Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

HHS Public Access
Author manuscript
Patient Educ Couns. Author manuscript; available in PMC 2020 July 01.

Published in final edited form as:
Patient Educ Couns. 2019 July ; 102(7): 1273–1279. doi:10.1016/j.pec.2019.02.006.

The Role of Self-disclosure by Peer Mentors: Using Personal Narratives in Depression Care

C. Truong[a,1], **J. Gallo**[a], **D. Roter**[b], and **J. Joo**[c]

[a]Department of Mental Health, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland USA

[b]Department of Health Policy and Management, Bloomberg School of Public Health, Johns Hopkins University, Baltimore, Maryland USA

[c]Department of Psychiatry and Behavioral Sciences, School of Medicine, Johns Hopkins University, Baltimore, Maryland USA

Abstract

Objective: Self-disclosure is recognized as an important aspect of peer support, but little is known about its use by peers. This study aimed to qualitatively understand peer self-disclosure in the context of depression care delivery to older adults.

Methods: 69 audio-recordings of peer-client meetings were coded for self-disclosure using the Roter Interaction Analysis System (RIAS). Peer self-disclosure was defined as a statement describing personal life experience with physical and/or emotional relevance for the client. A total of 3,421 discrete statements were organized into 770 disclosure episodes. The episodes were

Corresponding Author: Jin Hui Joo, MD MA, Division of Geriatric Psychiatry and Neuropsychiatry, Department of Psychiatry, School of Medicine, Johns Hopkins Bayview Medical Center, 5300 Alpha Commons Drive, Room 427, Baltimore, Maryland 21224, Phone: 410-550-2282, Fax: 410-550-1407, jjoo1@jhmi.edu. Christine Truong, MHS, Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, 624 North Broadway, Baltimore, MD 21205, ctruong1@jhmi.edu. Joseph J. Gallo, MD MPH, Department of Mental Health, Johns Hopkins Bloomberg School of Public Health, Hampton House 792, 624 North Broadway, Baltimore, MD 21205, Tel: 410-955-0599, Fax: 410-955-9088, jgallo2@jhu.edu. Debra Roter, DrPH, Department of Health, Behavior and Society, Johns Hopkins Bloomberg School of Public Health, 624 North Broadway, Baltimore, MD 21205, Phone: 410-955-6498, Fax: 410-955-7241, droter1@jhu.edu.

[1]Present Address: Loyola University Maryland, Psychology Department, 4501 N. Charles Street, Baltimore, MD 21210 USA

Declarations of interest: none

AUTHOR DECLARATION

We wish to confirm that there are no known conflicts of interest associated with this publication and there has been no significant financial support for this work that could have influenced its outcome.

We confirm that the manuscript has been read and approved by all named authors and that there are no other persons who satisfied the criteria for authorship but are not listed.

We further confirm that the order of authors listed in the manuscript has been approved by all of us.

We confirm that we have given due consideration to the protection of intellectual property associated with this work and that there are no impediments to publication, including the timing of publication, with respect to intellectual property. In so doing we confirm that we have followed the regulations of our institutions concerning intellectual property.

We understand that the Corresponding Author is the sole contact for the Editorial process (including Editorial Manager and direct communications with the office). She is responsible for communicating with the other authors about progress, submissions of revisions and final approval of proofs. We confirm that we have provided a current, correct email address that is accessible by the Corresponding Author.

Publisher's Disclaimer: This is a PDF file of an unedited manuscript that has been accepted for publication. As a service to our customers we are providing this early version of the manuscript. The manuscript will undergo copyediting, typesetting, and review of the resulting proof before it is published in its final citable form. Please note that during the production process errors may be discovered which could affect the content, and all legal disclaimers that apply to the journal pertain.

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

qualitatively analyzed to identify themes related to the content and function of self-disclosure within the peer-counseling context.

Results: Peer self-disclosure was used to 1) counsel through reframing perspectives, modeling positive behaviors, offering coping skills, and sharing mental health resources and health information; 2) establish rapport by emphasizing similarities unrelated to depression; and 3) show empathy and understanding of personal struggles. In addition, self-disclosure rarely only focused on the peer experience without relevance for the client.

Conclusions & Practice Implications: Peer self-disclosure can be purposively used in depression care delivery with older adults. Training and supervision in appropriate self-disclosure should be provided to peers to ensure purposive use.

Keywords

Self-disclosure; Peer Support; Counseling; Aging; Communication

1. Introduction

Self-disclosure is an important aspect of peer support that enables the sharing of lived experience. A peer is defined as someone with similar experiences who can provide “empathy and validation” to a person with a mental illness, and is characterized by its non-hierarchical nature, reciprocity, and empowerment [1]. Peer support provides ‘similar others’ who use their first-hand experience and unique perspective to support someone going through similar struggles [2]. When involving positive self-disclosure, unconditional regard, and role modeling, peer support is thought to increase participant feelings of hope, self-care, and sense of belonging in a community as well as decrease levels of depression; however, empirical support is lacking [3].

Much of what we think about self-disclosure is predominantly based on professional practice and may color our perspectives about self-disclosure in peer support. Self-disclosure is traditionally discouraged to prevent blurring of boundaries as well as to prevent disrupting the focus on the client [4]. However, self-disclosure has also been found to have positive effects on clients, such as providing new insight and perspective for change, improving the therapeutic relationship, and encouraging client self-disclosure [5, 6]. Rather than being either negative or positive, the impact of disclosure may depend on the context and the way in which it is communicated [6], [7], [8].

