

Negotiating mental illness across the lay-professional divide: Role play in peer work consultations

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Abstract

Patient involvement is a prominent policy aim in modern health care. Today, mental health services employ peer workers (PWs) who have personal experiences with mental illness. Based on 22 interviews with PWs and 26 audio recordings of real-life consultations, we show how PWs talk about their personal experiences as professional qualifications. Furthermore, we demonstrate how in real-life encounters, PWs and patients convert personal experiences into a professional approach through an interactionist role play that balance PWs role as former patients and current professionals. Our analysis shows that PWs combine the personal pronoun 'I' (stressing that it is personal) with the indefinite pronoun 'one' (referring to generalised patient experiences) when they recount illness experiences. This convey that PWs engage with mental illness as both a personal and professional topic. In addition, the analysis shows that PWs (and patients) use professional clues to manifest PWs' positions as professionals. Overall, the article demonstrates that instead of focussing on authentic patient relationships, as previous research has done, it is beneficial to investigate peer work from a symbolic interactionist approach revealing how PWs

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and patients skilfully manoeuvre the contradictions embedded in the PWs' dual role as former patients and current professionals.

KEYWORDS

mental health consultations, peer work, real-life data, role play, symbolic interactionism

INTRODUCTION

'Of course, you can be a professional while sharing your own experiences'

This quote stems from Mark, a peer worker (PW), who is employed within the mental health services because of his personal experiences with mental illness. He uses his personal experience with mental health illnesses to provide emotional, practical and social support to patients. The quote draws attention to PWs' dual roles, namely that their former roles as patients are a key qualification for their positions as professionals. Mark's use of 'of course' indicates that it may not be self-evident that PWs are seen as professionals, as it has traditionally been considered unprofessional for health-care providers to draw on personal experiences when interacting with patients.

Patients' experiences of illness—also called experiential knowledge—differ from biomedical knowledge (Arksey, 1994; Markens et al., 2010; Pols, 2014; Prior, 2003) and are considered a significant resource in health care today (Boardman, 2017: 187; Baillegerau & Duyvendak, 2016). According to Oborn et al. (2019), PWs' experience as patients is a subjective form of expertise (a private and personal way of knowing illnesses from the inside), which differs from an objective form of expertise (a scientific way of knowing illnesses from outside) (Oborn et al., 2019). Hence, in contrast to Prior (2003), who has suggested that patients may be 'plain wrong' (p. 45) about their illnesses, Oborn et al., (2019) argue that patients possess a unique subjective form of expertise.

As peer services have moved from its consumer-based origins into mental health-care services, a central research focus has been on how patient experiences have been transformed into credible and legitimate claims in work organisations (Meriluoto, 2018). Researchers have investigated whether and how organisational reframing and professional standards potentially threatens the authenticity of PWs' experiences and their relationships with patients (Scott, 2011; Scott et al., 2011; Voronka, 2019). While previous studies use PWs' own accounts to explore how they integrate personal experiences with professionalism, it remains an unexplored phenomenon exactly how PWs and patients negotiate their double role as former patient and current staff in real-life consultations.

In this article, we draw on interview data and audio recordings of real-life peer work consultations. We investigate how PWs talk about their personal experiences as a professional qualification, and how the transformation of personal experiences into a professional approach occurs in real-life encounters. Drawing on a symbolic interactionist framework (Goffman, 1990, 2008), we investigate the interactionist role play of PWs and patients as they manage the PWs' dual positions of being both former patients and current staff members. The research question informing

this article is: How do PWs, with the help of patients, transform personal experiences of mental illness into a professional approach?

The patient-professional tension in peer work consultations

An important policy aim in modern health care is the inclusion of patient experiences in health-care work (Andreassen, 2018; Martin, 2008a, 2008b). Previous research show how the illness experiences of patients are included through lay or professionally led self-care programmes (expert patient programmes) (Taylor & Bury, 2007), through the introduction of patients as consultants in research and project management groups (public and patient involvement initiatives) (Maguire & Britten, 2018) and—central to this article—through the employment of former patients as staff (PWs) (Solomon, 2004).

