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Letter

Peer support and the performative turn: when lived experience risks losing its radicality

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Peer support is an influential development in contemporary psychiatry that has challenged traditional hierarchies of knowledge and authority by formally integrating individuals with lived experience into mental health services. This evolution has rightly been welcomed as an ethical advance associated with empowerment, recovery-oriented care, and greater recognition of subjectivity.[1]

However, the rapid institutionalisation of peer support in high-income contexts also warrants critical reflection. These concerns should not be read as a critique of recognition and fair employment where formalisation remains a priority. As peer support becomes embedded in mental health systems, it increasingly functions as a normative framework that implicitly defines which forms of lived experience are legitimate, a process described in qualitative studies of peer role institutionalisation.[2] Lived experience risks being acknowledged primarily when it aligns with an implicit ideology of performative recovery, potentially distancing psychiatry from the more radical and irreducible dimensions of psychiatric suffering.[2]

Psychiatric knowledge has always depended on lived experience: as phenomenological traditions have emphasised, symptoms are constituted through subjective accounts and interpretations. This prominence of lived experience is historically rooted in earlier user and survivor movements from the 1960s and 1970s, and user involvement in mental health services during the 1980s and 1990s. These movements framed lived experience as a collective challenge to dominant biomedical models of psychiatric authority.

What appears new is the expectation that lived experience must be performed so to be recognised as valid. Within institutionalised peer support frameworks, experience tends to acquire legitimacy when it can be translated into a coherent, hopeful narrative of illness, insight and recovery, one that is communicable, therapeutically mobilisable and compatible with organisational objectives. Experience is no longer only what has been endured; it becomes what must demonstrate transformation.

This performative logic is not incidental. It is structurally embedded in the formalisation of peer support roles. Peer support workers are recruited on the basis of their capacity to translate suffering into a communicable, stabilised and hopeful form, one that remains compatible with dominant clinical recovery models, evaluative requirements and prevailing assumptions about what constitutes legitimate knowledge. The peer is implicitly positioned as a figure of recovery and reflexive distance, a living demonstration that psychiatric illness can be retrospectively reorganised into a meaningful trajectory.[2,3]

Peer support may therefore privilege certain forms of experience that can be narrativised and rendered institutionally useful. Experiences that remain resistant to narrative coherence may be less easily recognised as legitimate expertise. Critical scholars have shown how such processes risk converting epistemic challenge into managed participation, in which experiential knowledge is included but subtly reshaped to align with dominant clinical, managerial and research paradigms.[4]

Peer support offers powerful counter-narratives to stigma and therapeutic pessimism, enables identification with non-pathologised identities, and reassures institutions that suffering can be rendered meaningful and manageable. Yet when lived experience is filtered through performative expectations, other forms of suffering risk being marginalised, particularly those that remain fragmented, as documented in qualitative studies of institutionalised peer support.[2]

This concern becomes particularly salient when considering the nature of severe psychiatric suffering itself. Viewed through a philosophical lens on the limits of narrativisation, the radicality of such suffering often lies in its resistance to coherence. Severe mental disorders are often accompanied by fragmentation, contradiction, and experiences that cannot be easily integrated into narratives of growth or recovery. Psychotic experiences may remain disorganising rather than illuminating; depressive states may be marked by emptiness rather than elaboration; chronic conditions may unfold through oscillations rather than resolution. These experiences challenge not only clinical intervention but sometimes the very possibility of meaning-making.

Recovery risks shifting from a personal horizon to an institutional expectation. The ‘good peer’ is one who can speak about illness from a position of distance, reflexivity and improvement. Those who remain immersed in suffering, ambivalent towards care or unable to articulate their experience in socially intelligible terms may come to be perceived as failures of recovery rather than as subjects of care.[3,5] This critique does not deny plural, non-linear recovery frameworks, but it targets recovery when it becomes a normative criterion for legitimacy and recognition.

Peer support is often framed as a response to epistemic injustice, restoring credibility to voices historically disqualified within psychiatry. Yet when experiential knowledge is institutionalised, it risks losing its singularity. The peer’s experience may function as a model of what suffering ought to become once properly managed.[2,6] In this way, lived experience may become exemplary rather than disruptive and vulnerable to tokenism in the service of organisational agendas.[2,7,8] Preserving peer support’s critical edge requires attention to how experiential knowledge is recognised, including protecting peer autonomy and resisting frameworks that value only demonstrable improvement. Lived experience should be acknowledged not only when it reassures but also when it remains disruptive or resistant to institutional translation.

Paradoxically, the peer support movement may neutralise the very radicality it originally sought to preserve. Psychiatric suffering, in its most acute forms, disrupts identities, temporal continuity and social roles. It resists instrumentalisation and often exceeds the promise of recovery. Requiring that such suffering be translated into performative narratives risks domesticating it, rendering it compatible with institutional expectations of progress, hope and functionality.

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This critique underscores the need for conceptual vigilance. Peer support has played a crucial part in recentring psychiatry on subjectivity and challenging reductionist approaches to care. The difficulty arises when peer support is implicitly tasked with neutralising the discomfort generated by radical suffering, by transforming it into evidence of system effectiveness.[1,9]

A psychiatry genuinely committed to lived experience must resist conflating recognition with performance. For clinicians, policy makers and peer practitioners, this implies approaching peer support not as a tool for demonstrating recovery or system effectiveness but as a practice that requires ongoing vigilance towards how lived experience is recognised, constrained or instrumentalised.

Detaching lived experience from performative recovery does not mean abandoning hope; rather, it allows hope to be pluralised. It enables psychiatry to remain alongside those whose trajectories are uncertain, whose voices are eradicated or whose suffering remains unresolved, experiences that continue to lie at the very heart of clinical practice.

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