While there are many studies on the benefits and challenges of professional self-disclosure, empirical studies of peer support communication behaviors such as self-disclosure are rare [9, 10]. A qualitative study of breast cancer peer support suggested that the ability to appropriately share a peer’s own experience of breast cancer was perceived as an important component of effective helping [11]. Studies of existing peer programs for those with severe mental illness have suggested that peer self-disclosure is associated with instillation of hope and increased feelings of control, empowerment, and a sense of belonging [3,12]. When used skillfully, responsively, and appropriately, peer self-disclosure may be an effective

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

component of care that facilitates rapport, improves working alliance, and increases treatment engagement in psychotherapy [9,13].

This study is a follow up to our previous quantitative analysis of peer-client communication, in which we described and associated peer communication behavior to outcomes such as working alliance and depression. We found that peer self-disclosure was associated with increased working alliance and worsening client depression over time [14]. In order to understand this relationship more fully, we qualitatively analyzed peer self-disclosure statements to elucidate what peers talk about, when they disclose, and how peers self-disclose when providing depression care. Our study aimed to provide empirical evidence of the nature of peer self-disclosure to inform peer training.

2. Methods

Data for this study was collected as part of the 2014 Peer Enhanced Depression Care study, in which peers were trained to deliver depression care to older adults for an hour a week over eight weeks. Study procedures are described in detail elsewhere [15].

2.1 Recruitment of Peer Mentor and Client Participants

We recruited a cohort of six peers who were 50 years old, had a history of depression, received treatment with >5 years in recovery (obtained by self-report), and had previous mental health volunteer experience. Three peers participated fully in the study while two dropped out due to physical illness and one discontinued because of program time demands.

Older adults were recruited from senior centers, independent living facilities, and from other aging studies. Inclusion criteria for eligibility: aged 50 years; clinically significant depressive symptoms (score > 5) as assessed with the Patient Health Questionaire-9 (PHQ-9); and not engaged in specialty mental health care [16]. Older adults who met criteria gave informed consent and received a clinical mental health assessment by a geriatric psychiatrist prior to enrollment to assess appropriateness for the program.

2. 2 Training and Supervision of Peer Mentors

A geriatric psychiatrist conducted 20 hours of training with the peer mentors and focused on foundational mastery of communication techniques. In addition, peers received concurrent supervision with client meetings in order to reinforce continued and appropriate use of targeted skills.

Training emphasized a client-centered approach and focused on establishing peer support through four modules: 1) active listening; 2) relationship building; 3) provision of emotional support; and 4) encouragement to try something new. Peers were trained on purposeful use of self-disclosure as a strategy to be incorporated into modules two to four. It was emphasized that peers were only experts of their own personal experiences and not of depression as a whole. Peers were trained to provide information, options, and positive health messages to serve as client tools. Confidentiality, relationship boundaries, safety, ethical behavior, and not giving medical advice were also discussed. The trainer and peers practiced skills in role-play, and peers were given feedback on their performance.

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

Supervision was guided by a working alliance model of supervisory process described by Bordin [17]. Focus was placed on bonding and developing mutual goals between the peer and supervising psychiatrist. Peers met weekly for an hour with the supervisor. During these meetings, peers reported on client progress, impressions, and insights. They also worked collaboratively to problem-solve client challenges presented by the client. Furthermore, the psychiatrist continued skills development and provided modeling, guidance, and reinforcement of training concepts. Details of the training model have been previously published [15]. The Institutional Review Board (IRB) at Johns Hopkins University School of Medicine approved the research protocol for the original study.

2.3 Data Collection

2.3.1 Demographic information—Standard questions were used to obtain demographic information on age, educational attainment, marital status, ethnicity, medical problems, and health service use. The number of medical problems, history of counseling, and current antidepressant use was obtained through self-report during the clinical evaluation and baseline assessment.

2.3.2 Roter Interaction Analysis System (RIAS) coding—Audio-recordings were analyzed using the RIAS to assess the impact of training on peer communication and client outcomes, as described elsewhere [14]. For the current study, only the RIAS code for provider self-disclosure was used. During the coding process, the entry of each code into the coding record was attached to a time stamp that indicated when the statement was made in the session and its duration. These time stamps were used to efficiently locate the coded statements for transcription and qualitative coding.

2. 4 Analytic Strategy

All meetings between peer mentors and clients were audio-recorded; however, because of resource limitations, RIAS coding was limited to three recordings for each client. From a total of 159 recordings, we selected the first and last meeting as well as a mid-course meeting in order to assess changes in peer mentor talk over 8-weeks. In total, 69 recordings of sessions between 23 clients and 3 peer mentors were coded and analyzed. Following the analytic strategy of Beach [18], self-disclosure statements were grouped into episodes continuing the same idea and narrative context. In total, 3,421 self-disclosure statements were grouped into 770 self-disclosure talk episodes.