During the self-help movement of the 1960s, experiential knowledge first came to be seen as a ‘truth’ learned through personal illness experiences (Borkman, 1976: 445). Since then, studies have documented how patients come together to ‘manage’ and ‘cope’ with their illnesses through mutual efforts (Steffen, 1997: 99; Rich, 2006: 285; Koski, 2014: 75), form social ties to other patients (Gage, 2013; Locock & Brown, 2010) and engage in communities that may challenge medical authority (Allsop et al., 2004; Ussher et al., 2006; Whelan, 2007). The rise of the internet has furthermore led to an increase in the exchange of patient experiences online (e.g. Maslen & Lupton, 2019; Mazanderani et al., 2012; Petersen et al., 2020).

It was originally patients themselves who developed self-help groups and peer services outside institutional settings as an alternative to established professional practices. However, from the 1990s onwards, these services and various other user involvement initiatives have increasingly developed within health-care services (Rissmiller and Rissmiller, 2006). This development means that patients attempt to establish their experiential knowledge as a valid form of expertise in a medical setting where it is largely research-based knowledge that is considered the basis of legitimate expertise (Baillergeau & Duyvendak, 2016; Jones & Pietilä, 2020; Oborn et al., 2019).

Research on various user involvement initiatives within health-care services, for instance the aforementioned user consultants in research groups, document that users draw on ‘professionalised’ language that goes considerably beyond their experiential knowledge (Andreassen et al., 2014; Kerr et al., 2007; Thompson et al., 2012). Enany et al. (2013) find that patients who are invited to share their experiences in management committees and steering groups not only employ experiential knowledge, but also draw on ‘managerial’ knowledge acquired through former careers and user involvement training programmes. Hence, research has found that many patients also draw on certified forms of expertise to make credibility claims, thereby adopting the professional standards of the medical profession with which they are interacting (Thompson et al., 2012: 615).

Research on peer work also debate the professionalisation of PWs. For instance, it is debated whether mental health-care services will ultimately erode the basic principles of peer work (Faulkner, 2017; Lakeman et al., 2007; Noorani, 2013), e.g. by applying certain standards to the way in which PWs share their experiences (Byrne et al., 2016; Gillard et al., 2013). Peer workers have to change position from being a service user to a service provider and hence re-conceptualising their identity from ‘someone who is ill, incapable, disabled and disempowered to someone who is legitimate, empowered and validated’ (Hutchinson et al., 2006: 206). Hence, in contrast to many user involvement initiatives, PWs are not only expected to act as consultants to professionals, but also to act as professionals themselves. According to Voronka (2019), as PWs

adapt to their new role, they become distinguished from the patient group they initially expect to represent, undermining the definition of peer, which is being of equal standing with another person. This creates a 'crisis of authenticity' (Voronka, 2019: 569).

As a consequence, PWs are portrayed as individuals in an 'ambivalent' (Jones & Pietilä, 2020: 234), 'liminal' (Scott, 2011: 176) and 'paradoxical' (Voronka, 2019: 576) position as they are situated in-between the two otherwise distinct identities of patient and professional. In this in-between position, PWs are seen as at risk of becoming too neutral and distant in their approach with patients and act, consequently, less authentic and attuned to the patient's individual needs and preferences (Adams, 2020; Meriluoto, 2018).

This challenging position requires substantial identity negotiations among PWs that are required to 'pass as normal enough to work in workplaces and as disabled enough to authorise our authority' (Voronka, 2019: 10). PWs, then, engage in 'authenticity work' (Scott, 2011: 179), where they use their verbal and bodily language to establish mutual and honest conversations with patients. The goal is ultimately to bring the two parties—patients and PWs—closer to the ideal of having 'real, true interactions' (Scott, 2011: 177–8).

While prior research uses interviews to investigate PWs' accounts of balancing their dual role (see Jones & Pietilä, 2020; Scott, 2011; Scott et al., 2011; Voronka, 2019), our analysis also draws on audio recordings of real-life peer work consultations. Using interviews and audio recordings, we investigate both how PWs talk about their dual role and how this role is actually managed in real-life encounters with patients. Our approach makes it possible to explore how patients respond to PWs dual role, which is a perspective that is often overlooked in research on the peer work (Baillie et al., 2016).

