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**“FROM THE SAME MAD PLANET”. A GROUNDED THEORY STUDY OF
SERVICE-USERS’ ACCOUNTS OF THE RELATIONSHIP THAT DEVELOPS
WITHIN PROFESSIONAL PEER SUPPORT WORK**

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Doctorate in Clinical Psychology



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Thesis Abstract

Introduction

Professional peer support is an increasingly utilised service within health services and a means by which the government's policies on recovery, personalisation and self-care can be implemented. Peer support workers are being employed at an increasing rate yet the evidence for their clinical and cost-effectiveness is uncertain. This may be due to the relatively low quality research conducted thus far, combined with a lack of empirically validated studies exploring how peer support work may work. Service-user perspectives have also been neglected within the research literature, which is somewhat surprising given peer support's roots in personal recovery. There have been a number of psychological theories proposed to explain the mechanisms of peer support but these lack empirical validation and specificity to professional peer support.

Objectives

The specific objectives of this research project were to explore service-users' accounts of professional peer support work; to relate findings from these accounts to extant theory; and based on these findings the ultimate objective was to develop a theory that contributes to explaining the relationship developed within peer support work. **Design**

Semi-structured qualitative interviews were conducted with ten service-users who were currently, or had previously, engaged with a professional peer support worker.

Methods

Ethical and Research and Development approval was attained prior to the commencement of the study. Constructivist grounded theory was used from the formulation of research question through to analysis and development of the theory.

Results

Three overarching themes were constructed from the data. 'The process of disclosure' describes how disclosure of mental health difficulties, experiences as a service-user and wider disclosure about life experiences, interests and values facilitate the development of a shared identity and an in-group identity with the peer support worker. 'The product of disclosure' highlights the sense of being understood that is the result of the disclosure and

marks a deepening of the relationship. 'Dual roles' describes the tenuous position of holding relationships of both friend and professional with the service-user.

Discussion

This study offers an original contribution to the peer support literature. It highlights the value of disclosure in developing an in-group status that serves to address social isolation experienced by these service-users. It builds on existing theory whilst incorporating literature relating to social identity theory, therapeutic relationships and therapist self-disclosure. This study offers clinical implications for peer support and further implications for professionals that may benefit from its processes. However, due to the exploratory nature of the research, these implications should be treated as tentative until further research is carried out. There are a number of research implications including comparing professional peer support with other forms of peer support; to refine the theory developed through further study; to compare the effects of therapist self-disclosure with that found within peer support. There were several limitations within the study including limited diversity within the sample as well as difficulties within recruitment, each of which may be addressed by future studies.

Acknowledgements

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Statement of contribution

I, Hugh Alistair Bailie, declare that this research is the product of my own original work conducted since undertaking the Trent Doctorate in Clinical Psychology in 2012. I have been fully responsible for research design, obtaining ethical approval, collecting and analysing the data, and the final write up. I have received supported throughout this process by my Academic supervisors Dr Anna Tickle and Dr Mike Rennoldson. I was fully responsible for the recruitment process and received support and assistance with this from my field supervisor Liz Walker. A professional typist transcribed all the interview data. The systematic literature review was completed by Alistair Bailie and subsequently revised by Dr Anna Tickle for submission to the Mental Health Review Journal.

Contents

Effects of employment as a Peer Support Worker on personal recovery: a review of qualitative evidence	10
Abstract.....	10
Introduction.....	11
Methodology.....	12
Inclusion criteria.....	12
Searching	13
Critical appraisal.....	21
Synthesis of findings	21
Results.....	23
Quality appraisal.....	25
Synthesis	26
Increased knowledge about own mental health	27
Sense of identity.....	28
Position within a professional team	30
Impact of employment	32
Discussion.....	33
Conclusion	38
References	39
JOURNAL PAPER.....	45
Abstract.....	45
Introduction	46
Peer support.....	47
Types of peer support.....	47
Evidence regarding peer support.....	48
Mechanisms underlying peer support.....	50
Social identity theory.....	51
Aim of the project.....	52
Methodology	52
Current context.....	53
Recruitment	53
Procedure.....	54
Analysis.....	57
Results.....	58