One study team member (CT) reviewed a subset of self-disclosure talk to develop themes that were compiled into a codebook used to guide subsequent coding. Themes were generated using an inductive process of reviewing the self-disclosure episodes and categorizing based on the content and ways in which self-disclosure occurred. Three other study team members, a psychiatrist (JJ), a master’s level public health practitioner, and a master’s level public health research assistant independently reviewed, grouped, and coded all self-disclosure episodes. New emerging codes were added to the codebook during the analysis. Study team members met regularly to review the codes for in-depth discussion, and when disagreements arose, interpretations were resolved through consensus.

Author Manuscript

3. Results

3.1 Demographic Characteristics

All three peer mentors were women over the age of 60; two were African American and one was White; and length of education ranged from 12–16 years. All peers had a history of a mood disorder, were in recovery for > 5 years, and were actively volunteering or employed in mental health. The majority of older adult clients in this study were African American women who had 3 co-morbid medical problems. The average age of the clients was 68 years and approximately half had a history of professional counseling. The severity of depressive symptoms at baseline was in the moderate range with an average PHQ-9 score of 14.5. See Table 1 for a summary of the sample's demographic information.

3.2 Nature of Peer Mentor Self Disclosure

Peer quotes that exemplify self-disclosure themes and subthemes are included, and the frequency of each self-disclosure category can be found in Table 2. As reflected in the table, four primary themes emerged. The first and largest of the themes reflects the use of self-disclosure as a vehicle for common counseling techniques. This theme was found in 45.1% (N=347) of episodes and included four distinct techniques: (1) reframing perspectives (17.3%), (2) modeling positive behaviors (14.2%), (3) offering specific self-care skills (10.4%), and (4) sharing information about resources (3.3%). The second theme was reflected in 31.8% of disclosure episodes (N=245) and established similarity between the peer and client. The third theme, evident in 23.1% (N=178) of disclosure episodes reflected narratives of personal struggle that mirrored the client's struggles. Each of these themes and illustrative quotes are described below and in Table 2. The fourth theme, not mutually exclusive from the other themes listed above, was evident in only 2 episodes. This theme reflected self-disclosure that was lengthy and focused on an experience that the peer wanted to talk about but did not have apparent relevance for the client.

3.2.1 Self-disclosure as a counseling technique

3.2.1.1 Reframing perspectives: Peer mentors shared stories that ranged in topic from personal relationships and poverty to aging and deep depression. Commonly the peer described a personal experience similar to the client's and demonstrated how the peer was able to think differently about a situation to relieve emotional distress. In response to one client's story of financial struggle, a peer described a similar hardship and how she learned to view it in a different way that ultimately enabled her to take action to address the problem:

> I had no money coming in, they repossessed my car, they turned off all the utilities in my house […] And it hit me, wait a minute, right now I have a roof over my head. I have clothes to wear and food to eat. And that is abundance. And then, as it shifted so that I thought I had abundance, I found some things I could do that actually opened me to what the universe was trying to give me.

Peers who have experienced depression and were in recovery could describe perspectives gained through experience that helped with managing their illness. Depression is typically viewed as suffering, and one may conceive of going to the doctor to be 'cured', but one peer

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

shared her belief that people need to take responsibility for their illness and see the part they play in recovery:

> I call it managing our own recovery. We're not always suffering with depression. Sometimes we are in recovery and we have to manage it, you know. And the doctors can only do what we help them to do. They are our partners.

3.2.1.2 Modeling positive self-care behavior: Peer mentors disclosed narratives to model healthy behaviors and depression self-care. The peers specifically demonstrated formal and informal care strategies, attitudes they adopted, and behaviors they enacted to get through difficult periods. Typically, the peers were skilled in relating their experience to clients' current struggles in a personal and approachable, but also a non-directive way:

> I did go to a psychiatrist and I did go through a long period of therapy. And one of the things I came out with is that I'm a workaholic. But I have to take time for me. Because if I don't take time for me, everybody that's standing on my shoulders is just going to fall. So I'm telling you that story to see how it relates to your story cause you got a lot of people on your shoulders too.

Peer mentors also modeled depression-related self-care skills that touched on concerns such as insomnia, diet, isolation, and finances. One common struggle among clients was the impact of aging on their lives. When one client shared concerns related to losing independence by transitioning to a nursing home, the peer described what she did to address this concern:

> To smooth the way for myself, I'm going to pick some places that I would not mind going to. And, you know, I'm going to write down the criteria that I want them to use to decide whether or not it is time for me to go. And I'll put that in my living will and who will make the decision.

3.2.1.3 Offering specific coping skills: Peer mentors shared active coping skills to decrease negative feelings that clients experienced, such as frustration, anxiety, and depression. These included descriptions of strategies like positive affirmations, journaling, exercise, and volunteering.

> When I start feeling down about myself or feeling worthless. Or lacking that confidence. I tell myself something positive about myself. […] Thinking positively about yourself because, truly, there is no human being on the face of this earth that doesn't have positive qualities. We were given some positive qualities and tell yourself over and over again.

Peers also passed on what they had learned from their own experiences in mental health treatment. In response to one client who said she could not remember a time when she was not depressed, a peer described:

> I've looked back and tried to think of when wasn't I depressed and I can't find a period that I wasn't depressed. And I mentioned that to my doctor and he said 'you know what would be helpful? If you stay in the present.'