A SYMBOLIC INTERACTIONIST APPROACH TO PEER WORKER-PATIENT CONSULTATIONS

A key element in symbolic interactionism is its focus on how people develop a shared understanding of the situations in which they participate (Järvinen, 2020; Mik-Meyer, 2020; Mik-Meyer & Silverman, 2019). We use Goffman's (1990, 2008, 1981, 1956) concepts of role, performance, face work, impression management and definition of situation as 'sensitising concepts', that is, as 'a general sense of reference and guidance in approaching concrete empirical instances [which] suggest directions along which to look' (Blumer, 1954: 7). According to Goffman (1990), full information of the social situations in which individuals are part is seldom accessible to them. In this absence, 'the individuals tend to employ substitutes—cues, tests, hints, expressive gestures, status symbols, etc.—as predictive devices' (Goffman, 1990: 241). According to Goffman, it is the microinteractions—the changing of footing and the impression management conducted by, in this case, PWs and patients—that are key when investigating the way in which PWs and patients negotiate PWs' double role.

Goffman's (1990) use of metaphors from the theatre—role, performance and script—stresses that actions are ritualised practices where participants perform their role according to the script of the play (i.e. in this case, their perception of peer work). A goal of participants in an encounter is to arrive to a shared definition of the situation in which they take part. In order to do so, they have to combat the 'multitude of potential disruptions' (Goffman, 1990: 246) from the other participants. Participants change footing and challenge a script, are in the wrong face, or may be even lose face as they interact (Goffman, 2008) as they may not have 'full information'

of the situation of which they are part—or they may want to challenge the dominant definition of the situation (Goffman, 1990: 241). However, in most cases, individuals' social life—their interactions—follows a 'ritual order' (Goffman, 2008: 42). Individuals find out from 'hints and glances and tactful cues' from co-participants what their place is (Goffman, 2008: 42), and most individuals help each other to save face as there is not much to be gained from breaking the ritual order of the social situation (Goffman, 2008).

By using concepts from Goffman work, we investigate peer work consultations as ritualised encounters structured over microrules of how to stay in-face and overcome the potential disruptions of co-participants' actions. Peer worker consultations are defined by at least two contrasting definitions of the situation: as a mental health consultation or as a meeting between two equal patients sharing illness experiences. For this reason, participants will face a multitude of disruptions when they try to define the situation. However, as we shall see, both patients and PWs work to confirm the legitimacy of PWs' dual position as both former patient and current staff through an interactionist role play. Their face work and numerous microadjustments ensure that the PWs' dual role is constantly balanced, and in contrast to findings from previous studies, this duality does not seem to pose a problem for the encounter.

DATA AND METHODOLOGY

Setting

The first PWs were employed in the Danish health-care system in 2013. The employment of peer workers was inspired by peer-to-peer programmes in the United States, the United Kingdom, the Netherlands and Australia, and it was part of a general turn towards a strengthened empowerment and recovery-oriented approach to patients (Korsbek, 2017). While the precise number of employed PWs remains unknown in a number of countries, PW's associations report an increase in members (Leemejer & Noordengraaf, 2020). In the United States, peer services were added to the state's Medical Assistance Program in 2016 (Adams, 2020).

In Denmark, a recent survey from the national network of PWs report that there are currently around 200 PWs; with approximately two-thirds employed in the secondary sector in hospital care and outpatient treatment facilities and the rest in the municipalities in social care treatment (Poulsen & Sørsgaard, 2021). The PWs in this study worked in the secondary sector in hospital care units and outpatient treatment facilities, where they were employed to use their lived experiences and general knowledge about recovery to support patients through one-on-one conversations and group sessions.

Most peer workers are employed on permanent contracts, working between 11 and 30 h a week. Many are employed as unskilled workers with a salary corresponding to approximately two-thirds of the pay that social and health-care assistants receive. PWs are required to have a psychiatric diagnosis and have had contact with the secondary sector. Furthermore, PWs are increasingly expected to complete a training that prepares them to work as a PW. The training aims to familiarise PWs with the theory behind recovery and empowerment, train how PWs can work purposefully and reflexively with their lived experiences (rather than 'just' telling their entire life story) and give PWs an understanding of their own transition from user to employee. In 2020, 80% of all peer workers in Denmark had completed or were in the process of completing a peer worker training programme (Poulsen & Sørsgaard, 2021).