The process of disclosure.....	58
Disclosing.....	58
Disclosure beyond mental health	60
Disclosing mental health experiences	60
The product of disclosure	61
Dual roles	64
Discussion	68
References.....	73
Introduction	82
Recovery.....	82
Peer support.....	85
Types of peer support.....	86
'Informal' mutual support groups	86
Consumer-run services.....	87
Professional (Intentional) peer support.....	88
The role of peer support worker.....	89
Peer support and health policy.....	89
Peer support: What does the evidence say?	90
The effects of peer support work.....	91
Challenges of employing peer support workers.....	93
So how might peer support work?	94
Social comparison theory	95
Social Learning Theory	95
Social support	96
Experiential knowledge.....	97
Helper-therapy principle	98
Overarching Explanations.....	99
Supplementary Theories	100
Professional disclosure.....	100
Supportive relationships.....	102
<i>Nurse-patient relationship</i>	102
<i>Therapeutic relationships</i>	104
Extended Paper.....	107
Aims.....	108
Methodology	109

Study Rationale.....	109
Ontology and epistemology	109
Rationale for a qualitative methodology	109
Researcher Position.....	110
Grounded Theory.....	111
Critique of grounded theory	113
Alternative Qualitative Approaches.....	114
Thematic analysis.....	115
Interpretative phenomenological analysis (IPA)	115
Discourse analysis.....	116
Participants.....	116
Theoretical saturation.....	116
Sample size.....	117
Inclusion criteria.....	117
Ethical Considerations.....	117
Participant Recruitment.....	118
Procedure	118
Participant withdrawal	120
Data Collection.....	121
Semi-structured interviews	121
Analysis.....	121
Quality Assurance Methods.....	123
Audit trail.....	123
Member checking.....	124
Triangulation.....	125
Supervision	125
Evaluation.....	125
Results.....	126
The process of disclosure.....	126
Disclosing.....	126
Disclosing mental health experience.....	132
Disclosure beyond mental health	136
The product of disclosure	140
Dual Roles.....	146
Discussion	156

Section Introduction.....	156
Theoretical implications.....	156
Clinical Implications.....	158
Future Research.....	161
Relevance to Clinical Psychology	162
Evaluation of Research.....	163
Credibility.....	163
Originality.....	164
Resonance.....	164
Usefulness.....	165
Theoretical sufficiency.....	165
The theory	166
Limitations	167
Sampling.....	167
Sample diversity	168
Conclusions	168
Critical reflective component	169
Researcher positioning.....	169
Researcher or clinician?	170
Memo writing.....	171
References.....	173
Appendices	195
Appendix A	196
Appendix B	197
Appendix C	202
Appendix D.....	202
Appendix E	209
Appendix F.....	210
Appendix H.....	213
Appendix I.....	215
Appendix J.....	217
Appendix K.....	224
Appendix L.....	227
Appendix M	229

List of Tables and Figures

Figure 1: Flow chart outlining article selection p.14

Table 1: Article characteristics p.16-20

Table 2: Cross comparison of study reports (grouped findings) p.23

Table 3: Third order constructs and studies contributing to each p.27

Table 4: Participant information p.56

List of Appendices

Appendix A: Advertising poster

Appendix B: NHS research ethics approval letter

Appendix C: NHS Research and Development approval letter

Appendix D: Participant information sheet

Appendix E: Participant consent form

Appendix F: Socio-demographic information sheet

Appendix G: Interview schedule version 1

Appendix H: Interview schedule version 2

Appendix I: interview schedule version 3

Appendix J: Coding example from interview extract

Appendix K: Charmaz (2014) criteria for evaluating grounded theory studies

Appendix L: Substantial amendment approval letter

Appendix M: Example Memo

Effects of employment as a Peer Support Worker on personal recovery: a review of qualitative evidence.

Abstract

Purpose: This review systematically identified, appraised and synthesised qualitative research into how working as a peer support worker affects personal recovery.

Methodology: Ten articles were identified through a systematic search of seven databases, grey literature, reference lists, citations and contact with authors in the field.

