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Peer Support Specialists' Experiences of Microaggressions

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Abstract

Microaggressions and their consequences have been observed among people with mental illness. However, little is known about ways in which peer support specialists, those with lived experience who also provide mental health services, experience microaggressions or the impacts of these experiences. Using an online survey of open-ended questions, peer support specialists ($N = 65$) provided examples of microaggressions they have experienced on the job and described: the frequency of these experiences, the content of messages they received, and their responses and coping strategies. Data were coded using directed content analysis. Participants across a wide range of facilities and geographic locations reported experiencing microaggressions in the workplace. The content of microaggressions fell into two domains: 1) negative messages about the nature of having a mental illness and disclosing this information to others and 2) negative messages about the role of peer support specialists. Peers' responses to microaggressions included: feeling isolated, seeking social support, employing coping strategies, and demonstrating resiliency and increased motivation to do peer work. Some peers, however, also reported leaving positions due to these experiences. Findings indicate that microaggressions are a common experience for peer support specialists that can have detrimental impact on their sense of self and role as mental health specialists. Despite this, peers sought out support, identified coping strategies, and exhibited resiliency. Findings have implications for ways to better support peers in their roles as support specialists.

Keywords

Peer specialists; microaggressions; stigma; workplace culture; behavioral health

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Peer support specialists are people with lived experience of mental illness who are formally involved in providing support to others (Solomon, 2004). Peer support specialists are trained in using their personal experiences with recovery to help others and reflect a shift in the systems of service delivery whereby peers offer support to others with similar lived experiences (Bellamy, Schmutte, & Davidson, 2017; Schmutte, & Davidson, 2017). Peers can hold a variety of positions within an organization, ranging from volunteer to paid, full-time positions. Peer models of support have grown exponentially in the past several decades and represent an important advancement as a recovery-oriented and effective form of care.

Recovery-oriented services have been defined as being grounded in the belief that people with serious mental illness can achieve meaningful life goals, improve their lives, live in the community, and have an active role in determining their own care (Corrigan, Mueser, Bond, Drake, & Solomon, 2008; Davidson & Roe, 2007). Therefore, peer support is a natural extension of an approach that seeks the empowerment of people with lived experience of mental illness. The evidence base for peer support demonstrates positive outcomes for including peers as providers, particularly for people with severe mental illness in the domains of improved quality of life, hope, and empowerment (Bellamy, et. al., 2017; Chinman, George, Dougherty, Daniels, Ghose, Swift, & Delphin-Rittmon, 2014; Davidson, Bellamy, Guy, & Miller, 2012; Repper, 2011; Sells, Black, Davidson, & Rowe, 2008). Moreover, peer support services in case management services have demonstrated outcomes that are equivalent, or even at times superior, to services provided by non-peer staff (Davidson, 2004; Sells, et al., 2006; Solomon, 1995) and as cost-effective as compared to treatment as usual (Solomon, 2004; Cronise, Teixeira, Rogers, & Harrington, 2016).

The experience of being a peer support specialist has been examined and findings largely discuss the ways this role helps individuals embody recovery (Austin, Ramakrishnan, & Hopper, 2014). In particular, peer supporters report that offering support to others helps them in their own recovery journey (Bailie & Tickle, 2015). For people with serious mental illness, finding ways to give back to others, through both informal means and formal involvement as a peer support specialist, have been associated with enhanced quality of life, reduced symptoms, and increased self-reported recovery (Eisen, et al., 2015; Firmin et al., 2015). Participating in providing peer support has been linked to self-determination theory, with motivations often including finding work consistent with one's internal values and a sense of competence regarding the match between skill-set and job characteristics (Moran, Russinova, Yim, & Sprague, 2014).

The inclusion of peer support specialists in service systems often reflects a significant paradigm shift resulting in significant barriers being identified on treatment teams and in mental health service systems that contribute to slow or ineffective implementation of peer-provided support (Chinman, Young, Hassell, & Davidson, 2006; Gates & Akabas, 2007). At one level, these barriers impede service systems from changing in ways that promote improved outcomes for clients (Davidson, Chinman, Sells, & Rowe, 2006; Bracke, Christiaens, & Verhaeghe, 2008). At another level, these barriers also often have an impact on the peer supporters who are hired in these systems. Such challenges are beginning to be examined, and an early qualitative paper revealed frequent challenges reported by peers in mental health service systems including the lack of a clear job description, lack of

opportunity to use one's skills and life story, and negative aspects of carrying the "peer" label (Moran, Russinova, Gidugu, & Gagne, 2013).