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

3.2.1.4 Sharing information about community resources: Self-disclosure was also used to inform clients of available community resources that might be beneficial. Examples included transportation programs, volunteering opportunities, and local medical clinics. One peer also shared information about a peer-to-peer recovery education class offered at the National Alliance of Mental Illness (NAMI); this course provided information about mental illness and assisted in developing a relapse prevention plan:

> It's a wonderful course. I took it and it helped me tremendously. The mentors I had were excellent. […] It helps you to identify what your triggers are. And some of the exercises that you and I are doing here- I'd learned in those classes.

Again, the resources were not only related to depression, but also related to general self-care behaviors, such as screening exams for breast cancer. One peer shared resource information to her client based on positive personal experiences and benefits she derived from it. In response to a client was interested in obtaining a mammogram, a peer offered information:

> You can, definitely. [...] There's a women's group that makes sure you get mammograms every year. And in fact, I got a mammogram and there was a lump on my breast and the people said we'll pay for you to get a biopsy."

3.2.2 Establishing rapport through personal similarities without direct relation to depression—31.8% of self-disclosure episodes established rapport by highlighting similarities with client. At the beginning of the intervention, peers and clients knew that they had at least one similarity – the experience of depression; however, peers disclosed other similarities like having a dog or having seen the same movie recently. Peers self-disclosed about their backgrounds and recent life events, and often the client and peer discovered connections in regards to childhood experiences, family upbringing, and cultural history. In one self-disclosure episode, the peer and client, who were both African American, discussed how they felt when Martin Luther King Jr. was killed. The peer described it like this:

> I get up and I go because I was a kid when MLK was killed. And I remember people dying so that we can vote. So our generation is probably going to be the last generation that's alive during that time period. And I feel that too many people died. So I get up and vote.

3.2.3 Showing empathy through experiences of personal struggle—23% of self-disclosure episodes focused on showing personal understanding of client struggles. Peers described how they themselves felt despondent and vulnerable. They responded to client hardships by saying expressions such as "I've been there" and "I know"– statements that can diminish the loneliness of experiencing something difficult. As one peer told a client, "I've been through your stuff and your stuff is not trivial. You should never feel guilty. Everyone's pain is valid and you can't judge anyone's pain as less than your own."

Common personal hardships that were touched upon include loneliness, grief, health, and aging. Self-disclosure was especially used to show an understanding of deep depression. As one peer described: "I've been there. I have been to the point where I've walked around in

the same nightgown for 2 to 3 days. I have been there and that's not a good feeling. And that's not a good place to be."

One peer shared her family's history of mental illness with her client and, in response, the client shared about her own son's mental illness and the stress she feels as his caretaker:

> I know. It's kind of like my son. I'm worried about him because they diagnosed him with posttraumatic syndrome in earlier years. And now he might have been misdiagnosed and he could be bipolar. So I'm trying to help him get through his ordeal.

3.2.4 Self-disclosure focused on the peer—There were two instances in which one peer spoke at length about a quarrel that she had experienced with a family member. This story was described extensively to two different clients, was seemingly unrelated to the clients' depression, and instead focused on the distress of the peer (see full quotation in Table 2.) In both occasions, the client listened and eventually disclosed a story of her own where a family member also made her upset. In response, the peer transitioned her focus on the client's story and feelings.

4. Discussion and Conclusions

4.1 Discussion

We provide empirical evidence of how peers with training and supervision can use self-disclosure to provide counseling when delivering depression care, build rapport, and show understanding. The majority of self-disclosure statements were used for counseling purposes. Peers told personal narratives to encourage different perspectives on stressors, communicated coping skills, and informed clients of community-based resources. Self-disclosure was used for client benefit in most instances. However, instances when peers talked about their own experiences in a self-preoccupied manner did occur, and this suggests the need for peer training and supervision regarding appropriate use of self-disclosure.

The most common use of self-disclosure was counseling, which is consistent with the focus of their training.—Peers disclosed personal difficulties and how they overcame them through specific ways of thinking or behaviors– in effect, self-care behaviors that can be learned. Peers also used self-disclosure to model emotionally healthy behaviors, such as seeking social support and engaging with their physicians. Peers who have overcome difficult life stressors and can successfully manage their depression can serve as role models to those who are struggling with similar problems. Our results support theories of how peer support works, through role modeling and social learning [19], [20], [21].

Peers in our study were older, had experienced treatment, and were in recovery. As such, they had a large amount of life experience and learned lessons to draw upon. Self-disclosure enabled peers to communicate emotional understanding of client struggles. The peers described that they too had similar experiences and could empathize with relationship difficulties, homelessness, or with problems with aging. Openly expressed similarity between client and peer revealed through self-disclosure likely facilitated bonding and

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

relationship-building that is critical in providing depression care. Studies have found that when persons express similarity through self-disclosure, participants perceive the disclosing person as congruent and willing to be "known as persons". This can increase participant feelings of warmth, friendliness, and being understood [22], [23], [24]. Additionally, studies have also shown that a person is more likely to adopt a health behavior if they have interacted with others with similar health characteristics [25], [26].

The peers often told personal narratives to demonstrate a self-care behavior or a lesson they learned, and typically related it to the client in a non-directive tone. The exchange of personal stories may have relevance for behavior change, and peer self-care stories may be an effective way to change behavior regarding depression self-care. Studies on health communication show that narratives are more influential in changing a person's intent to engage in a health behavior, rather than statistical information [27], [28], [29], [30].

