expert by lived experience researcher 3. Discussing several peer supervision methods	1. Author 1, author 2 and all participants
Doing 1. Organizing a reflection space to explore how to use lived experiences as part of this profession 2. Establishing a social and safe climate	1. Facilitating peer supervision group + interviews 2. Promoting interactions in between peer supervision sessions	1. Author 1 2. Author 1, author 2
Reflecting 1. What is the common central theme? 2. Did we meet our goals? 3. How can we reach those who are not involved?	1. Evaluation meetings 2. Focus group interview 3. ,,	1. Author 1 and all participants 2. Authors 1, 2, 3, 4, 5, 6 3. All authors and all participants

The combination of data methods supported an iterative process in which outcomes of the interviews formed the input for the group consultations and vice versa. The data provided rich and multi-layered understanding of the context, culture and complex process of the participants.

The participants were working in different mental health in- and outpatient settings, as displayed in Table 2. Their ages varied from 37 to 65 years, amongst whom five female and three male.

Analysis

As part of an interpretive phenomenological analysis, Braun and Clarke's (2006) thematic analysis approach was used to identify, analyse and reflect on possible patterns or categories that emerged during the interviews and during discussions in the project team.

All data was triangulated by using this approach involving familiarisation, coding and generating recurring themes, reviewing and eventually defining them. In their double role, researchers and participants as part of a learning community, collectively reflected and discussed findings, which helped in the process of sense-making and analysis. Themes that emerged repeatedly were discussed and reflected on with the co-researchers and at the end of the project, a focus group was organised to discuss all results which helped to deepen the team's understanding and further led to the identified categories.

For example, there was discussion about the difference between disclosing and sharing. Disclosure was not only associated with a technical intervention, it was also referred to as verbally revealing information, while some of the participants experienced that disclosure sometimes shifted to "sharing" in the sense of mutuality.

Quality procedures

Several quality procedures were used to enhance credibility, authenticity and dependability of the data (Lincoln and Guba, 1989). First of all, these criteria were met by inviting the participants through different itineraries: partially via the broader research project and partially via in-person recruitment at the annual national congress for psychiatrists. This seemed helpful in reaching different psychiatrists and gaining trustworthiness. We searched for psychiatrists who had interest in and/or direct experience themselves with mental distress or via relatives.

Secondly, joining professionals over a longer period of time in the peer supervision group (2.3 years), helped gaining a deepened understanding of the context and work ("prolonged engagement"). Participants received a summary after the interview or group session to check if they recognised the script and had any additional reflections ("member check").

Table 2. *Participant characteristics*

Participant	Gender	Age	Mental health setting	Peer supervision group	Additional interview	Focusgroup
1	F	56-65	Geriatric inpatient care	x		
2	M	46-55	Ambulatory addiction treatment	x	x	x
3	F	56-65	Private sector	x	x	x
4	F	46-55	Private sector	x		x
5	M	46-55	Bipolar treatment	x		
6	F	36-45	Child and adolescent treatment	x		x
7	F	46-55	Psychosis treatment	x	x	
8	M	46-55	Adolescent in and outpatient treatment	x		

Thirdly, the active engagement of three psychiatrists as co-researchers (authors 3, 4 and 5) in the analysing and writing process further sharpened and validated findings. The first author kept a log of field notes and memo's in which important steps and changes were reported, as part of an audit trail. Triangulation ("capturing and respecting multiple perspectives using various methods and sources") contributed to the dependability and confirmability of the study.

Lastly, as part of transferability findings were discussed in the research team and related advisory board. Findings were also presented during an annual conference for psychiatrists in The Netherlands (April 2022) and the NHS International Wounded Healer Conference in London (March 2022) which fostered the transferability of findings.

Ethical considerations

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

The Dutch code of conduct for research integrity (VSNU, 2018) as well the research code of VUmc has to 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 has been transferred by email with end-to-end encryption. In addition to the informed consent for the interviews and confidentiality, various additional ethical principles were taken into

account 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). The involved professionals were invited for the interviews and peer consultations as part of the research project striving to further develop experiential knowledge. Ethical guidelines as well as dedicated time within our research team meetings and conversations with critical friends from the advisory board were helpful to further evolve discussions of power, ethics and responsibilities.

Findings

In answer to the research question we identified three main considerations related to the personal, professionality and clinical relevance comprising 11 facilitators and 9 barriers to harness lived experiences. Table 3 provides an overview of these facilitators and barriers.

Facilitators and barriers related to the personal

The choice to become a psychiatrist and work in mental health care was largely rooted in a personal background and struggle with mental health. The majority of the psychiatrists in the peer supervision setting openly shared about their issues from the beginning, e.g. in having dealt with depression, eating disorder, parents with psychiatric disorders, insecure attachment and (relational) trauma.