An important area of challenge for peers that has received less attention to date is that of stigma within the mental health service system itself. Overt stigma, the negative attitudes and behaviors demonstrated towards those with a mental illness (Link & Phelan, 2006), has been associated with worse outcomes and compounded challenges associated with mental illness (Corrigan, 2004; Corrigan & Watson, 2010). Stigma can also be experienced in less overt ways that have yet to be examined among peer support specialists, such as in microaggressions.

Covert forms of prejudice may be relatively invisible yet harmful to the wellbeing, self-esteem, and standard of living of many marginalized groups in society (Sue, 2010). Sue (2010) added that the frequent and subtle nature of expressions of implicit bias contribute to the difficulty of identifying, quantifying, and rectifying such exchanges. The hidden nature of this type of communication also prevents perpetrators from realizing their own participation in creating and perpetuating psychological dilemmas for targets of discrimination and prejudice and their role in creating and sustaining disparities.

One type of such subtle forms of discrimination has been referred to as microaggressions. Microaggressions are defined as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership" (Sue, 2010, p. xvi). They may be verbal, behavioral, or environmental and are often unintentional and unconscious (Sue et al., 2007, p. 273). There are three types of microaggressions: *Microassaults*, which include more traditional acts of overt and intentional acts or communications of discrimination; *microinsults*, which are largely unintentional behaviors or verbal expressions that convey insensitivity or demean a person based on a marginalized group identity; and *microinvalidations*, which may be verbal comments or behaviors that deny or dismiss the psychological thoughts, feelings, or experiential reality of a marginalized target group (Sue & Capodilupo, 2008). Microaggressions can be directed at any group that is marginalized by a cultural, social, political, or economic system or experiences exclusion, inequality, or social injustice (Sue, 2010) and have been found to have negative emotional, cognitive, and behavioral effects on their targets (Sue, 2010; Hill & Fischer, 2008).

Existing research on microaggressions has addressed dimensions of identity including race (Pierce, Carew, Pierce-Gonzalez, & Willis, 1978), gender (Capidolupo et al., 2010), sexual orientation (Nadal, Rivera, & Corpus, 2010), and social class (Smith, Mao, & Deshpande, 2015). One study explored microaggressions as experienced by persons diagnosed with mental illness and found that people with lived experience of mental illness experience microaggressions that communicate messages of invalidation, assumption of inferiority, fear, shame, experiences of overt discrimination, and related negative outcomes (Gonzales, Davidoff, Nadal, & Yanos, 2014). However, no research has been conducted to explore microaggressions experienced by peer support specialists. Therefore, this study investigated the following questions: 1) Are peer providers experiencing microaggressions in the workplace?, 2) What kinds of experiences are they having on the job?, 3) What ways (if any)

do participants say these experiences influence them (e.g., their own mental health, their job performance)?, and 4) How do peers cope with these experiences?

Methods

Participants

Sixty-five people with a previous or current psychiatric diagnosis who received mental health services who identify as peer support specialists participated in the study (see Table 1 for complete demographic information). Participants had a mean age of 47.5 (SD=11.3), an average of 15.5 years of education (SD=2.3), and the majority were female (60%) and White/Caucasian (68%). On average, participants had been employed as peers for 8.6 years (S.D.=9.9) at the time of the study and the most frequent settings of employment included Mental Health/Addiction Facilities, Non-profit organizations, and Hospitals (See Table 2).

Materials

The survey questions were developed in collaboration with researchers with lived-experience of mental illness and work in a peer role (see Table 3) and were based on existing literature on microaggressions.

Design

Participants were recruited using an online survey in Qualtrics, posted on local, national, and international list-serves. Eligibility criteria included being over 18 years of age, speaking English, and self-identifying as someone with a previous or current psychiatric diagnosis who received mental health services who also provided mental health services such as peer support. Participants were offered an opportunity to ask questions via email prior to completing the study.