Sample, recruitment and ethics

The basis of this article's analysis is 22 interviews with PWs and 26 audio-recorded real-life consultations collected in 2018 and 2019. For the interviews, Kessing recruited PWs via email invitation. The mail stated that participation was voluntary. All participants gave their written consent after being informed of the study. The interviews were semistructured and lasted approximately one and a half hours. The interviews focused on the PWs' reasons for applying for PW positions and how they viewed their positions and relationships with patients and their work colleagues. Kessing interviewed ten men and 12 women aged between 36 and 58 years. All had been diagnosed with a mental illness. Eleven PWs worked in outpatient treatment facilities, and eleven worked in a hospital care unit. Their working hours varied from ten to 37 hours a week.

Participant recruitment for the audio recording of real-life consultations occurred over one year via the interview sessions and email invitations. Again, Kessing stressed that participation was voluntary, and she gave the PWs who agreed to participate an audio recorder and instructed them in how to inform the patients about the project. The patients received an information letter about the project, which included information of anonymity, consent and their right to withdraw from participation at any point in time. Patients and PWs signed this letter of consent before the audio recorder was turned on. Kessing received all signed consent forms. All participants are pseudonymised; all mentioned names and places are fictionalised.

In total, 18 PWs agreed to participate and received an audio recorder. Ten peer workers handed over 26 recordings, amounting to approximately 26 h of audio-recorded data. Eight PWs did not record their sessions because they had quit their job (4) or had had difficulty recruiting patients (4). Of the 26 recordings, 19 were one-on-one sessions with a PW and a patient, and seven were recordings of group sessions facilitated by a PW and with participation of five to seven patients. In total, ten PWs and approximately 35 patients are represented in the audio recordings of real-life encounters. Eight recordings were of sessions held at an open ward, and 18 recordings were of sessions held at outpatient treatment facilities.

The audio-recorded data are not representative for all PW encounters with patients. First, the consultations were scheduled meetings between PWs and patients, where both had the opportunity to prepare. Second, the PWs themselves decided, which consultations to record and due to the sensitivity of the patients' situation, primarily recorded consultations with patients whom they had encountered before. Hence, most audio-recorded data reflect encounters wherein PWs and patients have already established a relation with one another. However, even though the audio-recorded data represent a particular kind of encounter between PWs and patients, it does provide unique insights on the transformation of personal experiences into a professional approach as it happens in real-life encounters, a perspective that has previously been absent from literature on peer work.

The one-on-one consultations were held in the patients' home or at the PWs' office, while meeting rooms at the psychiatric ward or outpatient treatment facility facilitated group sessions. Peer workers and patients themselves arranged the frequency, topic and length of the consultations and group sessions. All data—audio-recorded interviews and consultations—have been transcribed.

The study has been approved by the Danish Data Protection Agency. All ethical standards set by the Danish National Research Council and Danish universities with regard to data collection, publication and storage of data were followed. In addition, the BSA Statement of Ethical Practice from 2017 was followed.

The coding processes

Inspired by sensitising concepts emphasising the dynamics in the encounter and a constructivist interpretation of a grounded theory approach (Charmaz, 2006), we first conducted an open reading of the data to gain an in-depth understanding of the empirical world. From this reading, we discovered that PWs spoke of their work and to their patients alternating between personal and generalised manners. Our first coding emphasised quotes and dialogues of PWs using their own personal experiences ('I') or more generalised patient experiences ('one'). Most often, the PWs would shift back and forth between the two, indicating a form of balancing act in how they combined their own experiences with mental illness with a professional approach to patients. Second, we conducted a coding of the professional clue PWs often used in the consultations, for instance, when PWs explicitly referred to other patients and colleagues' professional opinions, time management and so on.

