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Embodying Recovery: A Qualitative Study of Peer Work in a Consumer-Run Service Setting

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Abstract

The use of peer support for persons with mental illness has been gaining force. While research has demonstrated the benefits of peer support, few studies have investigated the qualitative characteristics of how peer support aids persons recovering from mental illness. Therefore, this study sought to clarify the characteristics that constitute peer support and its contribution to recovery. We conducted ethnographic fieldwork and semi-structured interviews with nine peer advocates at a consumer-run organization in New York City, and identified three themes that describe how peer support influences recovery: transforming experience into expertise, understanding the mechanics of peer support, and launching peers towards their own recovery. Peer support plays a critical role in helping clients move beyond their patient role to an empowered sense of personhood. Additionally, the value of peer support highlights current deficiencies within the mental health system and how a bolder shift towards recovery might repair them.

Keywords

Peers; Peer support; Recovery; Agency

Introduction

From “total institutions” to virtual de-institutionalization in the span of a lifetime, mental health reform has ridden a pendulum of beliefs and corresponding identity shifts. Its most recent iteration is recovery, which introduced the idea that persons with severe and persistent psychiatric disorders can reclaim stability, social functioning and meaningful life planning while managing the adversities of their disorder (Jacobson 2004; Davidson et al. 2010; Slade 2009). That this would mean re-examining ingrained assumptions about persons with mental illness, their possibilities, and the institutional fields where they might be tested,

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was clear in the call for “profound change” within a public mental health system characterized as “a shambles” (Department of Health and Human Services 2003). Although the promise held out by the recovery movement was transformative, public mental health systems continue to grapple with the pragmatic difficulties of integrating recovery into their own practice.

Practitioners have issued correctives that attempt to situate recovery within a set of measurable social criteria, including lack of odd behavior and living independently (Bellack 2006). For their part, clients have upped the ante, viewing recovery as a process that constantly re-shapes treatment through regaining autonomy, re-engaging with the community, and reconstructing one’s identity as a whole person, not just as a psychiatric patient (Bellack 2006; Hopper 2007). For the moment, recovery suffers from an essential ambiguity—both promising and fraught—that allows for varied interpretations and misunderstandings of what should count as recovery-informed practice (Jacobson 2004). Both the intensely individual nature of recovery and the political uses of the term invariably work against any uniform definition of it.

With years of discriminatory treatment behind them, persons with mental illness began to share their experiences and advocate for themselves in the 1970s (Davidson et al. 1999; Jacobson 2004; McLean 1995). One striking development was “user-controlled alternatives” and the rejection of hierarchical relationships. Together with the Community Support Program beginning in 1975 and the affirmative commitment to involve clients in the creation of programming and policy in the early 1990s, this produced a wealth of client-driven programs, peer support initiatives, and attempts to integrate peers with traditional programs (Mclean 1995; Jacobson 2004; Goldstrom et al. 2006; Tanenbaum 2012; Chamberlin 1978).

Peer support is conventionally cataloged by the functions of peer work, including mutual support, consumer-run organizations, and consumers-as-providers. In addition to the concrete benefits peer support has been shown to provide, including reductions in psychiatric hospitalization, previous studies of peer support also show it to be uniquely beneficial, such that no other aspect of the mental health system can compensate for it (Landers and Zhou 2011; Chinman et al. 2001; Davidson et al. 2010; Felton et al. 1995; Fukui et al. 2010; Solomon 2004; Stastny and Lehmann 2007; Tandora et al. 2010). Since peer support is often less restrictive than the clinical encounter, it can allow for transactions characterized by “respect, shared responsibility and mutual agreement of what is helpful” (Solomon 2004; Alexander et al. 2009; Mead et al. 2001, p. 135). The benefits of peer support, therefore, may have less to do with their duties and more with the implicit influence of their presence and unspoken validation of clients’ own lives (Sells et al. 2008). As peer support gains momentum, authors have begun to establish the critical ingredients than define peer work settings, in particular their voluntary nature, experiential knowledge emphasis, and recovery-oriented shared beliefs (Rogers et al. 2009). Few studies, however, address the complexities of peer work and its impact on mental health clients, especially in the kinds of peer support relationships that are not purely mutual, but more asymmetrical or one-directional (Moran et al. 2012). In our qualitative study, we set out to explore the means and

mechanisms of peer work, the formation of peer expertise, and its potential contribution to recovery in a consumer-run agency.

