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Bringing Stories to Mental Health Care: A Dialogue Between Research and Practice

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A narrative psychological approach contributes to a person-centered perspective in mental health care that goes beyond mental illness. This article describes a dialogue between research and practice. In several sections, we describe the steps that were taken in the development of "An Empowering Story", a narrative intervention focusing on personal recovery in persons with personality disorder: our joint starting point involving different kinds of expertise, a needs assessment from different perspectives, a prototype development bringing the expertise together, a design process involving clients and practitioners, a feasibility study, an effectiveness study, a national implementation plan, and final steps toward using the intervention in new contexts. The article ends with a reflection on the dialogue between science and practice. We argue that the process was transdisciplinary, emphasizing joint responsibility and mutual learning rather than the simple application of science to practice.

Keywords: narrative; mental health

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Ethics

All empirical studies with clients and professionals were subject to ethical approval in line with the Dutch laws and regulations, in particular the Medical Research with Humans Act (WMO). All participants (clients and professionals) signed informed consent. The design study and implementation study were approved by the Institutional Review Board of the Faculty of Behavioral, Social, and Management Sciences of the University of Twente (18372 resp. 230791). The feasibility study and effectiveness study were approved by the Medical-Ethical Review Committee (region Twente, NL67907.044.18; region East-Netherlands, NL78033.091.21).

Part of this text (in particular, the description of the steps of development), have also been used in the manual for counselors (Pol, Rosenboom, & Westerhof, 2025). They were adapted to the needs of this article.

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Over the past decades, mental health care has relied heavily on the medical model, viewing mental health mainly as the absence of disorders and symptoms and focusing on their prevention and treatment as its primary task. Although this has contributed strongly to the development of evidence-based practices, this focus comes at the expense of a more person-centered approach that uses a broader, more positive definition of mental health. For example, researchers have advocated including a focus on the protection and promotion of mental well-being, i.e., a focus on engaging emotions, self-development, and societal integration (Bohlmeijer & Westerhof, 2021; Keyes, 2008). This focus is justified, as mental well-being is not the opposite of mental illness but rather, a relatively independent dimension. Even in the presence of mental illness, mental well-being can be promoted. In a similar vein, patients have also argued for a broader focus on recovery. Whereas clinical recovery addresses mainly a relief of psychological symptoms, personal recovery includes a broader perspective on issues like connectedness, hope, identity, meaning, and empowerment (Leamy et al., 2011). In recent years, not only mental healthcare organizations but also funding bodies and organizations that produce standards of care in the Netherlands, have embraced this broader vision of mental health beyond the absence of mental illness. However, an important question remains as to how this can be done in everyday clinical practice.

A narrative psychological approach in mental health care might give an answer to this question as it provides a person-centered approach that goes beyond mental illness.

First, this approach distinguishes between persons and illnesses (Westerhof & Bohlmeijer, 2012). Personal narratives can identify strongly with a disorder so that persons even construct themselves in terms of the disorder. "I am a borderliner" can be the very condensed story of a person with borderline personality disorder. However, personal narratives can transcend the disorder as well. "Despite my borderline personality disorder, I can lead a meaningful life" can be such a very condensed story. Narrative interventions aim to support clients in finding these kinds of alternative stories. Second, a narrative psychological approach starts from the perspective of the client rather than the professional: it recognizes the unique nature of every person's story (McAdams, 1996) and supports clients in their narrative literacy as the competence to narrate stories in a way that supports their mental health and well-being (Westerhof, 2025). Third, research evidence shows that narratives are related to mental illness as well as mental well-being (Adler et al. 2016; Lind et al. 2019). Several meta-analyses, in particular on reminiscence and life review, have shown that narrative interventions can contribute to both decreasing mental illness and promoting mental well-being (Pinquart, 2024; Pinquart & Sorensen, 2012; Westerhof & Slatman, 2019). To conclude, a narrative perspective can contribute to the change from a smaller, medically-oriented story of mental health care to a larger, more person-oriented story (Kenyon et al., 2011).

This paper will first introduce the intervention *An Empowering Story*. We will then describe the trajectory of development of this narrative psychological intervention. Last, we will reflect on the relations between narrative research, mental health practice, and biographical practice during this trajectory. The approach was not so much an application of basic science in practice, but a collaborative dialogue between science and practice.