Identified articles were critically appraised and their results synthesised using

metaethnography. **Findings:** There is potential to significantly improve the quality of the research in this field. Four categories were constructed to synthesise the findings of the reviewed studies, which demonstrated that being a peer support worker has the potential to be both facilitative of and detrimental to personal recovery. **Research**

implications: The quality of existing studies varies widely. Further, high-quality research is required to specifically investigate the effects of employment as a peer

support worker on personal recovery. **Practical implications:** The findings are tentative in light of the quality of the studies, but should be considered in the employment, training and ongoing support of peer support workers and the services they join.

Originality / value: Through its systematic methodology and appraisal of the quality of the studies reviewed, this review adds value to the literature about the effect of working as a peer support worker on personal recovery. It offers an original synthesis and criteria for measuring the quality of research in this field.

Key words: Mental Health; Peer Support Workers; Recovery; Metasynthesis.

Introduction

Whilst there is no universal definition of peer support work (PSW) it is based on the premise that those with similar experiences can relate to one another better and offer more authentic empathy and validation (Mead and MacNeil. 2006). This review focuses on 'intentional PS', specifically those "...who have experienced significant improvements in their psychiatric condition offering services and/or supports to other people with serious mental illness who are considered to be not as far along in their own recovery process." (Davidson *et al.*, 2006, p.444).

PSW within mental health is growing exponentially but there has been little research into peer support work (Bradstreet, 2006) and the provision of services appears to be outpacing supporting evidence (Pitt *et al.*, 2013) . Research has thus far focused on feasibility, comparing peers to non-peers in traditional roles, and examining unique contributions of PSW (Davidson, *et al.*, 2012). PSW has been evaluated as beneficial for clients, the mental health system and the peers themselves (Repper and Carter, 2010; Davidson *et al.*, 2012). A literature review (Miyamoto and Sono, 2012) highlighted potential benefits for peers in personal growth, learning of skills, contributing to others' recovery, and financial rewards. However, this study did not evidence how themes were synthesised or address the quality of the studies examined. It also only reported benefits to peers despite the reviewed studies referencing challenges and difficulties of the role. This appears to be a missed opportunity given the early recognition of the challenges of the role and attempts to provide solutions (e.g. Carlson *et al.*, 2001). Individuals providing PSW have been found to require and use a range of coping strategies to manage the complexity of holding dual roles as a service user and service provider (Silver, 2004). It would thus seem important for reviews to offer a balanced picture of the nature of the work, in order to offer guidance for optimising the potential of the role.

A later meta-summary of studies into the experiences of providers of PSW (Walker and Bryant, 2013) again aggregated findings from qualitative studies and highlighted improvements in confidence, self-esteem and social contacts for peers. It did report challenges, including non-peer staff paternalism, being treated like a patient, social exclusion by peers and difficulty balancing professional boundaries. There are some difficulties interpreting the findings because no distinction was made between specific PSW and consumer employees. The latter are individuals with lived experience of mental health problems who work in mental health settings but not necessarily providing support to other people with mental health difficulties. For example, they may take on purely administrative tasks. The difference in roles is distinct and should be distinguished in research findings as such in order to better understand the impact of both types of employment on the individual in recovery and the services they work in.

Given the noted limitations of the previous reviews, there is only partial understanding of the effects of employment as a peer support worker on personal recovery. There is also little known about the quality of the research to date. Consequently, the aims of this review were to: systematically identify qualitative accounts of PSWs regarding the effects they perceive their role to have on their personal recovery; appraise the quality of the identified research; and synthesise the studies' results.

Methodology

Inclusion criteria

Articles were included if they were written in English language and reported original qualitative research exploring the effects of being a peer support worker on personal recovery. This could include paid or unpaid roles and no restriction was placed

around the level of training peers had received. Studies using mixed methods were included, with only the qualitative data being extracted. If the research was conducted on both peer and non-peer workers, studies were included if the data from peer accounts could be extracted separately. There were no specific restrictions placed on the country in which the research took place, although it is recognised that the requirement for articles to be written in English language would have potentially excluded some papers.