Procedure

Responses were first de-identified and then coded using directed content analysis (Miles, Huberman, & Saldana, 2009). This approach was selected because the researchers were beginning with a knowledge of the existing literatures on microaggressions, and wished to compare previous findings and themes to those that would emerge in a new population. Thus, directed content analysis allowed the researchers to utilize the starting point of previous studies when developing initial codes, and yet modify the codes as appropriate to data in the new population (Hsieh & Shannon, 2005). Consistent with this approach to qualitative analysis, an initial code list was developed from relevant literatures regarding microaggressions experienced by people with mental illness, microaggressions experienced by people with other disadvantaged identity dimensions, and mental illness stigma (Hsieh & Shannon, 2016; Nemecek, Legere, & Swarbrick, 2015). The code list was modified iteratively throughout the coding process such that codes which were conceptually similar were combined and codes where new themes emerged were added (e.g., sub-types of emotional responses emerged). Each response was eligible to receive multiple codes where appropriate. Two researchers (S.M. and R.F.) independently coded data from all 65 participants (coding each response to questions 2-8 separately) and then met together to achieve consensus

(Bradley, Curry, & Devers, 2007). Themes were developed from coding of responses provided across the interview.

All procedures were approved by the institutional review board. Informed consent was obtained prior to completing the study, and participants were informed that participation was voluntary, anonymous, and they could end the study without consequence. Participants were not compensated. Data were obtained June through September 2017.

Results

Sixty participants answered the questions “Think about a time when you may have been made to feel uncomfortable because of your role as a peer support specialist. Please describe the scenario as best you can.” Six people answered this question by discussing microaggressions that were experienced for reasons that were not related to mental health or experiences as peer support specialists (e.g., microaggressions due to gender or age) and thus were not included in the following analyses. Table 4 lists the frequency with which participants reported experiencing microaggressions. These examples were largely due to encounters with fellow employees, but not exclusively. The quotes included were selected in order to illustrate the majority of responses and, thus, focus primarily on examples from encounters with fellow employees.

Results fell into three overall themes: 1) Negative Messages about Mental Illness and Disclosure, 2) Negative Messages about Peer Support Role, and 3) Responses to Microaggressions. Each theme is discussed below with illustrative quotes that have been disguised where appropriate to maintain participant anonymity.

Negative Messages about Mental Illness and Disclosure

First, participants described experiencing overt stigma, the message that they need to keep their personal experiences with mental illness private, and the experience of being defined by one’s diagnosis or as one’s experience with mental illness. Examples of overt stigma spanned “Hearing clinicians [joke] about recovery-oriented language, people making jokes about me being a ‘patient’),” and, included being the specific target of negative messages about mental illness:

When I heard others say that by hiring peers they were letting the patients run the asylum. Other times it was clear that our opinions were not valued at all on the clinical teams, the peer center was ‘oh that place down there’ having no idea what we or the clients did there, thinking we were volunteers not paid staff and colleagues, staff being upset when they were hiring for our positions when a peer would leave.

Participants described experiences in which other members of the team invalidated their role on the team and questioned their integrity as people because of their identity as a peer, such as “the doctor on the unit told other staff not to trust me or listen to me because I have my own diagnosis.” These experiences also impacted the ways peers were able to engage in their work with clients, as the negative messages that were communicated included denigrating their capacity to do the work: “When I was leading a group about going back to

work, an employment specialist with an ACT [Assertive Community Treatment] Team came in after and told his client, who was all excited about the many skills we had discovered he had, that he was too sick to think about going back to work at this time and that I had no business getting his hopes up because I was just another sick person.”

Negative Messages about Peer Support

Participants also talked about experiences of invalidation and assumptions of inferiority. Experiences of invalidation often included peers feeling ignored, dismissed, excluded, and undermined. Being invalidated by co-workers ranged from “being treated as if I was not there” to having limited access to client information as a support provider (e.g., having to leave a team meeting for reasons of “confidentiality”). Multiple participants talked about being undermined or corrected by their co-workers or supervisors in front of clients in various settings. Another peer described the “less than” status she perceived was being communicated by her co-workers because of her identification as a peer support specialist: “I am one of those people, and now on the other side of the desk, see that it is still the same way over here. Now, I see that I am not a colleague, I am something considerably less than that. Feels like I am just one of their ‘clients’ who hangs out with the other clients, while they wait to see the REAL professionals.” Being invalidated included being undermined or corrected in front of clients, or: “In a weekly team meeting of providers, I was told afterward that I had been speaking outside my expertise.”

Responses to Microaggressions

Participants described ways in which they responded to these experiences of microaggressions. First, emotional responses reflected a range of affect, including participants stating these experiences made them feel “worthless,” “helpless,” “angry,” “stressed,” “uncomfortable,” and “depressed.” Coping strategies participants reported similarly reflected a range of responses and diverse approaches to managing the affect that accompanied experiences of being invalidated. Many participants reported turning to social support, both among other peer support specialists, when possible, or among their personal social networks. Many also discussed individual coping strategies they employ, including mindfulness/meditation, prayer, and breathing exercises. Still other responses included interacting in ways that were protective at work, such as the response shared by one participant: “I become defensive and withdrawn and I know around my co-workers I’m afraid to be myself and I have to pretend.”