Overview of An Empowering Story

An Empowering Story is a narrative intervention that offers people with mental health problems the opportunity to work on personal recovery. The main focus is to draw the balance in positive and negative past experiences and provide possibilities to continue one's life after one or more critical life events. Participants do concrete writing assignments in the form of a triptych in 12 sessions. They focus (1) on the past, (2) on an important turning point in their lives where they took agency and (3) on their present and their future. The intervention can be delivered in a group of 8-12 participants or in an individual format. Depending on the context, counselors can be licensed psychologists, nurses, sociotherapists, art therapists, and/or biographical coaches. The sessions focus on explanation of the writing assignments, discussing the progress, and sharing written stories in the group or with their counselor or therapist. Participants can put their written stories into a digital document that also allows them to include visuals such as photographs. They can decide to let this digital document be printed so they can receive their printed personal life story book at the final session.

Figure 1 provides an overview of the 12 weeks. Participants start with drawing a lifeline that includes low points, high points and turning points in their lives. Next, they decide on an agentic turning point in their process of recovery. They describe this in vivid details, and this story becomes part 2 of their triptych. Participants then focus on their past. They describe both positive and negative moments in their lives, again in vivid details and they choose to share one negative and one positive moment in the group or with the counselor. These written stories about the past become part 1 of the triptych. Next, participants start working on the third part of the triptych, focusing on their present and future lives from a perspective of personal recovery. They focus on what they learned, their strengths, motivations and values while acknowledging their vulnerabilities. This completes the triptych. Besides putting their written stories into the digital document, participants work on two additional assignments: asking for appreciative contributions from significant others and writing a compassionate letter to themselves. The intervention ends with a celebratory session where each participant receives their printed life story book.

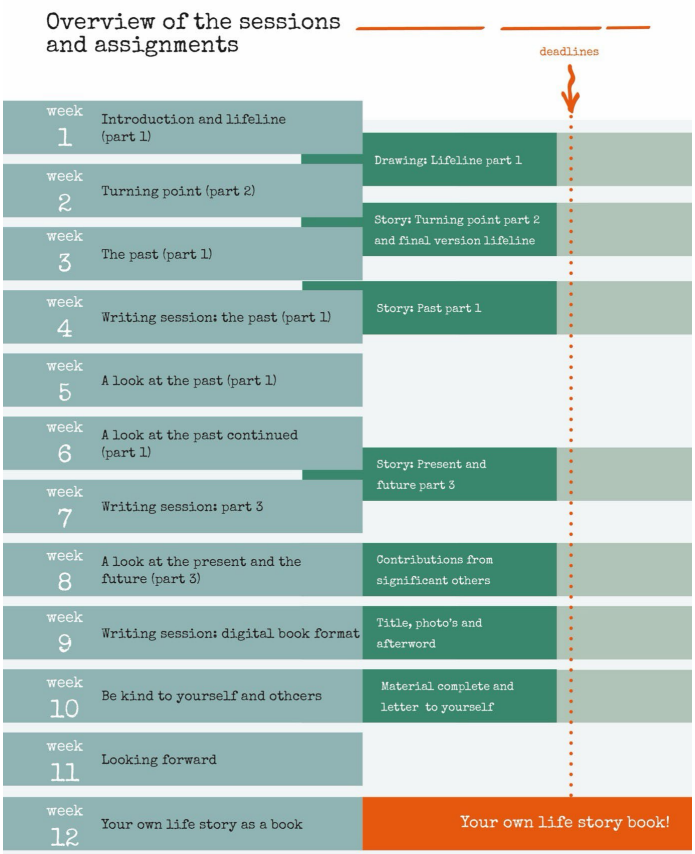

Figure 1. Overview of the sessions and assignments

Development of *An Empowering Story*

In this section, we will discuss the steps that we have taken to develop the intervention *An Empowering Story* (see Figure 2). As a starting point, we will give a short description of the context of the three partners involved: narrative research, clinical treatment, and biographical practice. Next, we discuss the sequential steps that were taken in the development of *An Empowering Story*. The first step is a *needs assessment* to develop the narrative intervention. The second step is the *development of a prototype* that integrates theoretical, clinical, and biographical expertise of the three partners. The following four steps were inspired by the model of the U.K. Medical Research Council for the development and evaluation of complex interventions (Craig et al. 2008): *design* (including the perspective of clients and professionals), *feasibility* (piloting the intervention in everyday practice), *evaluation* (assessing the effectiveness of the intervention in promoting personal recovery), and *implementation* (assessing what is necessary to implement the intervention on a larger scale beyond the context where it was developed). The guidelines of the American Psychological Association (2006) suggest that evidence-based interventions need to take into account not only the best scientific knowledge available, but the clinical expertise of professionals as well as the preferences of clients into account. Hence, we involved professionals and clients in the development in the intervention. The paper concludes with a *reflection* on the collaboration between research and practice.