The supervision group facilitated a safe space, enabling to non-judgementally discuss the relation between personal background, training/residencies and current work setting with peers (F1). However, most of the participants did not share their personal background in their daily working context as the cultural norm is not to be open, which appeared to be one of the important barriers (B1). Especially the implicit and sometimes explicit permeating messages about the possible harmful effects as well as striving for professional objectivity, impeded the opportunity to reveal more of the self at work (B2).

Table 3. *Overview of facilitators and barriers*

	Personal	Professionality	Clinical relevance
Facilitators (F)	1. Sharing and non-judgmentally reflecting on illness and recovery themes in safe peer group setting	4. Connecting overarching personal themes to their patients' recovery	6. Quality of relationship with patients
	2. Feeling convenient and confident in revealing personal experiences	5. Share and critically reflect with supportive colleagues	7. Reframing and socially validating experiences of patients
	3.Investing in personal-professional development and well-being		8. Not speaking out might be contra productive
			9. Structure of working context to not become overly involved was helpful
			10. Balancing out the amount of disclosure
			11. Catalyse openness and stimulate destigmatization among colleagues
Barriers (B)	1. Cultural norm of not disclosing in daily working context	6. Lack of acknowledgment of experiential knowledge in psychiatric discipline	9. Underestimated status of drawing on lived experiences
	2. Implicit and explicit messages about possible harmful effects as well as striving for professional objectivity	7. Institutional and disciplinary pressure as lead professional, role ambiguity and fear for loss of status	
	3. Low diversity tolerance in training and peer supervision culture	8. Negative associations regarding the use of lived experiences and vulnerability	
	4. Involving the personal can be seen as boundary crossing		
	5. Limited trained in recovery and resilience principles		

Participant 1: “Am I actually allowed to share and connect to patients on a personal level, I wondered at first?”

Even though all participants attended at least one other peer supervision group next to this one, they also clarified that these groups often did not tolerate the involvement of their personal narratives with mental distress (B3). Involving the personal was considered transgressive and made the impression of violating professional codes of conduct (B4).

Participant 3: “Previous peer supervision groups felt unsafe and the topics discussed remained very superficial. My personal disclosures were looked at as ‘acting out’. But in this group, I can really be myself, as a whole with all my issues and I don’t feel alienated anymore.”

Along those lines the training culture was frequently perceived as a barrier in exploring possible benefits of lived experiences and incorporating them into the professional realm. Participants state they were very limited informed in recovery and resilience principles (B5).

While learning therapy made participants aware of occurring countertransference processes it did not support a coming out nor an explicit use of lived experiences in clinical practice, and sometimes made it more burdensome. Participants sometimes for the first time, started sharing about their “patient identity” and mental distress. Sharing this in presence of peers, made them feel less ashamed and burdened. It facilitated the realisation that working with personal experiences requires that one feels sufficient convenient and confident in doing so (F2). Consequently, they became aware of the importance to invest in a personal–professional development and they realized how difficulties in reaching out for professional help earlier sometimes led to the tendency to self-diagnose and self-treat (F3).

Participant 6: “It has been difficult to accept help for myself, which perhaps has to do with some kind of parentification, but I eventually found a trusted learning therapist.”

Facilitators and barriers related to professionality

A lack of acknowledgement of experiential knowledge as a valuable (re)source in the psychiatric discipline was perceived mostly as a barrier (B6). Sharing collective narratives of recovery processes unrelated to specific psychiatric problems was often perceived as irrelevant in the working context and therefore risked a devaluation of one’s professionality.

Yet, the psychiatrists with lived experiences explored how overarching personal themes connected to their patients’ recovery, such as knowing how to cope with existential loneliness and alienation and the effort needed to rebuild one’s life after a period of crisis (F4).

Participant 2: “I often recognise the way people need to re-establish their lives, during and after treatment, and even though I never dealt with substance abuse, I can see parallels with my own recovery.”

Participants learned to value lived experiences as complementary to other sources of knowledge, and in this sense the possibility to critically reflect with supportive colleagues on harnessing lived experiences was paramount (F5). They emphasised the importance of having sufficient awareness of intention and function when drawing on lived experiences.

All stated however that the conditions to study and work professionally with lived experiences are currently suboptimal. Balancing out one's personal and professional development during their residencies often led to negative evaluations.

Participant 7: "When some of my issues came to the surface, I immediately was assessed negatively by my supervisor. We are supposed to be a role model in mastering all of our emotions."

The institutional and disciplinary pressure in work, as head of a team or medical director hinders participants to work with experiential knowledge. Participants fear for a loss of status, role-ambiguity and possible devaluation (B7). They argued that especially colleagues associated the use of personal experiences with "vulnerability" and "weakness", undermining the presumed neutrality of the physician, rather than seeing the strengths or qualities that might come along as well (B8).