For many peers, these experiences of microaggressions created a work environment that was hostile to the degree that they chose to no longer stay in that place of employment: “I resigned from the position. I have discussed [these experiences] with a therapist and currently have a position where [these challenges] can be freely discussed in clinical supervision.” For some participants, these experiences were used as inspiration to work harder as advocates in the systems perpetuating microaggressions: “[These experiences] only make me want to fight harder to advance peer work in the medical model system where I work” by showing resiliency in the face of demoralizing experiences: “Stigma is still very much alive...even so, I can still honor myself by remembering who I am and where I come from.”

Discussion

This study was the first to our knowledge to investigate peer support specialists' experiences of microaggressions on the job. Participants reflect a cross-section of health care settings, demonstrating the pervasive nature of microaggressions peer staff experience across these contexts. Peers reported microaggressions linked to their experience and their role as peers, along with strategies employed to cope with these microaggressions and outcomes of these experiences. Participants reported that microaggressions frequently have a negative impact on their personal well-being, job satisfaction, and job tenure as a peer; at the same time, peers initiated contexts for creating support (e.g., with other peers, finding supportive coworkers, family, or friends) and coping strategies, which for some led to resiliency and feeling a greater determination to work as a peer support specialist.

Our findings suggest that peers' experiences of microaggressions are in many ways consistent with those reported by people with mental illness (Moran, Russinova, Gidugu, & Gagne, 2013). However, our findings also suggest that peers experience an additional set of microaggressions that are specific to their role as a peer support specialist (i.e., negative messages about peer support). These experiences also shed light on the complex process of reacting to microaggressions. The previous literature on microaggressions has shown that responding involves a complex and interacting set of psychological delimits, that in and of themselves are taxing for the targets of the microaggressions (Sue, 2010). Moreover, being the target of microaggressions for multiple dimensions of one's identity requires even greater psychological resources, which is consistent with work on the ways intersecting disadvantage can impact poor outcomes among people with mental illness (Jones et al., 2017). An important area for future investigation may be understanding how experience with mental illness and other identity dimensions intersect and influence experiences with microaggressions. Given the covert form microaggressions can sometimes take (Sue, 2010), an important contribution of this study is the documentation of peers' experiences of microaggressions as prevalent and existing across a wide range of context and service systems. Unfortunately, these results suggest that peer supporters are experiencing microaggressions in the workplace. These findings both point to the urgent need to address and reduce microaggressions, while also validating and giving voice to the reality of their current presence in mental health systems.

Stigma reported by our participants may also have some overlap with stigma encountered by other (non-peer) mental health providers who work with people with serious mental illness (Vayshenker, DeLuca, Bustle, & Yanos, in press). Indeed, this may be an additional dynamic that contributes to peers being targets of sigma. At the same time, many of the sources of microaggressions were fellow employees who were not peers, so it seems likely that associative stigma related to working with a serious mental illness population may be only one of several factors contributing to the experiences of stigma reported by peers in our study. Furthermore, future work is needed to better understand whether stigma and microaggressions experienced by peers with certain psychiatric diagnoses and mental health experiences vary across populations. For example, do microaggressions vary for peers working with populations in substance use treatment. Understanding context-specific challenges facing peer service providers will be an important next step toward better

supporting the integration of these service providers and addressing negative impacts of microaggressions.

In light of the links between experiencing microaggressions and negative emotional, cognitive, and behavioral effects on the targets (Sue, 2010; Hilly & Fischer, 2008), it is important to consider ways to address the presence of microaggressions for the wellbeing of peer support specialists, service systems, and, ultimately, service recipients. While the presence of peers in mental health service systems is a powerful challenge to traditional models (Chinman, Young, Hassell, & Davidson, 2006; Gates & Akabas, 2007), power differentials are also part of the bias against peers in many systems. That is, some peers described being in positions that structurally provided them less of a voice (e.g., being asked to leave a treatment team meeting when clients are being discussed), and systemic change may be required to address the structural factors that perpetuate microaggressions and position peers as “second-rate” team members. Thus, additional supports and consideration of power dynamics and organizational culture should be considered by those in leadership.