The way in which peers are trained to self-disclose is important, because poorly done self-disclosure can have a negative impact. The challenges inherent in self-disclosure sheds light on our finding that increased self-disclosure was related to worsening depression in our previous study of peer communication. Peers may provide self-disclosure that is irrelevant to the client in terms of relationship building or providing useful self-care strategies. Self-disclosure can devolve into unhelpful and self-involved communication that does not benefit the client [9,31]. Peer providers can become emotionally involved as well as find it hard to set boundaries and balance disclosure. This occurred in our study, but was rare most likely because training and supervision were provided to peers during the study. Clients also may have a range of needs and expectations about peer support, and the most effective training program may guide peers to be flexible in their approach in terms of how much they self-disclose.

In order to address the challenges surrounding self-disclosure, ongoing training and supervision of peers is recommended [32], [33]. Self-disclosure issues that can be discussed during training include its role in establishing a strong peer-client relationship and how to use one's lived experiences positively for client benefit. Other training topics to address are the right to disclose, how much to disclose, appropriateness, purposefulness, keeping oneself 'safe', and remaining sensitive to the other person [33], [34].

While the results of this study provide empirical evidence to support the use of peer self-disclosure, it is important to acknowledge its limitations. The first is that the RIAS codes disclosure statements have emotional or medical relevance to the client. As a result, disclosures that occur during social conversation might not be included in our analysis. In addition, differences in theme coding were resolved through discussion and consensus among the research staff. As such, evidence is based on observations and researcher interpretation. Second, studies have found sex differences in self-disclosure in various kinds of relationships, with women self-disclosing more than men; however, no studies focused on relationships with peers mentors [35]. The three peer mentors in our study were all women. Had our study included male peer mentors, the ways in which self-disclosure occurred may have differed. Finally, the sample size of our study is small and thus not generalizable to all peer mentor self-disclosure. More research needs to be conducted in order to further

Author Manuscript

Author Manuscript

Author Manuscript

Author Manuscript

understand the role of peer disclosure in depression care delivery, and especially its use for the older adult population.

4.2 Conclusion & Practice Implications

In our study, peers used self-disclosure in purposive ways. Self-disclosure was used as a vehicle to build rapport and share depression self-care knowledge. It can serve as a communication strategy to enhance behavioral change efforts and facilitate self-care for depressed older adults. Peer support is accepted as a depression self-care intervention in primary care settings [36] and has been shown to decrease depression [37]. Given the limited availability of mental health services due to workforce shortages and lack of engagement of underserved groups in professional services, peer programs can be developed and implemented to enhance depression care services as well as increase access to mental health care.

Acknowledgments

The authors thank Essence Fisher-Hobson, MHS and Bernie Wong, MHS for their assistance in coding data and input related to theme development. We would also like to thank the peer mentors involved in the Enhanced Depression Care Delivery for their insight and perspectives during discussions related to their mentoring experience with clients.

Funding: This work was supported by the National Institute of Mental Health [grant number K23MH100705].

Biography

• Author Details

• All authors listed participated in the following in the development of this manuscript. Ms. Truong was involved in analysis and interpretation of data; drafting the article and revising it critically for important intellectual content; and approved the final version for submission. Dr. Joo was involved in the conception and design of the study, acquisition of data, and analysis and interpretation of data; drafting the article and revising it critically for important intellectual content; and approved the final version for submission. Dr. Gallo was involved in the conception of the study, analysis, interpretation, revision, and final approval. Dr. Roter was involved in analysis and interpretation of data, drafting the article and revising it critically for important intellectual content, and final approval of the version to be submitted.

References

[1]. Mead S & MacNeil C Peer support: What makes it unique. International Journal of Psychosocial Rehabilitation, 10 (2006), 29–37.

[2]. Borkman TJ Experiential, professional, and lay frames of reference In Powell TJ (Ed.), Working with self-help, 1990, (pp. 3–30). Silver Spring, MD, England: National Association of Social Work.

[3]. Davidson L, Bellamy C, Guy K, & Miller R (2012). Peer support among persons with severe mental illnesses: A review of evidence and experience. World Psychiatry, 11, 123–128. 10.1016/j.wpsyc.2012.05.009 [PubMed: 22654945]

[4]. Farber BA (2003). Patient self- disclosure: A review of the research. Journal of Clinical Psychology, 59, 589–600. 10.1002/jclp.10161 [PubMed: 12696134]

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

[5]. Constantine MG, & Kwan KLK (2003). Cross-cultural considerations of therapist self-disclosure. Journal of Clinical Psychology, 59, 581–588. 10.1002/jclp.10160 [PubMed: 12696133]

[6]. Knox S, Hess SA, Petersen DA, & Hill CE (1997). A qualitative analysis of client perceptions of the effects of helpful therapist self-disclosure in long-term therapy. Journal of Counseling Psychology, 44, 274 10.1037/0022-0167.44.3.274

[7]. Beach MC, Roter D, Rubin H, Frankel R, Levinson W, & Ford DE (2004). Is physician self-disclosure related to patient evaluation of office visits? Journal of General Internal Medicine, 19, 905–910. 10.1111/j.1525-1497.2004.40040.x [PubMed: 15333053]

[8]. Hanson J (2005). Should your lips be zipped? How therapist self-disclosure and non-disclosure affects clients. Counselling and Psychotherapy Research, 5, 96–104. 10.1080/17441690500226658

