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

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KEYWORDS

Mental Health professionals, Experiential knowledge, Users recovery

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

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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.¹ Experiential expertise is based on a lived experience with a particular disease, disability, or other disruptive life event.² 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."³ 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."³ 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.² 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.⁴

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.⁵ 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.^{6,7} 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.⁸ Despite these inconclusive results, investments have been done in the promotion and uptake of peer support internationally.⁷ 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.⁹ 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.¹⁰ Other issues are related to an institutional culture, which, in most cases, is still dominated by the medical model.^{11,12}

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.¹³ However, all helping professions, from psychotherapy to social work, are known to attract individuals with a history of psychological troubles in general.^{14,15} 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%.^{1,16} Being aware of one's vulnerabilities is basic to the training of psychoanalysts, the Rogerian tradition, and other humanistic approaches.¹⁷ To 'know oneself' was, in fact, crucial in a number of psychotherapeutic traditions.¹⁸ 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.¹⁹ Weerman et al. explain how working alongside a peer support worker eventually facilitated the coming out of mental health professionals in The Netherlands.¹⁹ 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.²⁰ 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 added 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.

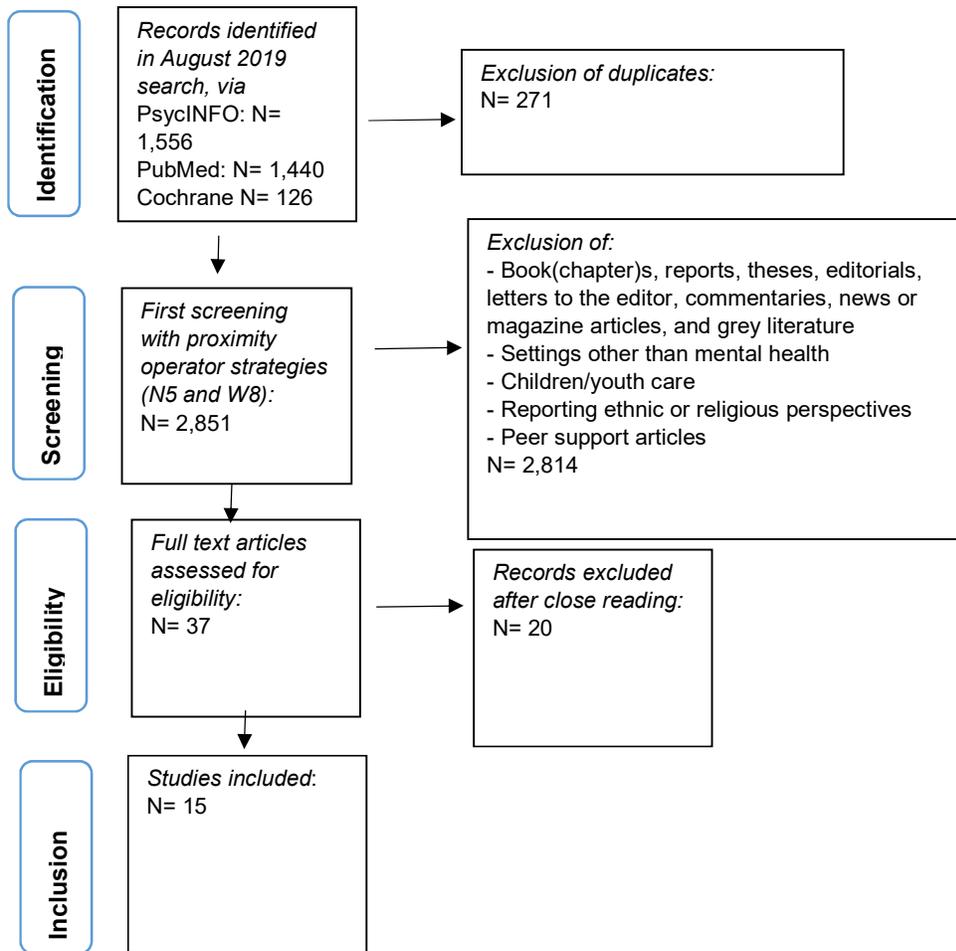
The literature search was conducted by the first author and two information specialists. A preliminary check with three different search strings resulted in more than 3,000 publications. Duplicates were excluded. By using a 'near operators' search strategy* this number was reduced to 2,851 articles in 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.