Future work is needed in several important directions. One such area includes developing a provider intervention to increase awareness regarding implicit biases and microaggressions. Literature on stigma reduction suggests that increased contact with a stigmatized group can influence biases, but only when those in the targeted group are positioned as equals (Rusch, Angermeyer, & Corrigan, 2005); therefore, systemic changes in the way peer roles are established may be warranted. In this regard, some systems that have substantial experience with training and hiring peer staff (e.g., Connecticut, Philadelphia, and Texas) have begun to offer agencies tools for integrating these staff into conventional settings in ways that both minimize the risk of microaggressions and optimize the peer staff’s chances of making the kinds of contributions for which they were hired (e.g., Philadelphia DBHIDS & Achara Consulting Inc., 2017).

Next, while many peers discussed finding ways independently to buffer the impact of microaggressions (e.g., seeking out social support, employing coping strategies), supporting peers systemically is also warranted. Little is known about which types of microaggressions occur most frequently (e.g., microinsults, microinvalidations, microassaults) in this population. Relatedly, future research is needed to investigate more specifically what peers see as helpful in responding to microaggressions. Participants varied in how they responded to microaggressions (e.g., anger, resiliency) and little is known about ways these responses are related to potential protective factors or specific types of microaggressions; therefore, work should investigate both peers’ perspectives on how to reduce microaggressions and how to support peers most appropriately when these do occur.

Limitations of the study should also be noted. All coding was done by individuals who are not peer support specialists and future work should include persons with lived experience. Responses were gathered electronically, which precluded the ability to ask participants follow-up questions, data was collected via self-report using non-validated instruments, and measures of affect and behavior were not collected. While participants reflect a range of sociodemographic backgrounds, these findings are only generalizable to samples with shared characteristics with our participants. Place of employment and sociodemographic

factors may have influenced our findings, and our sample is relatively small and it is possible that participants who self-selected to be in our study may be more likely to have experienced microaggressions.

Conclusions

Microaggressions are known to have a breadth of negative impacts on the targets. Our findings suggest that peer support specialists experience microaggressions due to their role as a peer, not to mention potential additional dimensions of an individuals' identity that may further compound these experiences. Although peer-provided services are increasing and have become a central component of recovery-oriented care, little previous work has investigated the presence or impact of microaggressions experienced by peers. The present findings point to the scope of microaggressions peer support specialists experience, the potential negative impacts of these microaggressions, and the resiliency of peers despite these hostile experiences. Future work is needed to develop improved support for peers working in service systems, as well as to address systemic factors which may be contributing to peers' experiences of microaggressions.

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Table 1

Demographic Information

	Mean	SD
Age	47.5	11.3 (25 –65)
Education	15.5	2.3
Gender	<i>N</i>	%
Female	36	60%
Male	23	28%
Other (“neutral”) ^a	1	2%
LGBTQ	11	18.3%
Race		
African American/Black	10	17%
White/Caucasian	41	68%
Other	6	10%
Ethnicity		
Latino/a	9	15%
Not Latino/a	45	75%

^aNote. Information gathered using open-ended text and response reflects participant’s chosen wording.

Table 2

Mental Health/Substance Abuse Agency Type Where Peer is Employed

	Frequency	Percent
Private Non-Profit	20	34.5%
Other Hospital or Health Facility	16	27.6%
State/Government/VA	14	24.1%
Peer-run	7	2.1%
For-profit	1	1.7%

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Table 3

Survey Questions

Question Set 1	Demographic information
Question 2	“Think about a time when you may have been made to feel uncomfortable because of your role as a peer support specialist. Please describe the scenario as best you can.”
Question 3	“How often have these experiences occurred (if at all)?”
Question 4	“How did you feel after the event(s) occurred?”
Question 5	“How did these experiences impact you (if at all)?”
Question 6	“How have you reacted to these situations (immediately and/or after some time had passed)?”
Question 7	“How did you cope with these experiences?”
Question 8	“What were the outcomes/consequences of these experiences (if any)?”

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Table 4

Frequency of Microaggressions Experienced

	Number of Participants (N = 60)	Percent
None	5	8.3%
Rarely (only once)	5	8.3%
A few times/several times/occasionally/once a month/every 2 weeks	19	31.7%
Often/regularly/a lot/frequently/daily	23	38.3%
Other/depends *	3	5.0%
N/A or no response	5	8.3%

* This included statements that did not clearly fit into a frequency, such as "it depends" or "less than before."

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