Next, we coded the interviews with PWs. The interview guide included questions on qualification criteria of PWs and asked openly how they used their personal experiences with illness in their work. We conducted a systematic coding on how PWs talked about using their personal experiences, resulting in analytical categories such as 'presenting experiences of illness as a professional qualification', 'different perspectives on professionalism' and 'using personal experiences professionally'. We then analysed the interview quotes and sequences from the coding of the audio recordings to identify patterns across the dataset. Finally, we selected 'proof quotes' and 'power quotes' (Pratt, 2008: 501) that could serve as illustrations of the patterns in the article. The proof quotes show the prevalence of a point, whereas power quotes are the quotes that are 'poetic, concise or insightful' (Pratt, 2008: 501) in regard to illustrating the patterns found in the dataset.

FINDINGS

Reframing the personal as professional in interviews

The PWs often present their patient experiences in interviews as a professional qualification. For example, Sophie explains that she listed all her illness and treatment experiences on her job application. John put together a PowerPoint presentation that focussed on his illness history and presented it to his new colleagues. Frank, who had been on sick leave while he worked as a PW, presented his leave of absence as a 'study stay', and Mary explained that instead of taking an ordinary education, she had 'gone to the school of life'.

Peer workers' unique professional qualification contrasts a more classical understanding of professionalism, where the personal and professional are kept separate. Peer worker Emma elaborates:

Interviewer: What are the most important qualifications for your position?

PW: [...] I think that there is an authenticity in the fact that I have tried it myself. To be able to talk about it and use my lived experiences in the conversation. Several of my colleagues are taught that they should not reveal too much about themselves, because it is unprofessional. However, in my discipline, sharing your experiences is what is considered professional.

According to the PWs in the study, their personal illness experiences qualify their approach to patients, providing the PWs with a certain 'authenticity' (Emma) and creating a 'sameness with patients', as another PW, Lucas, explains. The fact that PWs' patient experiences are the key qualification

for their position as professionals challenges the traditional divide between being a patient (sick and seeks technically competent help) and being a professional (highly trained and possesses skills and knowledge to help patients).

The key thing, according to PWs, is that transforming one's personal experiences with mental illness into a professional approach requires skilled work. Peer workers explained that they knowingly share their illness experiences to help patients (Mia, Jimmy, Heidi), think thoroughly about which experiences to share and when (Sascha, Jeanette, Patrick), and acknowledge that their experiences are unique and not necessarily directly relevant for all patients (Jimmy, David, Poul, Mary, Victor, Mia, Frank, Jane).

Turning to the audio-recorded consultations, we see how this transformation of personal experiences into a professional approach entails sophisticated interactionist role play, depending on the joint performance of both PWs and patients. Central to this performance is the PW's dual role as former patient and now staff.

Managing the PWs' dual role in real-life consultations

In all of the consultations, the PWs shift between using the personal pronoun 'I' (stressing that it is personal) and the indefinite pronoun 'one' (referring to patient experiences in general) when they report on illness experiences. This frequent shift helps PWs perform not just as prior patients ('I') but also as professionals ('one') that can present a more general perspective than their own. For instance, when a patient, Ian, talks about his suicidal thoughts, the PW David responds:

PW: I get really moved by what you are saying, because I have felt for a very long time that it didn't matter what I did. [...] For me, the change started when I let go of feeling responsible towards people that I shouldn't feel responsible for. [...] My mum was completely irresponsible, so I got this enlarged sense of responsibility towards everybody. [...] But now I have started to get a more sincere positive feeling.

Patient: Yes, it makes sense. [...] I'm either really happy or really sad. It was a nurse that made me aware of that [...] Sometimes you [professionals] see something in me that I know is there, but it isn't until someone says it out loud that I can understand it. I'm blind to it before that.

PW: Well, in consultations like this one... when one is talking to a nurse or a psychologist or a former patient that knows something about what it is like to be in a certain life situation... [...] Now I'm no therapist, but I have heard of something called warm cognition. When one has these experiences that just make sense, one gets this physical warmth. [...]

Patient: Yes, I can relate to that.

David, the PW, starts by drawing a parallel between his own and the patient's experiences and positions himself, like the patient, as a person who has suffered. He then moves into a more professional role, using the indefinite pronoun 'one'. The patient prompts this shift by introducing a nurse in the story and grouping the PW with her. The PW picks up immediately and converts his story to a professional one. However, when the PW performs as a professional, he still reminds the patient that he is not a professional ('I'm no therapist'). The sequence demonstrates how both parties are engaged in a ritualised role play that aims at legitimising the social order of peer work defined by the coexistence of PWs' double role as former patients and current staff.