[9]. Pistrang N, Clare L, & Baker C (1999). The helping process in couples during recovery from heart attack: A single case study. British Journal of Medical Psychology, 72 (Pt 2), 227–237. 10.1348/000711299159970 [PubMed: 10397427]

[10]. Tracey T, & Toro P (1989). Natural and professional help: A process analysis. American Journal of Community Psychology, 17, 443–458. 10.1007/BF00931172 [PubMed: 2610203]

[11]. Pistrang N, Solomons W, & Barker C (1999). Peer support for women with breast cancer: The role of empathy and self- disclosure. Journal of Community & Applied Social Psychology, 9, 217–229. 10.1002/(SICI)1099-1298(199905/06)9:3<217::AID-CASP509>3.0.CO;2-5

[12]. Naslund JA, Aschbrenner KA, Marsch LA, & Bartels SJ (2016). The future of mental health care: Peer-to-peer support and social media. Epidemiology and Psychiatric Sciences, 25, 113–122. 10.1017/S2045796015001067 [PubMed: 26744309]

[13]. Audet CT (2011). Client perspectives of therapist self-disclosure: Violating boundaries or removing barriers?. Counselling Psychology Quarterly, 24, 85–100. 10.1080/09515070.2011.589602

[14]. Joo JH, Hwang S, Gallo JJ, & Roter DL (2018). The impact of peer mentor communication with older adults on depressive symptoms and working alliance: A pilot study. Patient Education and Counseling, 101, 665–671. 10.1016/j.pec.2017.10.012 [PubMed: 29128295]

[15]. Joo JH, Hwang S, Abu H, & Gallo JJ (2016). An innovative model of depression care delivery: Peer mentors in collaboration with a mental health professional to relieve depression in older adults. The American Journal of Geriatric Psychiatry, 24, 407–416. 10.1016/j.jagp.2016.02.002 [PubMed: 27066731]

[16]. Kroenke K, Spitzer RL, & Williams JB (2001). The phq- 9. Journal of General Internal Medicine, 16, 606–613. 10.1046/j.1525-1497.2001.016009606.x [PubMed: 11556941]

[17]. Bordin ES (1983). A working alliance based model of supervision. The Counseling Psychologist, 11, 35–42. 10.1177/0011000083111007

[18]. Beach MC, Roter D, Larson S, Levinson W, Ford DE, & Frankel R (2004). What do physicians tell patients about themselves?. Journal of General Internal Medicine, 19, 911–916. 10.1111/j.1525-1497.2004.30604.x [PubMed: 15333054]

[19]. Gillard S, Gibson SL, Holley J, & Lucock M (2015). Developing a change model for peer worker interventions in mental health services: A qualitative research study. Epidemiology and Psychiatric Sciences, 24(5), 435–445. 10.1017/S2045796014000407 [PubMed: 24992284]

[20]. Repper J, & Carter T (2011). A review of the literature on peer support in mental health services. Journal of Mental Health, 20, 392–411. 10.3109/09638237.2011.583947 [PubMed: 21770786]

[21]. Vet R, De Wit JBF, & Das E (2010). The efficacy of social role models to increase motivation to obtain vaccination against hepatitis B among men who have sex with men. Health Education Research, 26, 192–200. 10.1093/her/cyq074 [PubMed: 21106651]

[22]. Hill C & Knox S "Self-Disclosure" in Psychotherapy relationships that work: therapist contributions and responsiveness to patients, First Edition. (Ed.), John C. Norcross. New York: Oxford University Press, 2002, 255–265.

[23]. Mann B, & Murphy KC (1975). Timing of self-disclosure, reciprocity of self-disclosure, and reactions to an initial interview. Journal of Counseling Psychology, 22, 304 10.1037/h0076694

[24]. Murphy KC, & Strong SR (1972). Some effects of similarity self-disclosure. Journal of Counseling Psychology, 19, 121 10.1037/h0032435

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

[25]. Centola D (2011). An experimental study of homophily in the adoption of health behavior. Science, 334, 1269–1272. 10.1126/science.1207055 [PubMed: 22144624]

[26]. Flatt JD, Agimi Y, & Albert SM (2012). Homophily and health behavior in social networks of older adults. Family Community Health, 35, 312–321. 10.1097/FCH.0b013e3182666650. [PubMed: 22929377]

[27]. Ajzen I, & Fishbein M Understanding attitudes and predicting social behavior, Pearson, 1980.

[28]. Chen M, Bell RA, & Taylor LD (2016). Narrator point of view and persuasion in health narratives: The role of protagonist–reader similarity, identification, and self-referencing. Journal of Health Communication, 21, 908–918. 10.1080/10810730.2016.1177147 [PubMed: 27411000]

[29]. de Graaf A (2014). The effectiveness of adaptation of the protagonist in narrative impact: similarity influences health beliefs through self- referencing. Human Communication Research, 40,73–90. 10.1111/hcre.12015

[30]. Hinyard LJ, & Kreuter MW (2007). Using narrative communication as a tool for health behavior change: A conceptual, theoretical, and empirical overview. Health Education & Behavior, 34, 777–792. 10.1177/1090198106291963 [PubMed: 17200094]