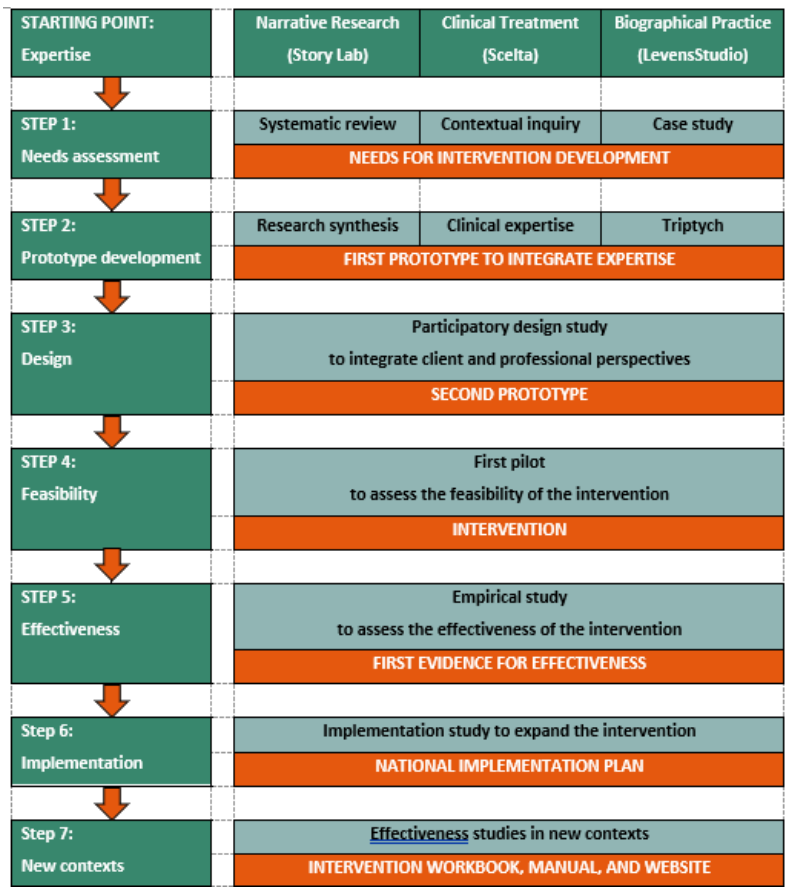

Figure 2. Overview of the steps taken in the collaboration between research and practice

Starting Point: Three Partners With Expertise in Research, Clinical and Biographical practice

The collaboration engaged three partners with expertise in research, clinical treatment, and biographical practice. The *Story Lab* at the University of Twente, the Netherlands, is the expertise center for narrative psychology. Its aims to understand stories in a changing world, innovate storyline analyses, and design narrative interventions that promote community, well-being, and mental health. Researchers collaborate across disciplines ranging from the arts and humanities to behavioral, social and computer sciences, as well as with professionals in mental health, hospitals, care for older adults, social work, and education. They develop, evaluate, and implement narrative interventions tailored to groups such as frail older adults, people with personality disorders, or people with combined intellectual disability and psychiatric complaints. We use both quantitative and qualitative methods for formative and summative evaluations. An overview appears in Westerhof (2021).

Scelta, part of GGNet, is a treatment center for personality disorders requiring specialized care. Clients usually have long histories of treatments before referral, where thorough diagnostics precede admission. Most clients present borderline, avoidant, or dependent personality disorders, often with trauma, mood, or anxiety comorbidities. The average age of clients is 33, over 80% are women, and all education levels are represented. Treatment lasts up to nine months; inpatient or part-time. Inpatient care involves four days a week with overnight stays, using group dialectical behavioral therapy, schema therapy, and, more recently, sensorimotor therapy. Programs host 24 clients in groups of eight. The part-time program runs three days weekly, offering compassion-focused therapy for 27 clients in groups of nine. Scelta's multidisciplinary team includes psychiatrists, psychologists, psychotherapists, art therapists, and nurse practitioners. Research shows reduced symptoms and improved well-being. Nationally recognized as a top-clinical centre, Scelta collaborates with the University of Twente on research and innovation.