In another setting, a patient, Marie, explains how she is ‘walking around in this bubble and feels like nothing is really happening’. The PW, Emma, responds that she has felt the same way and continues ‘one gets impatient, and one gets angry and restless and one gets a 100 things. And that is how it is. Or I can’t say that is how it is for everybody, but that is how it is for many’. Again, the PW smoothly draws on her own experiences, then moves into a more generalised patient experience to finally demonstrate her position of authority (‘And that is how it is’). However, the PW is quick to withdraw her judgement (‘or...how it is for many’), aligning her performance with the ritual order of peer work where the ‘maintenance of a single definition of the situation’ is not possible (Goffman, 1990: 246).

Overall, the data show many instances of PWs sharing their personal experiences with patients, but to stay professional, they simultaneously distance themselves from these experiences. This manoeuvring of PWs is one strategy through which personal experiences are incorporated into a professional context. By a quick change of footing between personal and professional accounts, PWs skilfully manage their impression, so that it aligns with the social order of peer work. The patients help the PWs manoeuvre by being supportive of the different roles of PWs. Through their role play, PWs and patients become simultaneously positioned as different (patient and professional) and the same (individuals who know suffering from within).

Professional clues in real-life consultations

Another way PWs manage their dual role is by mimicking traditional professional behaviour defining mental health consultations. Peer workers introduce organisational schemes and other professional clues that function as ‘predictive devices’ (Goffman, 1990: 241), manifesting PWs’ status as professionals. However, it is a balancing act as some patients start exercising resistance if the PWs come forward as too professional in their approach to patients.

Working with various organisational schemes, PWs emphasise that it is the patient’s situation that is in focus. For instance, PWs make patients fill out a ‘recovery scheme’ to remember to do positive activities (Jeanette); they facilitate group sessions, helping patients identify ‘milestones and long-term goals’ (Jimmy); they propose a ‘crisis plan’ with information such as who to contact in case of an emergency (Lucas). Others work with ‘activity schemes’ (Louise), ‘weekly planners’ (Poul) and ‘weekly challenges’ (Emma). Thus, the consultations follow a more classical script for mental health consultation as the tools foreground the patient’s challenges and needs, placing the PW’s own illness experiences in the background.

Most patients accept this more classical role play and work with the organisational schemes; however, some patients challenge this approach. For instance, patients state ‘I am perfectly capable of making a week planner, I just don’t follow it’ (Hanne); ‘I have read a pamphlet about crisis plans once. It’s about who to contact if it goes... blah blah blah’ (Lars); ‘I have tried to work with long-term goals, but I simply forget them, because I’m not that goal-oriented’ (Jasmine); ‘I take one day at a time’ (Martin); ‘To be honest, I really don’t feel like doing the weekly challenge’ (Sanne). The patients’ disruption of the PWs’ manifestation of their status as professionals demonstrates that this position cannot be taken for granted. Some PWs respond to such disruptions by highlighting previous peer work experience, emphasising that other patients have benefited from a particular approach. Through this quick microadjustment, PWs remind patients that they are indeed experienced professionals and not (just) patients even though they have personal experiences that are similar to the patients.

In addition to organisational schemes, PWs routinely use verbal clues to draw attention to their roles as professionals and not just as former patients. In the following, we highlight three

central clues that PWs use throughout the consultations. First, PWs employ busyness as a professional clue. Their work calendars are busy (Jeanette, Emma), and they have colleagues and patients patiently waiting for them to finish the consultation (Poul, Victor). These time clues point to the organisational context of 'work' that the PWs are part of and remind patients that this is a place with scarce time resources.

Second, PWs praise patients, demonstrating that, as professionals, they observe and assess patients' efforts and progress. In the following example, we see how a PW (Mark) compliments a patient (Lisa) for knowing her illness 'really well':

PW: Last time we spoke, I thought to myself that you knew your illness really well.

Patient: I have always been told that. 'You have so much health literacy, you have so many resources'. Yes, I have heard that one before.

PW: It is the feeling one is left with, when one talks to you. It is not because... The illness is what it is. You have suicidal thoughts...