Methods

We conducted a mixed methods study that included participant observation, semi-structured interviews, and a member-checking focus group with peer advocates at Baltic Street, AEH (Advocacy, Employment, and Housing), Inc., a consumer-operated service organization in New York City. Baltic Street AEH was chosen for specifically for the nature of peer work they sponsor. Like most consumer-operated service organizations, Baltic Street AEH is governed by consumers, relies on extensive community-based networks, and emphasizes empowerment and recovery values throughout their diverse programming, which includes free-of-charge benefits assistance, housing support, consumer advocacy, and wellness programming for clients with severe mental illness (Tanenbaum 2012). Peer advocates may, for example, help clients prepare supportive housing applications, accompany clients to benefits-related meetings, or advocate for clients to remedy an unsatisfactory condition in their environment (such as lack of air conditioning). They also broker negotiations with parties throughout the mental health system, including clinicians, case managers, city and state government offices, and housing agencies. All peer advocates employed in one of Baltic Street's sites were eligible to participate in this study. After learning about the study, 9 of 11 peer advocates agreed to participate. Advocates were employed full or part time; they represented diverse cultural backgrounds, and their experience varied from 6 months to over 10 years.

Subjects participated in one semi-structured, in-depth interview and multiple periods of participant observation. Interviews typically ran for forty-five minutes and were audio recorded and transcribed. During the interview, we asked peers to discuss their experiences working as advocates, interacting with clients, and reflections on the mental health system. Our interview guide was informed by over 6 months of ethnographic fieldwork with peer advocates prior to the study. Participant observation occurred in the peer advocates' office, where we observed the peers individually for multiple periods of one to two hours at a time, engaging them in informal questioning and taking notes on their activities and interactions with clients who offered verbal consent.

We conducted a grounded theory analysis of the transcripts produced from each interview and of the fieldnotes from each participant observation session (Charmaz 2006). We began by closely reading and coding the interviews and fieldnotes during the data collection phase, and then moved through progressively higher layers of analysis attempting to draw out prominent themes and patterns from the data, using analytic memos and regular meetings to resolve differences in interpretation. This process of inductive coding and analysis was ongoing throughout the research, allowing us to continuously compare and refine our inquiry as data was collected. Eventually, drawing from the codes, memos, and analyses that developed over time, we formulated a working set of key themes that characterized the nature of peer work and its influence on clients, recovery, and peers themselves. Towards the end of the study, we presented our preliminary findings in a member-checking focus group, and integrated the second-order data their comments and critiques represented into

our final results. Our study was approved by the Columbia University Medical Center Institutional Review Board. There were no known conflicts of interest for any of the authors involved in this study, and all authors certify responsibility for this manuscript.

Results

Our analysis of the data produced three major themes that describe the nature of peer work and its impact on mental health recovery: transforming experience into expertise, understanding the mechanics of peer support, and launching peers towards their own recovery.

Theme I: Transforming Experience into Expertise

I.a. Re-appropriating Experience with Reflexivity—Peer advocates represent a variety of mental health histories and diagnoses, but share a general (although not always linear) trajectory of disruptive crisis, diagnosis of illness, stabilization, empowerment and recovery. Through engaging in the mental health system as peers, they consciously evaluate and reevaluate their experience as they interact with the system in a new way. This process of conscious evaluation that melds their service-user insight with their service-provider capital gives peers a more reflexive stance, in that they gain greater awareness of the impact of their lived experiences on their recovery. Peers then bring this unique perspective that we term reflexivity to their work with clients.