Facilitators and barriers related to clinical relevance

Participants expressed clinical relevance to drawing on lived experiences, despite its underestimated status in the field (B9). Most of them attributed relevance to the quality of the relationship with patients which they identified as most important facilitator (F6).

Participant 5: "I was one of the few to whom she was able to securely and safely attach, her loneliness resonated with me. I felt I did well, sharing on such human level."

Participants mentioned that patients may benefit from the personal contact, as it enhanced a social function in validating their experiences and may decrease loneliness or estrangement. They searched for ways to re-frame personal distress and transfer it to meaningful insights for patients, sometimes by normalising their experiences (F7). For instance, they looked at the affective and ethical meanings of lived experiences.

Alternatively, they began questioning whether not being transparent about personal issues might be equally harmful and counterproductive (F8). Not speaking up about these issues may lead to unattendance in how the personal becomes entangled with the professional.

Participant 8: "The moment you are unaware of countertransference processes and you don't reach out to reflect, your lived experience might get in the way."

Accordingly, participants explored the value of involving their lived experiences in both psychotherapy and medical consult settings with patients who seemed open to input from their practitioner. Some clarified that the structure of their work setting was helpful in this regard, to not become over-involved (F9). Balancing out to what extent personal information was used to provide hope and recognition, seemed crucial (F10).

Participant 4: "I saw a female patient in treatment for psychosis after sexual trauma. I needed to make the right estimation whether my experience could be helpful to her, and to what extent I would reveal about myself. I realised that my experiences with treatment and medication could make her feel less ashamed."

Aside its impact on the recovery and healing of the individual, participants considered it to be insightful for colleagues as well, as it could catalyse openness and stimulate destigmatisation (F11). Especially for trainees who aim to incorporate lived experiences this seemed challenging because of their junior position.

Discussion

To our knowledge this is the first study researching the considerations upon the use of lived experiences by psychiatrists. Despite previously expressed acknowledgments of self-disclosure from nationwide professional bodies (Psychopathology Committee of the Group for the Advanced of Psychiatry, 2001; Royal Australian and New Zealand College of Psychiatrists, 2016), this study reveals that the use of lived experiences by psychiatrists is rather exceptional. The emphasis on neutrality and standardised approaches, driven by harm and risk-reduction principles, divides the personal from the professional. There is an overall lack of education in methods and skills during the training period regarding harnessing lived experiences. Nowadays primary curriculum in The Netherlands is prevailed by psychopharmacology and (cognitive behavioural and psychodynamic) psychotherapy, leaving psychiatrists unequipped to adequately integrate their lived experiences.

Due to the introduction of experts by experience in the workforce, established mental health professionals are becoming more and more aware of the value of personal stories in the professional arena. Consistent with our previous findings upon the use of experiential knowledge by nurses and social workers (Karbouniaris *et al.,* 2022) some psychiatrists acknowledged the value of using personal experiences. They underline that this can contribute to the recovery of patients, and can provide hope and inspiration, supporting patients to make sense of their experiences and take control over their lives. At the same time the psychiatrist profession entails its own typical challenges. At a system level, the psychiatrist is supposed to be a medical leader subject to disciplinary regulations, which leaves little room for being human and showing imperfections. Medical expertise is often deficit-laden and pathologising and sustains stigmatised views on psychiatry and ignores the freedom for different subjective narratives (Harper and Speed, 2012). Hence it largely ignores the relational and humanistic aspects of the physicians' work.

Findings from this study confirm that psychiatrists who desire to engage their lived experiences need to first become aware of internalised framings such as the stigma and burdens associated with mental health conditions. The peer supervision group seemed especially helpful in this regard.

Limited research exists focusing on the professional identity and "self" of psychiatrists and these studies have pointed out that the fluid nature of professional identity over time tends to shift from a reliance on technical expertise to one's own experience, values and knowledge that integrates professional and personal identities (Borchers *et al.,* 2014). Peer supervision settings are not only a mandatory part offering space for discussion with colleagues to review difficult or challenging decisions with others, they also allow room for reflection (van den Goor, 2020). The current peer supervision setting offered a space for such "deliberative practice". It re-sensitised participants to their personal narratives, unleashing its demystifying, destigmatising and humanising potential. While the peer supervision group might be seen as an attempt to re-sensitise professionals for their personal frame of reference, some argued to de-personalise the use of lived experiences and emphasise its collectiveness, searching for universal values and existential issues (e.g. fear of loneliness) that connect psychiatrists to the lifeworld of their patients.

Contractionary to social workers who were stimulated to reflect and discuss those reflections with patients as part of a deliberative practice (Karbouniaris *et al.,* 2022), psychiatrists seem to be caught in the object–subject dualism. Trained as both medical expert and psychotherapist, their traditional perception on epistemology seems to undermine knowledge derived from lived experiences.