The *LevensStudio* is a self-employed company that engages in the

development of life story books and biographies, narrative coaching and support, and narrative project development in a variety of contexts. Renée Rosenboom has been working as a biographical coach since 2010. She completed a four-year study at the Institute of Biography (Biografiek). The Institute of Biography addresses lifespan development across different life phases from a phenomenological, philosophical. and spiritual point of view with a focus on positive health. The field of biography involves working with life stories, both individually and in groups, where people are invited to reflect on life experiences in various ways: through storytelling, autobiographical writing, and visual expression. This approach contributes to strengthening one's identity and inner strength, enhances the connection with others and people's self-healing abilities (Antonovsky 1998).

Step 1: Needs Assessment

The *LevensStudio* played the role of a catalyst in the start of the project. The biographical coach had just finished writing a life story together with a person living with personality disorder across the lines of a triptych, i.e. a specific form of biographical life story work. Both the coach and this person evaluated this project as very successful. The coach then contacted the Story Lab with the goal of making this specific form of life story work more broadly available. The Story Lab brought her into contact with Scelta.

Scelta recognized the need for a narrative intervention focusing on personal recovery in persons with personality disorders. In addressing severe and complex disorders, Scelta applied a person-centered approach emphasizing acceptance, compassion, and mature personality characteristics, supporting clients beyond clinical recovery toward personal well-being. Practitioners also needed tools to work more effectively with life stories. Traditionally, all clients wrote life stories for treatment allocation (Pol et al., 2024), but Scelta aimed to give these stories a more central treatment role. An observational study asked clients to rewrite their life stories post-treatment (Pol et al., 2023). This study revealed positive changes in agency and communion, showing that stories became more empowering while highlighting individual variation over time. Clients and practitioners found rewriting to be meaningful, while both noted that clients would benefit from more structure and support in this process. These findings, along with practice observations, supported developing an intervention to help clients rewrite life stories to promote recovery.

The Story Lab aimed to build evidence for a narrative intervention supporting personal recovery in people with personality disorders. A systematic review in Scopus in 2020 found no studies on narrative interventions with this focus. Narrative exposure therapy had been used for PTSD in individuals with borderline personality pathology but without a recovery focus (Pabst et al., 2014). One intervention supported personal recovery in this group but was not narrative-based (Mortimer-Jones et al., 2016). Existing reviews on personality disorder treatment (Finch et al., 2019) and personal recovery (Van Weeghel et al., 2019) confirmed this gap. However, a review found personal recovery to be important for those with borderline personality pathology (Ng et al., 2016), while another identified issues in narrative identity among people with personality disorders (Lind et al., 2020). Thus, we concluded there is a lack of studies on narrative interventions for personal recovery in this group despite a clear need for such research.

Step 2: Development of a Prototype

Having described the three partners with their different expertise and needs assessment, the next step was to develop a prototype. We describe in this section how the prototype is rooted in an existing biographical method, the triptych, and how clinical expertise and a synthesis of narrative research were used to further develop the prototype from this method.

Triptych. The prototype was developed using the *triptych*, an existing, generic biographical method in a visual format (Boon, 2023). In her work with a person with personality disorder, Rosenboom, with her background as a writer, adapted it into a written triptych, also incorporating elements from autobiographical writing approaches (Prinsenberg, 2010; Soer, 2013). The first part focuses on the past, written in the third person and past tense to create emotional distance. The second part explores a personal turning point, described richly in the first person and past tense to strengthen agency by detailing one's active role in this moment. The third part focuses on the present and future, written in the first person and present tense to affirm its reality. Here, guided assignments help participants envision a positive and vivid next chapter of their lives. The triptych is created through a series of autobiographical assignments, and, upon completion, it is printed as a life story book, offering participants a tangible, empowering narrative of their recovery journey.

Clinical expertise. The triptych method was adapted to fit Scelta's intensive treatment context for individuals with personality disorders. First, while the focus on the past was retained, it was kept broad and not directly tied to personality problems, emphasizing the person rather than the illness. By contrast, the "turning point" section was adjusted to highlight a moment when clients felt they actively took charge of recovery of their personality problems. The third part, describing the present and future, encouraged clients to consider living with and beyond their disorder rather than imagining a life entirely without it. Second, the intervention considered the specific emotional challenges clients may face when engaging with their life stories, as well as the dynamics of group therapy. Emphasis was placed on creating a safe "holding" environment for participants. Finally, practical adjustments were made to integrate the intervention into Scelta's broader treatment program. The triptych was offered in a group format

consistent with other program components, structured to last a maximum of 12 weeks, and positioned as an optional module alongside other optional treatment modules, allowing clients to choose it according to their individual recovery needs and readiness.