> Ben: If they understand the reason why they're here, other than - truly understand, not just understand the aspect of looking for housing, and that's a great deal why a lot of clients come here, but just understand that mentally, they need to be stable mentally to maintain the housing. Anybody can just get a place to stay. The question is, can you keep it?[1]

The quote above demonstrates how as a client, the drive is for simply getting housing, whereas a peer is more concerned with having the stability to maintain housing. Peers' experience as clients gives them this distinctive awareness and knowledge of the resources within the mental health system that can impart to clients to support recovery. The following excerpt demonstrates how peers can turn their experiences as clients into on-the-job expertise:

> After the client leaves, the peer says, "During the meeting, she [the client] got anxious about certain things and was pissed off. I didn't want her to leave anxious. I try to bring people out of it, to let go of that. So I talked to her about movies. It's become second nature. All of us do this, but we might not be aware. When I was in a bad time in my life, a psychiatrist told me that we would talk it through and I'd leave without the anxiety. But she was interrupted. The anxiety stayed with me when I left. But her words have stayed with me too."(Cheryl)

By applying techniques she had learned as a client and relating elements of her personal history to clients in order to guide them, Cheryl converts her lived experience into a form of

[1]All subjects were given pseudonyms for this publication.

expertise that allows her to better understand how to meaningfully assist and motivate clients (Coniglio et al. 2012).

I.b. Using Experience to Construct Expertise—One of the most distinctive ways peers use their experience is through purposeful disclosure. Peers emphasized that they do share "a little bit" about themselves (Scott). Yet for peers, the objective of this disclosure is not to build solidarity, but to earn the credibility that permits them to guide clients along in their recovery. The stories that peers share are within this constructive light, such as "what happened, and what they did to recover, and what they did to maintain it" (Ben). Peers transform their experience into a tool to encourage their clients to work towards recovery in ways that could not be accessed by non-peers. One subject gave a particularly poignant example of how this happens when she described her former struggles with her clinician and how a peer might have helped her:

> Mary: Well, you know, sometimes a peer will have a bit of common sense to thrust upon you. If I had had a peer to discuss that analyst with, they would've said: […] "You know, you haven't slept in three months? Get yourself to a doctor, any old doctor. […] Don't just lie there!" […] I didn't have that common sense and I didn't have a connection to anyone that I could talk to about this and get that kind of reaction.

Peers draw upon an experience-based awareness that allows them to effectively help clients work towards recovery by delivering well-timed doses of practical reason, the sort of reason that peers know that the dependency nature of the patient role can undermine.

Theme II: Understanding the Mechanics of Peer Support

II.a. Becoming Credible Embodied Evidence of Recovery—When clients work with peers, they are able to witness recovery in action. Peers embody how to maintain stability and wellness, find self-sufficiency, and navigate a variety of social interactions and roles that take shape in one's life. As one peer puts it, "most of the time I'm providing a decent example" for how to live a recovered life (Mary). This aids clients in moving from an abstract and unattainable conceptualization of recovery to a realizable model and aspiration.

> Cheryl: For some of them we're like their goals. For some of them we become their new goals - 'I would like to work in a place like you do and help others like you because you helped me, and if you could do it I can do it, if everybody here can do it, I definitely can do it.'

The fact that peers both demonstrate and embody recovery makes their support that much more meaningful. They can more authentically understand their clients' perspectives, and thus can more effectively help their clients overcome challenges and achieve goals. This means more than just appreciating their clients' attitudes, but also understanding their behaviors, so when challenges such as slippage or not following through occur, peers "don't ever give up on the client," and call upon their experience to put themselves "in the position with the client" (Mark).

> Mary: We know that we're both in recovery, that we're both trying to overcome certain things, and that we can trust each other at that level, and go forward, and

forgive each other and ourselves for any kind of backsliding that may occur, and try again.

II.b. Giving Meaning and Purpose to the Mental Health System—One of the most unique aspects of the peer perspective is how peers ascribe meaning to clients' experiences within the system. When asked what it means for clients to finally receive the benefits they seek help for (such as housing and SSI), not a single peer cited the practical elements of the benefit itself. Instead they explained that:

> Cheryl: It means they got a gold medal. They got a gold medal, because they didn't have this before, it took them months to get this step, and they're one step closer to freedom.

The value of getting housing is the agency it affords clients and the impact that agency has on their well-being. Gaining resources means "a new chance, a new hope," and a point from which the will to recover can spring (Mary). Peers expressed their belief that recovery is not only a "technical problem" but also "an emotional" one, "a kind of re-adaptation" that requires the client to be "elastic, pliable, and open to the experience" (Scott). As peers see it, recovery comes in two parts: recovery from illness and recovery from the system. It is this second part, "getting over the mental health system itself," necessitates skills such as optimism "because it's very difficult to put up with the kind of weight bureaucracies impose on you" (Scott; Mary). For peers then, part of recovering is coming to terms with the mental health system, having the fortitude to withstand it, but also maturing to the point that they can take part without being engulfed by it.