[31]. Bottrill S, Pistrang N, Barker C, & Worrell M (2010). The use of therapist self-disclosure: Clinical psychology trainees' experiences. Psychotherapy Research, 20, 165–180. 10.1080/10503300903170947 [PubMed: 19821185]

[32]. Eaton J, McCay L, Semrau M, Chatterjee S, Baingana F, Araya R,... & Saxena S. (2011). Scale up of services for mental health in low-income and middle-income countries. The Lancet, 378, 1592–1603. 10.1016/S0140-6736(11)60891-X

[33]. Moran GS, Russinova Z, Gidugu V, & Gagne C (2013). Challenges experienced by paid peer providers in mental health recovery: A qualitative study. Community Mental Health Journal, 49, 281–291. 10.1007/s10597-012-9541-y. [PubMed: 23117937]

[34]. Kemp V & Henderson AR (2012). Challenges faced by mental health peer support workers: Peer support from the peer supporter's point of view. Psychiatric Rehabilitation Journal, 35, 337 10.2975/35.4.2012.337.340. [PubMed: 22491374]

[35]. Dindia K and Allen M. (1992). Sex differences in self-disclosure: A meta-analysis. Psychology Bulletin. 112, 106–24. 10.1037/0033-2909.112.1.106

[36]. <Yeung A. Self-management of depression. Cambridge, UK: Cambridge University Press, 2010.

[37]. Pfeiffer PN, Heisler M, Piette JD, Rogers MA, & Valenstein M (2011). Efficacy of peer support interventions for depression: A meta-analysis. General Hospital Psychiatry, 33, 29–36. https://doi.org/S0163-8343(10)00198-2 [PubMed: 21353125]

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

Highlights

- We qualitatively analyzed peer self-disclosure to assess content and function.
- Self-disclosure was purposively used for counseling through modeling and reframing.
- Self-disclosure was also used to build rapport and share personal struggles.
- Rare self-disclosure episodes not focused on the client suggest need for training.
- Peer self-disclosure can be purposively used in depression care for older adults.

Author Manuscript
Author Manuscript
Author Manuscript
Author Manuscript

Table 1.

Sociodemographic Characteristics of Clients in Peer Enhanced Depression Care Study (n= 27)

Demographics	**N**	**%**
Age (mean ± standard deviation)	68.9	± 6.6
Female	23	85
Race/Ethnicity		
African American	20	74
White	6	22
Other	1	4
Education		
Grade 1–8	2	7
1–4 years of high school or GED	8	30
1–3 years of community college or technical school	11	41
4 years of college or more	6	22
Total medical problems		
0	1	4
1–2	8	30
3	18	67
History of major depressive episode	22	81
History of counseling	14	52
On antidepressants currently	8	30

Author Manuscript Author Manuscript Author Manuscript Author Manuscript

Table 2.

Themes and counts of self-disclosure episodes by theme (N=770)

Theme	Peer Quotes
1. Counseling A statement about the peer's personal experience that could guide client action 347 episodes 45%	
1a. Reframing Perspectives Offering a different perspective to guide action 133 episodes, 17%	Maybe you should think that about your friend. He could've been all alone and not have anyone to do anything with. You were there and helped him and unfortunately he left earth. But you were there and you were there to help him in his last years. To bring care into his life and that's a good thing. I've experienced that myself. And what you were doing was the right thing, getting out and volunteering. That's helpful. It makes you get up, get dressed, and get out. I told my mom- these are your retirement years. They should be happy. You shouldn't do anything that doesn't make you happy. It doesn't make your day pleasant. If it's not going to make your day pleasant- I'll do it. Don't talk on the phone to someone who is going to give you grief. I said 'mom hang up'. She says she can't just hang up on them- it's rude but I say yes you can. I don't think you're all alone there. I mean, I have a big family, but when I was so sick there were two people I could depend on: my mother and my brother. Three, a friend. Those 3 people stuck with me. Not my sister, not my younger brother, not my nephews. They would not come down.
1b. Modeling Positive Behaviors Demonstrating an attitude, thought or behavior involving self-care for depression 109 episodes, 14%	And then, I thought about me and how always I would have my business. But I have a lot of people. I wouldn't say a lot but I would say 5 or 6 people that helped me and showed me how to get my business together. I talk to them on a regular basis, especially if something comes up. One of my goals was- I was feeling in the same position as you- to be a good example for my daughter who had bipolar disorder. I didn't want her to give up and I wanted to be a good example for her. So every time I felt like giving up, I said 'no that's not going to be a good example for my daughter'. I wanted to be a role model for her since I had depression and she has bipolar disorder. And actually- that's one of my biggest successes, because she is taking charge of doing her recovery and managing her health. And she says 'mom, I do it because I look at you and you do it.' […] So the two of us are a big support network. For me anyway, when I feel off, the first thing I check is my physical health. Because often there is a reason for that. And with my physical health, it's very hard for me to stay up with severe cramps in my stomach.
1c. Coping Skills Offering specific coping skills to manage difficult situations 80 episodes, 10%	Client: I used to listen to music. I like to dance. Those are basically the things I do- and meditate. Peer: Those three are the top of my list of coping skills too. I found it helpful to write what triggers my symptoms. Yeah, you ruminate sometimes. I do. I ruminate sometimes. And I found that it's helpful to put my hands to doing something. I make jewelry. I was the same way. Now I break things down into little tasks. And I have a calendar at home and my tasks are written down day by day. And I cross them off as I do it. It's like my calendar is my to-do list. And I hold myself accountable every morning. When I start feeling down about myself or feeling worthless. Or lacking that confidence. I tell myself something positive about myself. Cause I call the other way of thinking "thinking thinking". And thinking positively about yourself because truly there is no human being on the face of this earth that doesn't have positive qualities. We were given some positive qualities and tell yourself over and over again. I had a girlfriend once that used to do that year after year after year. And one year I decided that every time she was going to recycle the same problem. I decided let's do the serenity prayer. And I do the serenity prayer with her. And after a couple of times doing the serenity prayer, she stopped bringing that same problem up. I am too. That's one of the things that I do that relaxes me. And I have arthritis real bad and it hurts and everything. But I take that 10 minutes walk and notice a little bird eating a french fry. You know a squirrel in a tree. It doesn't cost any money. It's not popping extra pills.
1d. Sharing information about community resources 25 episodes, 3%	I know when I was in Pennsylvania, they had a service called Call a Senior. And you have different seniors, I don't know if they have it here. But in Pennsylvania, you will call these seniors once a day/week- however they have set it up. And me and my girlfriend had 5 a piece and we would keep in contact and have a little conversation and say something uplifting. My daughter has bipolar disorder and she goes there [a clubhouse]. They have activities. I was instrumental in helping to start that clubhouse. And my daughter goes there. She loves it. And it's just that- a club house. It's not like a drop in center. It's more structured.
2. Establishing rapport through personal similarities without direct relation to depression A statement indicating that the peer has personally shared the same experience as the client, unrelated to depression 245 episodes, 32%	Right, that's what I do, too. That's near where I live. I have a dog and it's the same way. We had company for lunch yesterday, and Emmy started whining and crying, and I excused myself and went into the living room by myself and sat down on my couch so she could come sit next to me and quit crying. Peer: She [her grandmother] used to tell me stories about different things like the snake and the guy brought him in and took care of him. Client: Yeah! Yeah! You had that story too?? Peer: Yeah!