Research synthesis. A research synthesis was made in 2017 based on reviews of several psychological approaches, each with their own approach to life stories: cognitive psychology of autobiographical memory (Singer et al., 2013), lifespan developmental psychology of reminiscence and life review (Westerhof & Bohlmeijer, 2014), narrative personality psychology with a focus on narrative identity (Adler et al., 2016), and clinical psychology of narrative therapeutic change processes (Angus & Greenberg, 2011). Additionally, several meta-analyses provide evidence for the effectiveness of using stories to enhance mental health and well-being (Gwozdziewycz & Mehl-Madrona, 2013; Pinquart & Forstmeier, 2012), underscoring the potential of narrative interventions within mental health care. A later review by Lind et al. (2020) mainly confirmed the following conclusions.

Across these sources, several characteristics of life stories were identified as important for personal recovery: expressing emotions within stories; telling vivid stories about unique life events, engaging in autobiographical reasoning about the personal meaning of these events, the extent to which these meanings reflect individuals' sense of control over their lives (agency) and their connection with others (communion), the degree to which these stories are combined into a more overarching story about one's entire life course, and the degree to which these stories are created and shared within supportive relationships with practitioners, peers, and personal networks. This synthesis was used as a framework for complementing and enriching the foundational concept of the triptych. We also took into account methods from evidence-based narrative interventions (Bohlmeijer, Mies, & Westerhof, 2007; Westerhof & Bohlmeijer, 2014).

Step 3: Participatory Design

The goal of the third step was to better integrate the intervention prototype with the clinical expertise of professionals and the values of clients in everyday practice. To achieve this, we conducted a participatory design study involving ten professionals with diverse educational backgrounds and eight clients with varied demographic and clinical background (Pol et al., 2024). The study proceeded through three iterative phases: individual semi-structured interviews, two focus groups—one with clients and one with professionals—to address unclear or contested issues, and individual member checks for final evaluation of the prototype revisions. We evaluated a draft manual for counselors, a draft workbook for clients, an initial version of a digital platform as well as example instruction texts and graphic design layouts.

An inductive thematic analysis revealed that the intervention was generally well accepted. Managing the homework writing assignments improved by setting time limits, clarifying expectations, and offering additional support, including two dedicated group writing sessions. A significant challenge identified was the emotional difficulty of writing and sharing stories about clients' often painful life experiences. To address this, we introduced structured support, integrated well-being exercises inspired by relaxation and mindfulness techniques, and established clear guidelines to help contain emotions during writing (such as time limits) and sharing (such as responding with a single appreciative word). While some suggestions, like extending the number of sessions, could not be accommodated due to program constraints, member checks showed unanimous agreement that the intervention was motivating and added meaningful focus to existing treatments, supporting personal reflection and recovery-oriented goals within therapy.

Step 4: Feasibility

The next step involved conducting a feasibility study (Pol et al., 2024). The intervention was delivered by an experienced, licensed clinical psychologist alongside a master-level psychologist. Eligibility criteria required clients to have been in treatment for several months and demonstrated at least some capacity for self-reflection. Exclusion criteria included limited Dutch language proficiency, emotional instability, acute crisis, psychosis, or acute suicidality. Participation was discussed and agreed upon with the client's primary treating professional. Thirteen clients were recruited for the study that used multiple methods: (1) an independent observer conducted session observations, (2) both clients and professionals evaluated individual sessions and the intervention overall, (3) characteristics of clients' life stories were analyzed, and (4) personal recovery was measured before, during, and after the intervention.

Results indicated the intervention was feasible, being delivered largely as intended and receiving very positive evaluations from clients and professionals alike. The life stories produced exhibited qualities associated with improved mental health and well-being, and personal recovery showed positive changes. However, areas for improvement were identified, particularly regarding time management within and between sessions and managing the emotional challenges involved in writing and sharing personal stories. Notably, five participants did not complete the intervention. While they valued the experience and reported increased self-compassion, they found the timing unsuitable due to emotional instability. Feedback from the study informed further refinements, leading to the development of a final version of the intervention prototype better tailored to client needs and treatment contexts.