II.c. Building Relationships that Activate and Condition Towards Recovery—In working to build strong connections with their clients, peers avoid the usual power agendas at work in service settings that might occlude the space for clients to have a truly open presence.

> Scott: If I disclose, I see myself as being more empathetic. [The client] and I become more equal in this context. It comforts both, comforts me and [the client]. […] It's something like an empathetic equalizer.

Peers engage in active "authenticity work" to reshape the spaces in which they build relationships with clients (Scott 2011). Once peers have developed such relationships, they begin to incorporate recovery goals into their work with clients. Here, Cheryl describes how she maintains her persistence for recovery despite the client's inability to see beyond his current stage.

> Cheryl: For some, based on their body language or tone of voice, you'll hear the interest, whatever level, and so you push nicely, quietly, kindly; but you get them to where they need to be, because in the end when they're recovered, they know that they need to be there themselves.

Her persistence yields an opportunity to move towards recovery, exemplifying the "tenacity coupled with an unwillingness to accept failure" that is so characteristic of the "committed work" peers engage in (Hopper 2006, p. 221). Peers take responsibility for helping clients gain self-sufficiency in their own lives, even if clients themselves do not see the benefit.

> Ben: I work very hard to help them empower themselves, I don't want to just always just do the work for them, you know even if for awhile I have to do that than I'll to do that […], but intermixed with me doing that every now and then I will just drop a seed or something like that to try to encourage them to empower themselves.

These hints show clients that peers are interested in their greater well-being and encourage clients to reciprocate the effort peers put forward for them. Hints also nudge clients to think from a recovery perspective and act on their own volition. When clients come to their office, "they may just be focused on no further needs than what is there" (Ben). Peers "try to open them up so they will become more aware of the world and advocate for themselves" (Cheryl). These seeds and hints, as peers call them, are how peers condition clients for their own recovery.

> Mary: I had one client who learned how to read the [housing agency] vacancy list. It's full of little abbreviations, you know, it's a little bit tricky when you first look at it, but I showed it to him a couple of times, and I said - 'listen, I have about 30, 40 other people, so if you would help me keep track of these updates, and call me when you find a vacancy that says 'mental health' and, you know, 'supported housing',' - the level, whatever level that he was at that he needed. And he started doing it. He'd go to the library and use the computer, he'd call me and he'd say - 'agency such and such has a vacancy' - and I'd mail it off, and it was great!

As one peer states, "for us to do the work where they could do it themselves, is kind of detrimental to their future full recovery" (Cheryl). For peers then, the ulterior objective of their work with clients is "not enabling them" to depend on peer support in the first place, but instead constantly encouraging clients in their recovery (Mark).

Theme III: Launching Peers Towards Their Own Recovery

III.a. Locating Illness and Refining Narrative—Peer work also aids peers in their own efforts towards recovery. Through interacting with clients, peers gain perspective and reflexivity about their own illness experience, aiding them in forming their own narratives:

> Mark: You know, you look at some of the clients that you work with, and you see that you didn't have it that bad. You may have been depressed or whatever but some people really have it bad.
>
> Jerry: If I wasn't in recovery, I wouldn't be able to tell the story.

III.b. Shrugging off the Weight of the System—Despite the weight of a mental illness diagnosis, peers frequently cited the weight of the mental health system itself as more foreboding. The process of seeking the right services and needing the system for basic needs such as food and housing can take a greater toll on clients than the symptoms of their illness. As their work provides insider knowledge of the system, peers are encouraged to transform the system that for them was harsh and ineffective into something positive for someone else.

> Scott: In a sense I'm trying to get away from, […] psychologically away from, the mental health system. This puts me back into it, but in a positive sense.

The peer work environment is itself a novel space for recovery, as it forgives them their shortcomings and values their history with mental health, ultimately respecting them as professionals, not clients.

> Mark: You basically don't have to disclose. You can go right on in there and feel comfortable because you're among friends. So you don't have to worry about someone finding out or whatever, and blaming that on your work.