Searching

A systematic search was conducted on Medline, PsychInfo, PsychArticles, Embase, CINAHL, Web of Knowledge, and ASSIA databases in July 2013. The search terms used in Medline were: 1) (peer\$ OR user\$ OR consumer\$ OR survivor\$) adj. (support\$ OR specialist\$ OR provider\$ OR consumer\$ OR staff); 2) Mental OR psychiatric\$ OR recover\$; 3) Qualitative OR mixed; 4) 1 & 2 & 3. Equivalent searches were used in each database.

Reference lists of selected articles were reviewed to identify further literature. Authors within the field were also contacted to highlight any additional articles. The Psychiatric Rehabilitation Journal, which publishes a large amount of peer reviewed articles on peer support was also hand searched for further articles. Grey literature was searched using GreyLit and OpenGrey databases, to account for publication bias. A flow chart of the search is shown in Figure 1.

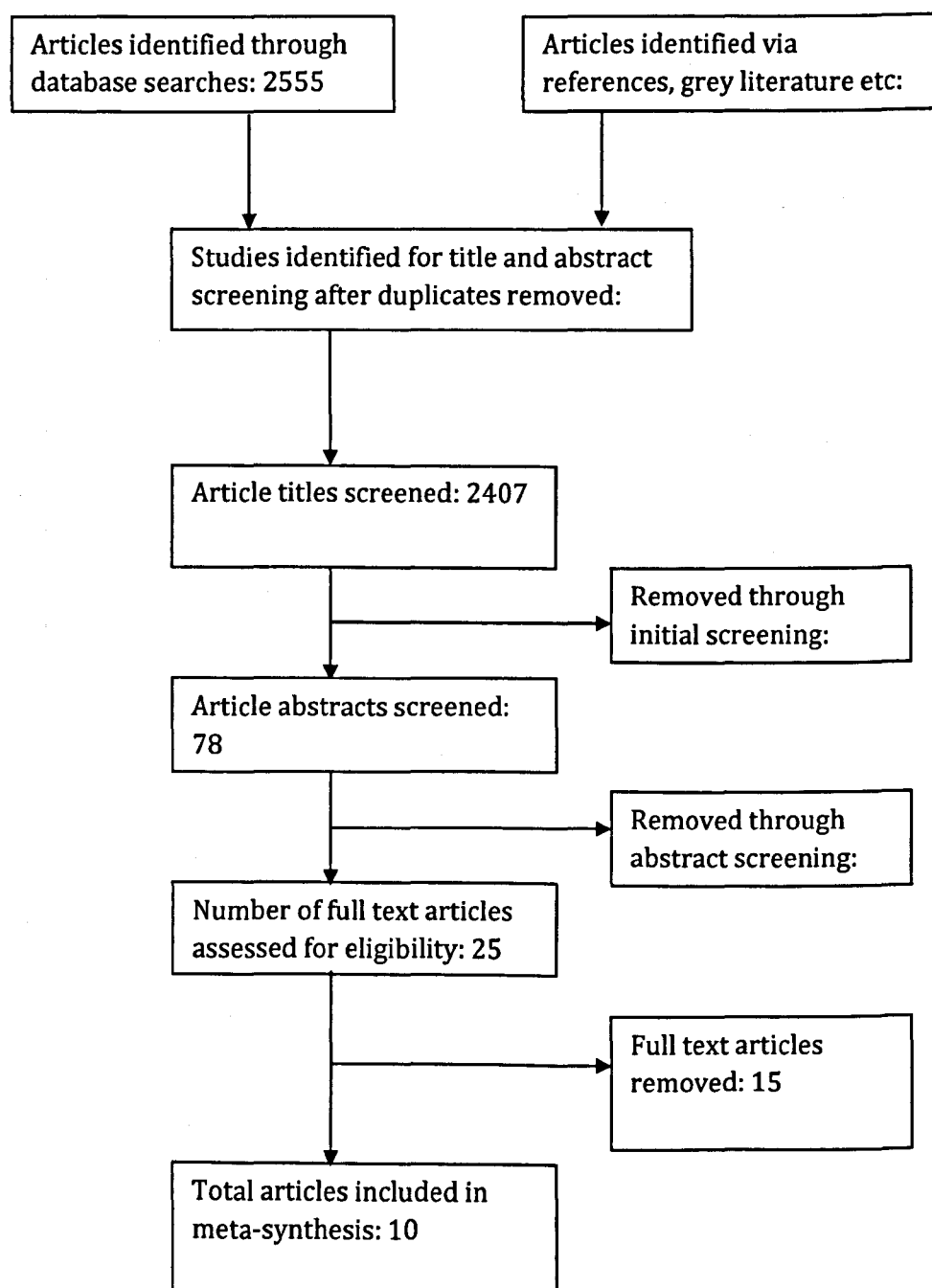


Figure 1: Flow chart outlining article selection

Ten studies were included. Table 1 describes their general characteristics and shows the number (1 – 10) assigned to each study for the purposes of the review. These numbers are referred to for the sake of brevity throughout the results section. The total number of

participants is between 101 and 107, with the exact number unclear because study 7 did not state whether the same individuals were recruited to both focus groups. Studies 7 and 8 appeared to use the same participants but the data is generated through different methodologies in each article. Studies 5 and 6 use the same participants and data but the aims and findings differed between the studies.

Table 1: Article characteristics

	Authors (year), location	Study aims	Qualitative data collection method	Sample	Data analysis method	Key findings
1	Doherty <i>et al.</i> , (2004), UK	To provide firsthand account of being a consumer-employee healthcare assistant (HCA) within an assertive outreach team and examine effect on team members.	Semi-structured interviews (SSI) after 6 months and 18 months.	2 Peer HCAs and 8 non-peer professionals*	Content analysis.	Benefits to clients, staff and consumer-employees. Work to do regarding treating consumer-employees and their views with respect.
2	Dyble, (2012), UK	To explore individuals' transition from their own lived experience of MH difficulties to providing a service to support others with their MH difficulties.	SSI	7 Peer support workers (5 female, 2 male)	Interpretative phenomenological analysis.	PSWs voiced a number of challenges. The role and its effects are complex, dynamic and interchangeable.