Patient: They are there [the suicidal thoughts]. I feel like I want to act on them, and I might even make plans for how to do it.

PW: I assume that the staff is aware of this.

Patient: They are involved.

Lisa's objection to the PW's praise is one of the many examples that demonstrate how patient and PWs end up negotiating the PW's position as professional. Similar to the example above, we see how PWs, in some instances, have to withdraw from their professional position and call upon 'the staff' when patients entrust them with severe problems or questions related to their specific treatment, e.g. the patient's medicine. Hence, they fall back on their position as (former) patients.

Third, PWs refer to colleagues to strengthen their positions as professionals. In one case, a PW, Lucas, introduces the work of a colleague in a consultation. Just before his statement, the patient recounted a conversation he had with a staff member, Emily, about how he often discloses very personal details to other patients at the psychiatric ward. According to the patient, Emily stated that this type of behaviour might be a warning sign of his bipolar disorder. Following this account, the PW says:

PW: If I may add something, I think... Now all my colleagues are extremely skilled, but I really think that is a good observation that Emily makes there.

Patient: She is really good, Emily.

PW: She is extremely skilled. She was one of the people that hired me. I had my job interview with her. She really is.

The PW and patient continue talking about the importance of having a safety net of professionals even when things are starting to get better. The PW explains that he still has three appointments a year with a psychiatrist to discuss his medicine, even though he is no longer a psychiatric patient. He has even explained to his psychiatrist that they are co-workers now. Referring to health-care professionals as colleagues, the PW emphasises his role as a staff member.

Overall, we see how PWs' use of professional clues tone down their sameness with patients and manifest that their position differs from the patients'. However, as touched upon in the analysis, patients may create disruptions in the role play and challenge PWs' positions as professionals if PWs do not strike the right balance between their two roles. To avoid a communicative breakdown in the role play, PWs employ microadjustments that savour the social order of peer work.

DISCUSSION

This article explores how PWs adapt their personal experiences of illness into a professional approach in peer work consultations. We use PWs' own accounts gathered in interviews and data stemming from real-life peer work consultations. The analysis based on interviews demonstrates that PWs talk about their experiences of illness as a unique skill that qualifies their approach to patients. They explain how their illness experiences provide them with an insider perception of a patient's situation, giving them a certain authentic position that benefits their work. By reframing their illness experiences as a professional resource, PWs transition from a disempowered position as patients in need of help to an empowered position as professionals who can provide help. Thus, working professionally with personal experiences requires a reflexive practice attuned to patients' challenges and needs. These findings resonate with previous studies' findings that show that the use of personal experiences with mental illness require skilled work and qualify PWs' approaches to patients (see Jones & Pietilä, 2020; Mancini, 2019; Oborn et al., 2019; Scott, 2011; Toikko, 2016).

Interview data provide insights into how PWs perceive their particular set of skills and expertise as former patients and now staff (Jones & Pietilä, 2020; Mancini, 2019). However, interviews cannot answer *how* PWs balance their dual role as former patients and current staff in real-life consultations—or whether this balancing act is challenged or supported by patients. Our audio recordings of real-life consultations contribute novel data to this perspective. From our study, it is clear that peer work is a balancing act. Peer workers do not only emphasise their sameness with patients, that is, their experiences with mental illness (speaking in first person 'I'), but they also continuously draw attention to their position as staff, showing they are now professionals (speaking through the generalised position as 'one' and sending out professional clues). Peer workers routinely shift between 'I' and 'one' in their approach to patients, and their persistent use of professional clues, 'hints and glances and tactful cues' (Goffman, 2008: 42) suggests that the social order of peer work consists of a 'multitude of potential disruptions' (Goffman, 1990: 246) that has to be managed by both PWs and patients.

The contradictory organisational context of peer work consultations—a mental health consultation or a meeting between two equal patients sharing illness experiences—is paramount for understanding the balancing act of adapting former illness experiences of PWs to their professional position as staff.