Step 5: A First Effectiveness Study

The next step was to conduct a rigorous effectiveness study. While a randomized controlled trial (RCT) is the

gold standard, it was not feasible within the Scelta setting. Therefore, we chose a multiple baseline single-case experimental design, which intensively tracks participants over time to identify changes in personal recovery before, during, and after the intervention (Pol et al., under review). Eleven participants were recruited following similar criteria as in the feasibility study. They completed personal recovery questions twice weekly during three phases: baseline (pre-intervention), intervention, and follow-up. Baseline lengths were randomized for each participant, enabling each to serve as their own control. Results showed a significant average increase in personal recovery starting when the intervention began, with eight of eleven participants improving individually. In a second part of this study, participants completed longer questionnaires on personality pathology and personal recovery at baseline, intervention start, intervention end, and follow-up. No change in personal recovery occurred from baseline to intervention start, but improvements emerged during the intervention and persisted at follow-up. Personality pathology remained stable before and during the intervention but improved only at follow-up. Last, all participants were interviewed, and their interviews were analyzed via themes of Connectedness, Hope, Identity, Meaning, and Empowerment (Leamy et al., 2011). The interviews revealed positive changes across all themes except Meaning. Overall, this study provides initial evidence supporting the intervention's effectiveness, though generalizability is still limited by the single-group design.

Step 6: National Implementation Plan

The sixth step expanded the intervention to new mental health contexts through an implementation study. Alongside a train-the-trainer program and feasibility testing, the main goal was a national implementation strategy. The study used Fleuren et al.'s (2014) model of determinants of health care innovations, covering the intervention, users, organizations, and broader socio-political context.

In the first part, 26 practitioners completed an implementation questionnaire (Fleuren et al., 2014) after training. They judged implementation feasibility (mean 7.0/10). Ratings for the intervention from clients and practitioners were high (7.8–8.6/10). Colleague support, organizational alignment, and the sociopolitical environment were rated as satisfactory (6.6–6.8/10). Key concerns were the need for early managerial support and awareness of concurrent organizational changes.

In the second part, 16 stakeholders were interviewed: managers, policy officers, client organizations, professional associations, health insurers, quality assurance bodies and post-master educational organizations. Thematic analysis identified many facilitators (N=211) and fewer barriers (N=47). Stakeholders supported the intervention's aims, target group, and structure, and they saw potential for broader use, while warning against excessive heterogeneity. They stressed practitioner skills in group facilitation and dedicated training. Stakeholders found the intervention aligned with their mission at the organizational level, although they noted that limited awareness, resources, and competing changes could hinder uptake. Stepwise implementation was advised to address these barriers. At the sociopolitical level, stakeholders noted capacity benefits and alignment with system reforms. They recommended networking and promotion, while highlighting instabilities in the sector, funding needs, and the importance of further effectiveness and cost-effectiveness research.

Based on these findings, a national implementation plan was designed, informed by Fleuren et al. (2014) and the Consolidated Framework for Implementation Research (Damschroder et al., 2022). This structured plan outlines clear steps for scaling the intervention while ensuring fit with practice, organizational capacity, and the evolving mental health landscape (see Figure 3).

Step 7: Delivering the Intervention in New Contexts

In line with the national implementation plan and to make the intervention available in new contexts, we took several initiatives.

We partnered with the publisher Boom to publish the intervention. It is now available as a participant workbook (Rosenboom, Pol, & Westerhof, 2025), a counselor manual (Pol, Rosenboom, & Westerhof, 2025), and a website with digital materials for participants and counselors (www.boom.nl/eensterkverhaal). The participant workbook was redesigned for both the general public (e.g., life events) and people with diverse mental health issues beyond personality problems. The counselor manual was rewritten for a wide range of professionals, with chapters on theory, practice, research, and implementation as well as applications to various disorders (personality, psychotic, eating, addiction, depressive, trauma) and contexts (forensic care, recovery centers, outside mental health).

We developed and evaluated a one-day train-the-trainer program, offered several times a year. Over 120 counselors have been trained, including psychologists, psychiatric nurses, art therapists, experts by experience, and biographical coaches. Feedback is highly positive on trainers, materials, and experiential approach, with an average score of 9.0/10. Graduates can join a closed LinkedIn group or attend booster sessions to exchange experiences in implementing and delivering the intervention.