However, consistent with Martin *et al.* (2020), sharing histories of personal vulnerability can lessen stigmatised views on mental health. This requires the psychiatrist to pass the "medical gatekeeper era", and start searching for a moral and normative professionality (van Os and Gülöksüz, 2022). This consequently corresponds with changing perceptions on the profession of the participating psychiatrists with lived experiences, taking into account relational ethics, such as shaping the relationship horizontally and a virtue based practice. Our study shows that respectful spaces where professionals are invited to share their insights rather than technically disclosing or introspectively analysing seem crucial.

Originality

The aim of the current study was to explore the considerations upon the use of lived experiences by a group of Dutch psychiatrists. The main finding of this study is that psychiatrists with lived experiences stimulate the integration of experiential knowledge into the professional realm, even though the acknowledgement of this type of knowledge is still in its early stages of development. Facilitators and barriers on the use of lived experiences are related to the personal, professionality and clinical relevance. Psychiatrists from the peer supervision group positively explored the possible value of their lived experiences with stress, trauma, complex family histories etc. They looked for opportunities to process, reframe and harness its meaning for the recovery of patients. At the same time the fear that those insights are not perceived as "professional" and considered a devaluation of the profession, held them sometimes back to openly share their considerations. The peer supervision setting in this study stimulated to share personal experiences rather than technically disclosing. It led to mutual recognition and re-sensitised participants to associate their personal background to their clinical practice and stimulated a learning process on how to incorporate lived experiences in a constructive manner contributing to its demystifying, destigmatising and humanising potential.

Practical implications

To conclude, we suggest the following future directions for practice, research and education. Firstly, to overcome shame and stigma attached to personal vulnerability, and start discovering the positive sides and potential of lived experiences, the format of the peer supervision group has proven to be useful. Looking at related mental health professions such as nurses, psychologists and social workers could provide even more inspiration on how to incorporate lived experiences (van Zelst, 2020).

Secondly, there is a growing urgency to feed the current curricula for upcoming psychiatrists with recovery informed principles, including the reflective use of experiential knowledge.
Thirdly, we recommend more research on peer supervision to develop a framework how experiential knowledge can supplement and be integrated in the existing body of knowledge of psychiatry. Research is also needed to collect substantial evidence on the added value of experiential knowledge related to treatment outcomes. Future research to subtle forms of stigma, and collaboratively reflecting with psychiatrists on their perceptions of professionality, can stimulate changes in mental health culture.
Lastly, psychiatrists “coming out” with their personal experiences can act as ambassadors and positive role models, showing in real life how this can enrich the profession.

Limitations

The current study was conducted locally and there are no similar comparable international studies known. It was small in its size with a homogeneous group due to its qualitative nature and therefore may lack generalisability. In addition, it seems of value to further explore the perceptions of colleagues (psychiatrists and psychologists) who to date remain reserved in the development of using lived experiences.

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Reflection III "Fascination and flow"

I got fascinated by psychiatrists as professional beings, already at a young age. Not particularly because they felt safe. My first encounter dates back to me being 17 years and seeing a psychiatrist.
I was intrigued but also intimidated by his way of reasoning, his pace and his knowledge, although he clearly could not reach me. And after one year he gave up. I was too complex, too introverted and he probably realised my attachment issues were in the way of establishing rapport.

During my research, I felt again intrigued by some of the professionals whom I met, and followed for some time. I learned that many of them used a discretionary space to relate to their clients, often in very creative and unconventional ways. Some of them invested in 'positive risk taking', and made the contact more unconditional in a way.
It was interesting to guide the group of psychiatrists with lived experiences for more than 2 years. Their journey was critical at times, in experiencing vulnerability instead of mastery. Often in contrast to nurses and social workers who were already more accustomed to working with their lived experience. Despite their career and position, or perhaps due to these, feelings of fear and anxiety resonated throughout the group dynamics, when revealing personal stories. The flow of the group was compelling.
If only we could use this energy for the transformation of the services. If lived experiences are more validated, would they be able to contribute to system changes? Or would they feel hindered perhaps by possible disciplinary consequences?

Upon my leave from this group of psychiatrists I received a card with the following writing: "You are the noblewoman who offers a rose to the blind men and women who -luckily are capable of taking off the blindfold. Thank you for your enthusiasm, openness and effort in favour of us as psychiatrists with lived experience… ."

Illustration 1. *The received card ("the blind play"- Cornelis Troost in 1740)*

Given the prematurity of integrating the personal into the professional realm, I wondered which actors and what kind of strategies would be needed to contribute to system change in the established services. What are current organisational struggles and how can we overcome these and look for ways to advance experiential knowledge? How can experiential knowledge become as essential as other knowledge types in mental health? These were some of the questions I tried to answer in the final study.

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