III.c. Helper Identity—Finally, helping clients achieve success gives peers feelings of accomplishment and positivity that further promote their well-being. Peers genuinely benefit, emotionally and psychologically, from supporting their clients:

> Scott: When I do something positive for them I feel very positive about myself; […] there are some incentives that come with our help, that are not material incentives, it's not money that counts, it's the emotion, the psychological satisfaction having to have done something really well and to have had some good results, to have done something for another human being.

This final dimension of peer work, while not new, is worth underscoring (Solomon 2004). For peers who are recovering from illnesses that dramatically influence their mood and emotional health, employment that provides them with both a sense of purpose and positive emotions highly supports their recovery.

Discussion

The conversational excerpts and observed moments woven throughout our qualitative study help to illustrate how peer support can create a distinctive and beneficial space in the mental health system. Drawing from their lived experiences as clients and a reflexivity that is refined over time, peers bring nuanced expertise, empathy, and credibility to their interactions with clients. These mutually beneficial relationships in turn shape the recovery experiences of both parties through the ways peers uniquely solve problems, embody hope and resilience, and cultivate self-advocacy in clients.

Investigating peer support is important in its own right, as well as for what it reveals about the mental health system. Clients may value peer support not only because it guides them towards recovery, but also because it addresses long-standing inadequacies that have characterized their experiences within the system. Because historically clients have not always been invited to be part of the decision-making process about the services they receive, they continue this pattern of forgoing agency "because it is what they have come to expect from the mental health system" (Angell et al. 2006, p. 516). As clients become increasingly dependent on the system for care and guidance, they start to accept their "unequal exchanges" with it "as fair" (Lennon and Rosenfield 1994, p. 526). However, as Angell et al. (2006, p. 516) found with assertive community treatment (ACT) teams, interpersonal influence leverages information and relational power instead of punishment and authority; it "represents a more stable and productive form of power than coercion". Peers utilize interpersonal influence under even more radical terms when they offer clients the opportunity for reciprocity, a chance to actively engage in their care. In doing this, peers

help clients amplify their own agency, thus allowing for more freedom and developments of self within the client– peer relationship (Sen 1999). Ultimately, this leads to a “shift in self-perception from ‘sick person’ to a ‘productive, contributor”’ within clients (Coniglio et al. 2012).

As peers condition clients for recovery, they help clients develop the “capacity to aspire” for recovery and broader goals (Appadurai 2004, p. 69). Clients, often disenfranchised by the mental health system, may have “a more brittle horizon of aspirations” and lack the navigational capacity to pursue progress beyond their status quo or to strive for the plurality of goals (Appadurai 2004, p. 69). Yet peer advocacy presents clients with occasions to cultivate the will and means to recover and reclaim that capacity. This crucial ability—a renewed sense of what is possible in one’s life—kickstarts their momentum forward towards self-awareness, empowerment, and recovery.

Our study has two limitations that may affect its generalizability to the field. First, the peer advocates at Baltic Street occupy a distinctive position that may not be typical of other peer roles. Consequently, the experiences of these peer advocates may not be readily transferable to other forms and settings of peer work. Second, Baltic Street itself is unique in that it is a consumer-run organization. This may influence the perspectives and liberties peers have in their work with clients. While this does not discredit the study’s findings, we should note that the setting may enhance or constrain leverage in peer work.

As our study only considers peers’ perspectives, future research should investigate clinical perspectives on recovery to more specifically explore how peer work and clinical care can complement each other. It is also crucial to examine how clients respond to peer support, and how it influences their recovery over time. This will be vital not only for documenting the significance of peer support, but also for qualifying how recovery reshapes the client experience within mental health.

Through their interactions with the mental health system, clients work with various providers to manage their illness, yet this can lead to a “formation and continuity of the self” that accepts the chronicity of their patient role (Giddens 1991, p. 33). By dichotomizing the roles to client and provider, the system does not always emphasize other possibilities for persons with diagnoses, which “negates the possibility of transformation” beyond the patient role (Benjamin and Sullivan 1996, p. 232). This structure has challenged the opportunity for discussions of difference and dissatisfaction, and thus “reduced the possibility of a consideration of change” (ibid. p. 226, 227). Peers provide clients with embodiments of recovery, and the system must capitalize on this example by allowing for a plurality of roles. Involving peers in the delivery of mental healthcare would help to transmit the recovery ideology throughout the posture and practice of the system, constantly communicating to clients that being a patient is only part of becoming realized as a person.

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