The intervention is now recognized as an innovative treatment in the Dutch standard for mental health care (section: personality disorders). To strengthen evidence, we are conducting a multi-center effectiveness study using a similar multiple baseline, single-case design as in the first effectiveness study (Pol et al., under review), including two outpatient clinics for adults, two for older adults, and one neuropsychiatry expertise center. The intervention is

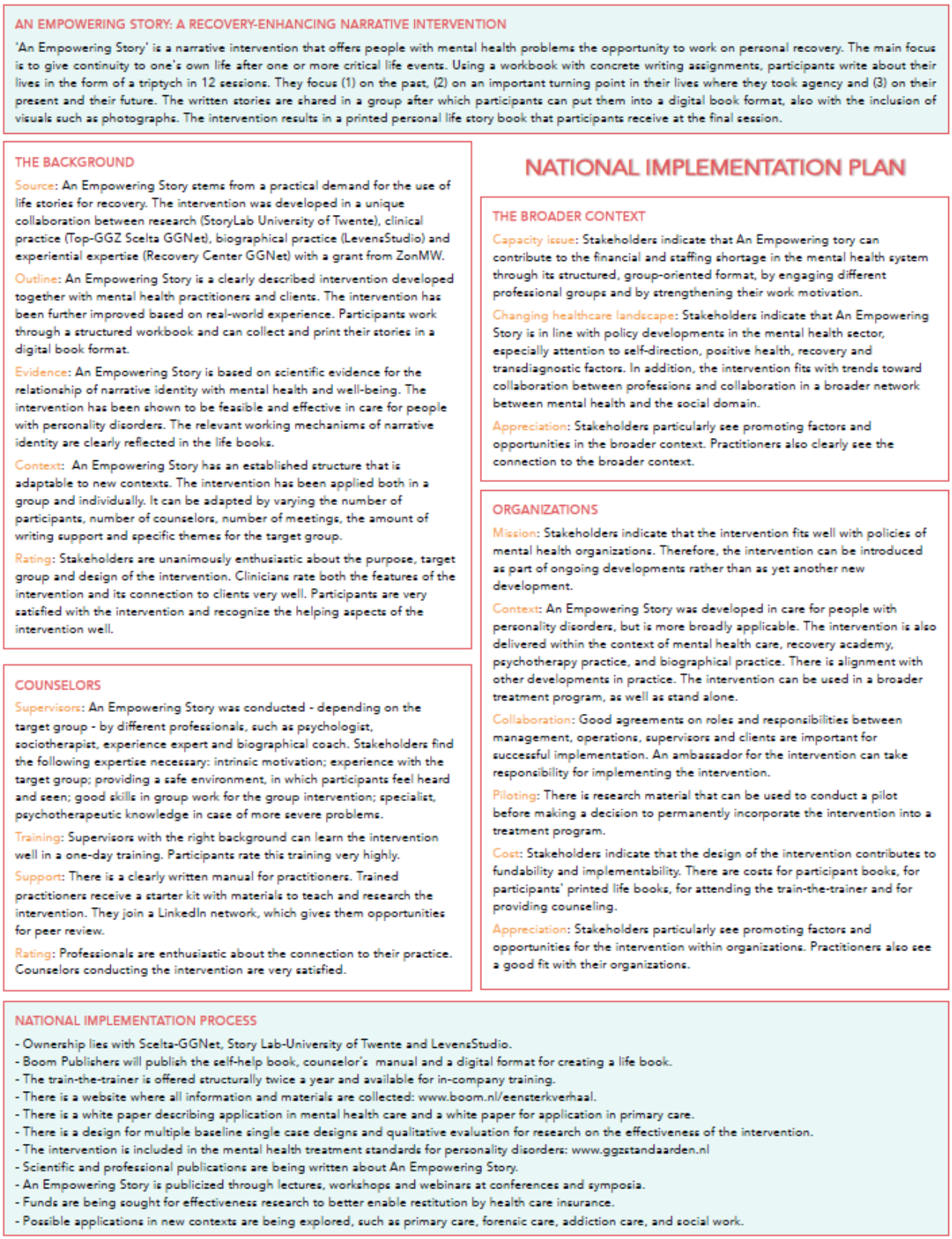

Figure 3. National Implementation Plan

also being developed into an art therapy for application in forensic care.