3	Manning & Suire, (1996), USA	To evaluate a program to train consumer case manager aides in order to inform further study of integration of 'prosumers'.	Interviews	16 consumer case manager aides*	Not specified	The roles of patient and staff are in transition. Consumer –employees can bring innovative and unique skills and perspectives to the mental health service system and can benefit personally.
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Study	Authors (year)/ location	Study aims	Qualitative data collection method	Sample	Data analysis method	Key findings
4	Moll <i>et al.</i> , (2009), Canada	To identify the issues and challenges of integrating peer support services into traditional mental health services	SSI	6 PSW (2 female, 4 male) and 6 managers	Collective case study	In order to fully benefit from the benefits that peer support can bring to clients, the mental health system and the peers themselves, strategies need to be put in place to support the unique needs of the worker and the workplace environment.

5	Moran <i>et al.</i> , (2012), USA	To identify the benefits resulting from being a peer provider	SSI	31 Peer specialists (17 female, 14 male)	Grounded theory	Peer-provided services are a promising field with benefits to the provider in a range of areas. Role and work environment related mechanisms highlight areas for improvement in training and support.
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Study	Authors (year)/ location	Study aims	Qualitative data collection method	Sample	Data analysis method	Key findings
6	Mowbray <i>et al.</i> , (1996), USA	To provide a description of consumer employee involvement and challenges within vocational programme attached to case management teams.	Two focus groups	11 consumer employees in first focus group, 6 in the second*.	Not specified	Consumer-employees can make valuable contributions to peers within the community and on site. Role innovation can also create ambiguity, role conflict and strain and personal stress for the incumbents.

7	Mowbray <i>et al.</i> , (1998), USA	To examine the benefits and limitations of an integrated case management/vocational services demonstration site by peer support specialists (PSS)	SSI	11 PSS (5 female, 6 male)	Not specified	Experiences as PSS contributed positively toward skill development and personal growth. Administrators can minimise the cost to PSS and the system through proactive planning and consensus building that recognises the personal and systemic transformations needed.
8	Salzer & Shear, (2002), USA	To identify the benefits of the helper-therapy principle in Peer support work	SSI	14 PSW (6 female, 8 male)	Thematic Analysis	The helper-therapy principle can have beneficial effects for those in the early stages of recovery as well as those in the latter stages.