When previous research explores the dual role of PWs as former patients and now professionals, the PWs' position is characterised as 'ambivalent' (Jones & Pietilä, 2020: 234), 'liminal' (Scott, 2011: 176) and 'paradoxical' (Voronka, 2019: 576). The argument is that PWs experience a 'crisis of authenticity' as they have to represent two perspectives at once (Voronka, 2019: 569). A key focus in this research is how organisational demands are placed on the PWs to maintain a critical distance to their own experiences when they interact with patients (Meriluoto, 2018: 305). Due to this, PWs are seen as at risk of simply replicating a traditional professional-client relationship (Adams, 2020) and—in order not to do so—must work hard to preserve an 'authentic' (Voronka, 2019: 578, Scott, 2011: 179), 'honest' (Scott, 2011: 178) and 'mutual' (Adams, 2020: 262) relationship with patients.

This research acknowledges that identities continually reshape (Voronka, 2019), and they maintain a critical approach to a romantic notion of PWs connecting to patients with a deep inner self (Scott, 2011). However, the focus of this research is still to examine how PWs can best give voice to their patient experiences given the organisational limitations placed on them. This indicates that some experiences are truer and more authentic than others. Furthermore, this

research rests on the assumption that the duality embedded in the PWs' positions are problematic for PWs and—most importantly—for their ability to connect with patients.

Inspired by symbolic interactionism, we have examined how PWs and patients adjust their behaviour to one another (impression management) and to the 'ritual order' of peer work (Goffman, 2008: 42). From our real-life recordings, it is clear that PWs and patients skilfully manoeuvre the dual roles of peer work and work together to position PWs as legitimate actors in a setting dominated by medical knowledge and research-based information. As found in other studies using real-life recordings, both participants give each other clues if their roles become threatened (Mik-Meyer & Haugaard, 2021; Mik-Meyer & Silverman, 2019). The constant shifts in roles of PWs demonstrate a pattern in the dataset—and a ritual order of peer work. When PWs draw too much attention to their own illnesses, they automatically and swiftly move back to a more detached role of staff and start talking about anecdotes from colleagues, or else the patient introduces a theme that directs attention away from the personal illness stories of the PW. Both parties seem to be well aware that illumination of one of the PWs' roles—former patient or current staff—will lead to a breakdown of the social order of peer work defined by the coexistence of these two contradictory roles. From the analytical framework of symbolic interactionism, it is not surprising that PWs and patients do their utmost to ensure that no one is in the wrong face because this could lead to a communicative breakdown (Goffman, 2008).

The PWs' use of a generalised position and professional clues can be interpreted as elements of professionalisation of lay participants (Enany et al., 2013; Jones & Pietilä, 2020). However, our findings do not indicate that PWs' patient experiences are less authentic because of this. The dataset does not indicate that patients do not fully accept PWs' dual role as former patients and now staff. These findings suggest that neither PWs nor patients are best understood in terms of whether they are 'authentic' individuals participating in 'real, true [patient] interactions' (Scott, 2011: 177–8). Similar to previous studies, our interview-based analysis shows that PWs emphasise the authenticity that comes from their patient experiences as a central element in their relation with patients. However, our analysis of real-life consultations reveals their position as staff is of equal importance when approaching patients. Rather than thinking in lines of authentic patient roles and authentic relationships, we suggest investigating peer work with a focus on how the participants negotiate PWs' double role of patient and staff. Our study complements and develops the existing research on the dual role of PWs by emphasising that the PWs and patients alike skilfully manage this challenging double role. Both parties engage in a difficult balancing act where there is always the possibility that PWs' acts are perceived by themselves or patients as too professional or too detached from their personal illness experiences when turning their experiences into resources for others, as Meriluoto's (2018) study also found.

Real-life recordings have proven ideal for seeing new aspects of the social world that may be difficult to capture in interviews. Through the article, we have demonstrated how this new approach to an investigation of PWs' positions led to new observations of PWs' double role that may qualify future research on peer work.

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AUTHOR CONTRIBUTIONS

Malene Lue Kessing: Conceptualization (equal); Formal analysis (equal); Funding acquisition (lead); Investigation (lead); Methodology (equal); Writing – original draft (equal); Writing – review & editing (equal). **Nanna Mik-Meyer:** Conceptualization (equal); Formal analysis (equal); Methodology (equal); Writing – original draft (equal); Writing – review & editing (equal).

DATA AVAILABILITY STATEMENT

Research data are not shared due to privacy and ethical restrictions.

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