Author Manuscript

Theme	Peer Quotes
3. Showing empathy through experiences of personal struggle Express agreement, validation and empathy by sharing personal struggle 178 episodes, 23%	Yeah it does. Because I have things that I've done and I'll use it as an example in relation to my children. I have things that I've done. And feel I was right, but maybe I should have used a different approach. I can accept that's what I did, I did out of the best knowledge I had at the time. For me, I got so sick… I have chronic joint pain all over my body and it hurts. And I could barely lift things or do laundry or anything else. I felt that way before, you know. I thought nobody cared whether I lived or died. And when I felt that way. Everyone dumped me at that point, and I felt that way too. I was about to lose my home and I lost custody of the kids. And I was homeless so nobody took me in and I lived on the streets. I lived on the streets for a couple years. My husband took custody of the kids. I was severely depressed where I was unable to take care of the kids. I was overwhelmed by the physical taking care of the kids. I felt that no one cared about me and no one wanted to be around me. I spent some time in the hospital and when I got back, I got myself a place to stay again. I still felt like no one cared. I think everyone was busy with their own lives and didn't pay attention to me. They didn't treat me well. But at that point I thought about suicide. Client: Who wants to take me on at my age with all the things that are going on wrong with me? They're going to say 'I can't take that woman.' You know, I feel like I'm stuck between a rock and a hard place. Peer: I know. I felt that way too. I lost the one doctor that I had that would take care of me- cause I have a mental illness and sometimes I feel like they discriminate against me or they stigmatize me because of my illness.
4. Self-disclosure focused on peer [a] 2 episodes, 0.26% A lengthy description of the peer's personal experience that has seemingly little relevance for client	You know my niece did that to me on Christmas? I fixed up a huge spread for Christmas dinner. And my daughter sent her a ticket to come down from New York. She came down from New York to stay with my daughter. Christmas day I have all this food and I'm sitting here waiting. My sister calls me from Tennessee and she says she get there yet? I say no. I haven't heard from her since she got here from New York. She says that's funny. So she calls my sister and says "well I'm not going to my for Christmas dinner." And she said, 'well when did you intend to tell your aunt?" I went all out. I had crab cake- all kinds of stuff. And she did not show up and wasn't gonna call. My sister made her call […] I hate people that do that. Oooh. I'm telling you I was upset. But I told my mom 'that's the last time I'll invite her for dinner to my house' […] Some people are like that. They think the world revolves around them. I ran into the same situation this Christmas, and I'm thinking--I was at this huge Christmas dinner. And the people I had invited did not come and did not call... I had ribs, a roast, crab cakes, potato salad, mashed potatoes, collared greens, stuffing….I did, I did. I left a party to come home and cook for them. And so you know, people don't always show us that they appreciate us the way they want them to. And I had to figure out how I'm going to address that, but I will address it. But I'm trying to wait to ease down on the feelings... And I want to come at the person respectfully because it's the respect I didn't get. So I have to give respect while I'm asking for it. … I said I was going to do that rather than, the money I spent fixing that huge dinner, I'm going to think about it, but I could have gone to a place for a couple days. … Because I'm going to address my issue that I had this Christmas, but I'm going to wait until I can do it right.

[a] All themes are mutually exclusive except for Theme 4.