Study	Authors (year)/	Study aims	Qualitative data collection	Sample	Data analysis method	Key findings
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	location		method			
9	Yuen & Fossey, (2003), Australia	To explore the views of consumer staff on the rewards and challenges of consumer provider roles	Observation and SSI	3consumer staff*	Thematic Analysis	Employee consumer provider roles can enable meaningful occupation and facilitate the empowerment of consumers in these roles. Programmes must provide appropriate remuneration, training and supervision within supportive working environments. Further support for such programmes is essential.

Critical appraisal

The appraisal of the quality of studies within literature reviews is essential, yet regularly neglected (Dixon-Woods *et al.*, 2007). The quality assessment used within this study is an expanded version of the Critical Appraisal Skills Programme (CASP) tool (Critical Appraisal Skills Programme, 2006). This tool was expanded as in other studies (e.g. Campbell *et al.*, 2003) to provide more evidence regarding quality. Eighteen quality criteria were applied to each article, scored as follows: zero if not met; one if it was unclear; and two where definitely met (see Table 2).

Implications of quality appraisal within metasynthesis are debated. Views range from it being a method for inclusion and exclusion, to an interpretative view of developing insight and exploration (Spencer *et al.*, 2003). This review used it as a means to further explore the papers, acknowledging that despite poor quality scores, all studies may contribute useful findings (Sandelowski *et al.*, 1997).

Synthesis of findings

In the absence of consensus regarding how to synthesise multiple qualitative accounts, meta-ethnography (Noblit and Hare, 1988) has been shown to be the most frequently used method (e.g. Britten *et al.*, 2002; Campbell *et al.*, 2003). Meta-ethnography involves synthesising the key concepts of original studies through a process of interpretation. Common themes are identified through reciprocal translation (Noblit and Hare, 1988), meaning that similar concepts from across the reviewed papers are identified and grouped together. Each group may be accounted for using an existing concept from one of the studies or, if this is not possible, a new construct can be developed that accounts for the interpretation of the similar findings across the studies. Refutational accounts are then sought to highlight contrasts

between the findings in different papers, before developing a 'line of argument' synthesis of all identified concepts (Noblit and Hare, 1988).

The exact process that takes place "cannot be reduced to mechanistic tasks" (Britten *et al.*, 2002, p.201) but involves linking together the first and second order themes into an overarching model of new, 'third order' themes. Themes within reviewed studies are referred to as 'second order' themes, in that they are developed by the researchers based on the 'first order' data from participants. A process of cross-comparison was used to synthesise the themes from the studies into 'third order' themes: those developed by the reviewers.

Results

Table 2 Cross comparison of study reports (grouped findings)

Third order theme - Subtheme	Doherty et al (2004)	Dyble (2012)	Manning & Suire, (1996)	Moll et al (2009)	Moran et al (2012)	Mowbray et al (1996)	Mowbray et al (1998)	Salzer & Shear (2002)	Yuen & Fossey (2003)
Client factors									
- Helping others	*				*	*	*	*	*
- Being a role model	*			*	*				
- Disclosing personal stories to clients.		*			*				*
Team factors									
- Acceptance and belonging	*	*	*	*	*		*		*
- Disclosure of personal story to team.		*	*	*	*	*			
- Dual role as consumer and provider.	*	*	*	*		*	*		*
- Social inclusion / exclusion			*				*		*
Peer role factors									

- Dis/Empowerment		*	*	*	*				*
- Increased knowledge about own recovery.		*			*	*	*	*	
- Increased wellness.		*			*	*	*	*	
- Moving on from the role.	*	*			*	*	*	*	*
- Effects of employment					*	*	*	*	*

Quality appraisal

There was significant variation in the overall quality of the studies, with total scores ranging from 15 (3) to 34 (2). It must be acknowledged that the study deemed to be of the highest quality was a thesis and therefore not subject to the restrictions of journal word counts.