Reflection

The different steps in the process have shown that the intervention is well-supported by professionals and clients (design study), is feasible in everyday practice (feasibility study), shows preliminary evidence for effects (effectiveness study), and has a potential for wider application (implementation study). However, all studies until now included relatively small sample sizes. To further build evidence, we aim for further steps: after assessing evidence in new settings as outlined in the previous paragraph, we aim for a larger study on effectiveness and cost-effectiveness. In line with our earlier studies, we find it important to not only assess changes in personal recovery, but also to involve clients, professionals, and managers in qualitative studies to make their experiences and expertise heard. We hope that this will allow a good implementation in practice on the one hand and better scientific answers to the questions of how the intervention works and for whom.

At the start of this paper, we argued that *An Empowering Story* emerged from collaboration between scientific, clinical, and biographical expertise. Throughout the paper, we aimed to show how research and practice informed each other. Our main message is that this was not simply applying research to practice but involves a genuine dialogue. In this section, we reflect on the factors that supported this dialogue, drawing on Scholz and Steiner's (2023) analysis of transdisciplinary processes.

Scholz and Steiner (2023) define transdisciplinarity as collaboration between science and practice, which produce different kinds of knowledge; science, inspired by curiosity, develops empirically validated models, while practice, inspired by everyday feedback, generates situated knowledge of what works for whom. A key dimension is *process ownership*, i.e. who controls the collaborative processes. At one end of a science-practice continuum, there are cases where science takes control, like applied science or knowledge transfer. At the other end, there are cases where practice takes control, like consultancy and contract-based research. Transdisciplinarity occurs when both share responsibility, as in participatory research or triple helix collaborations. Such processes are characterized by collaboration, co-leadership, and mutual learning.

Collaboration requires a challenge relevant to both sides. Our project found common ground in valuing life stories for mental health, person-centered care, and salutogenesis. This shared orientation was reinforced by our institutions: the University of Twente's entrepreneurial mission, Scelta's focus on evidence-based innovation, and the LevensStudio's ambition to expand biographical practice. Psychology's ideal of the scientist-practitioner who integrates the best of both worlds helped attract students, clinicians in training, and a clinician doing her PhD. More broadly, mental healthcare demands research-practice integration, as only evidence-based interventions are included in care standards and health insurance.

Several models supported our collaborative efforts. The UK Medical Research Council framework for complex interventions helped to divide the process in steps of design, feasibility, effectiveness, and implementation (Craig et al., 2008). APA guidelines (2006) on evidence-based practice supported integrating science with professional expertise and client preferences. Implementation frameworks (CFIR, 2022; Fleuren et al., 2014) helped to construct the national implementation plan. These supported our process but were not designed for narrative interventions, raising the need for models tailored to narrative research and practice.

Joint responsibility is another central issue in transdisciplinary work. Besides illuminating the common ground, this asks for recognition of otherness. Although specific tasks were done by those with corresponding expertise (e.g., project proposals by the researcher, pilots by the clinician, workbook texts by the biographical coach), all work was shared, discussed, and reviewed together in regular meetings. Recognizing each other's working contexts—academic, clinical, or self-employed—was essential for sustaining collaboration despite breaks or pressures. Being a professor at a university involves tasks such as research, teaching, and academic service. Being a clinician in a clinic requires caring for vulnerable people, a responsibility often more urgent than working on a project. Being self-employed demands securing the financial means to keep the company alive. It was only by recognizing these contexts that the collaboration could continue, even when there were breaks and ups and downs.

Besides the three parties taking leadership together, stakeholder involvement was also key. Clients and professionals co-designed and evaluated the intervention; managers and policymakers contributed during the implementation study. Although not co-leads, their voices shaped outcomes. In later stages, an "expert by experience" joined the core team, and a stakeholder sounding board supported national implementation, balancing ownership between the initiating partners and wider contributors.

A final characteristic of transdisciplinarity is how mutual learning occurred across roles. Mutual learning took place as our different expertise and interests could take shape in different products of the project: scientific articles, articles for professionals, train-the-trainer materials for professionals as well as a workbook for clients. The researcher learned to translate narrative theory into accessible exercises for clinical use; the clinician learned to conduct research and practice appreciative listening; the biographical coach learned to build evidence in healthcare and manage group work.

To conclude, collaboration, joint responsibility, and mutual learning have been key characteristics of our transdisciplinary process that may have contributed to its success. Yet, reflection also makes clear that it is important to further develop models for collaboration in narrative

research and practice, to make deliberate decisions about who shares responsibility and has a voice, and to enable mutual learning under these conditions. We hope our project can inspire future collaborative projects from the concept of transdisciplinarity to arrive at well-founded and practice-based narrative interventions.

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