* 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.²¹ Some studies report that traditional professionals became inspired after working alongside peer support workers.^{22,23} Byrne, Happell & Reid-Searl state that mental health nurses tend to enjoy closer relationships with consumers than other professionals.²⁴ 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.²¹ 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.^{25,26} 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.²⁷ 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.^{22,23} Goldberg et al. identified the transformation process 'from patient to therapist' (here, clinical social workers) in Israel.²⁷ 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.²¹ 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.²⁷ 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.²¹ Levitt et al. also stress that using one’s own experiences might also be influenced by personality styles and work preferences.²⁵ 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.²⁸ 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.^{21,24} 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.²³ They are trained to be self-effacing.²³ 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.^{25,29,30,31} The risk to be portrayed as an impaired professional and the negative connotation thereof have hindered these practitioners.³² Oates et al. address the taboo of disclosure and debate the extent to which personal and professional boundaries are negotiated during clinical encounters.²² It takes effort and self-reflection to critically bring these taboo and power differentials to the foreground.²³ 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.²³ 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.²⁴ 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.²¹ Self-care techniques seem important mediators against these identified risks.²⁴ Other possible beneficial factors in this regard include therapist self-insight, adequate training and guidance, and a safe work environment.²⁶

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.^{25,31,33,34} Some professionals use their experiential knowledge for specific therapeutic purposes, such as providing new insights into the recovery process, modelling, and enhancing hope.^{30,26} De Vos et al. argue that users with eating disorders benefit from being treated by a recovered therapist.²⁶ 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.²⁶ Another study shows how the lived experience instantly increased empathy and deepened the understanding of anxiety, low mood, or suicidal thoughts.²² When recovered from certain distress, these experiences enable the professional to see openings of recovery for others.²⁶ Identification, as an underlying dynamic, is associated with increased commonality and helps to normalize mental distress.²¹

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 out about hidden personal histories with mental health distress.^{21,22,23} 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.^{25,26} 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.^{21,22,27} Giving help can also be beneficial for professionals themselves.²⁸

Secondly, research illustrates the mental health system is struggling to meaningfully incorporate lived experiences of professionals.^{21,24} 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.^{24,26}

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.²⁶ The lived experience may increase empathy and deepen understanding of anxiety, low mood, or suicidal thoughts.²²

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.

Table 1. List of selected publications

Authors	Title	Journal	Year of publication	Sample	Site	Objectives	Findings
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 phenomenological study (n=10 therapists)	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.
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	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.
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	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.

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	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.
Goldberg, M. Hadas-Lidor, N. & Karnieli-Miller, O.	'From patient to therapist: Social work students coping with mental illness'	Qualitative Health Research SAGE	2015	Qualitative narrative analysis (n=12)	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 'therapists'. 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.
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)	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.
Levitt, H. M., Minami, T.,	'How therapist self-disclosure relates to alliance	Counselling	2016	Naturalistic study of 52 therapy dyads	U.S.A.	To examine types and functions of therapists' self-	Findings indicated that the number of disclosures not significantly correlated with outcome or alliance scores, but disclosures

Greenspan, S. B., Puckett, J. A., Henretty, J. R., Reich, C. M., & Berman, J. S.	and outcomes: A naturalistic study'	psychology quarterly		(n=16 therapists and 52 users) quantitative analysis		disclosure in relation to therapy alliance and outcomes	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.
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)	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.
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)	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.
Oates, J., Drey, N., & Jones, J.	'Your experiences were your tools'. How	Journal of psychiatric and mental	2017	Qualitative interviews with nurses with lived	U.K.	To explore the extent and influence of mental health	The influence of personal experience in nursing work was threefold: 1) through overt disclosure, 2) through the 'use of the self as a

	personal experience of mental health problems informs mental health nursing practice'	health nursing		experiences (n=27)		professionals' personal experience of mental ill health on clinical practice	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.
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)	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.
Richards, J., Holtum, 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)	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.
Simonds, L. M., & Spokes, N.	'Therapist self-disclosure and the therapeutic alliance in the	Eating Disorders: The Journal of Treatment	2017	Quantitative study (n=120 women with history of eating problems)	U.K.	To model relationships between different types of therapist self-disclosure,	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

	treatment of eating problems'	& Prevention				therapeutic alliance, service user self-disclosure, shame, and severity of eating problems	patient disclosure and reduce shame and eating problems.
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)	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.
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	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.

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