All studies clearly reported their aims, which were varied but all made some reference to the potential effect that engaging in employment as a peer support worker could have for personal recovery. Qualitative methodology was appropriate, although three studies (3, 7, 8) did not report use of a recognised qualitative methodology. All studies used appropriate samples to meet the aims of their studies, but four (1, 3, 4, 9) inadequately detailed the recruitment process, limiting assessment of whether the recruitment strategy was appropriate to meet the aims of the research. Of the six studies (2, 4, 5, 6, 8, 9) that specified the gender of the participants, roughly equal numbers of each gender were recruited (35 female, 34 male). With regards to data collection, most studies reported using semi-structured interviews, one used focus groups (7) and one simply stated that interviews were used (3). Two (1, 3) did not report how information data was recorded, affecting the reader's ability to accurately appraise the research process and results.

All but one study (1) provided sufficient data to support the themes developed. Interestingly, no studies mentioned data saturation, whereby new accounts of participants only confirm existing themes rather than develop them or provide new insight (Guest *et al.*, 2006). This is likely to be a consequence of sample size being determined a priori by the greatest number of participants available within the various

restrictions of a study. All but three studies (6, 7, 9) identified contradictory accounts within data. It is useful to highlight these to show the range of views and to develop a more critical approach to the themes developed.

Only two studies (2, 9) acknowledged the role of the researcher in the research process and the potential influence of bias. Due to the subjective nature of interpretation found within qualitative research, a failure to acknowledge or even recognise potential biases limits the reader's ability to evaluate the study fully.

Of concern, six studies (1, 3, 4, 5, 7, 9) did not provide adequate information to evaluate ethical standards. This may be based on an assumption of ethical approval, but this should be reported as a guarantee that the participants' rights were upheld.

All studies made clear statements about their findings and contributed to developing understanding of peer support work by examining the subjective experience of those employed within such positions. Three (1, 3, 6) omitted discussion of the credibility of their findings. Eight studies highlighted areas for future research. It is perhaps surprising that two (3, 7) did not, given these studies were conducted close to the beginning of research into peer support where relatively little had been examined.

Synthesis

Four main third-order constructs were developed to synthesise the results of the reviewed studies in order to address the question of what effects peer support workers perceived this role to have on their personal recovery. These were: 1) Increased knowledge about own mental health; 2) Sense of identity; 3) Position within a professional team; and 4) Impact of employment. Third order themes and subthemes are presented in Table 3 with identification of the studies contributing to each.

Table 3: Third order constructs and studies contributing to each

Third order constructs:	Study Number								
	1	2	3	4	5	6	7	8	9
Increased knowledge about own mental health.	*	*	*		*			*	
Sense of identity:									
- Impact on sense of self		*	*		*	*	*	*	
- Helper and role model	*	*		*	*	*	*	*	*
- Dual role as consumer and provider	*	*	*	*		*	*		*
Position within a professional team									
- Clarity of the role and support to fulfil it	*	*	*	*	*	*	*	*	
- Acceptance and belonging	*	*	*	*	*		*		*
- The value of the role		*	*	*	*	*	*		
Impact of employment									
- Benefits of employment					*	*	*	*	*
- Challenges of employment	*	*	*	*		*	*	*	*
- Moving on from the role	*	*			*	*	*	*	*

Increased knowledge about own mental health

Participants within five studies (1, 2, 3, 5, 9) spoke of having learned more about their own mental health and consequently enhanced their wellness. This included knowledge about oneself, knowledge about recovery and mental health more generally and being reminded to utilise this knowledge:

“one thing that has really helped me about being a peer provider is reminding myself of the things I need to do to keep myself well, like, things that I encourage other people to use but I don't necessarily use them myself. So it's kind of a reminder bouncing back of them that, you know, you need to be doing this for yourself, (name). So that's been important to me.” (Moran et al., 2012, p.307).

One participant identified the reciprocal nature of sharing knowledge with clients:

"... I give them (program participants) my knowledge and even learn from them. A lot of times, I learn things from them that I didn't know myself and that's a good feeling also." (Salzer and Shear, 2002, p.285).

The connection between the specific role of PSW and personal recovery was epitomised by a participant saying:

"This job is all about recovery and it helps me practice more my recovery, you know, even in the work-place and that is something that you rarely get" (Salzer and Shear, 2002, p.285).

Sense of identity

'Sense of identity' was relevant in every study in relation to at least one of the subthemes: 1) Impact on sense of self; 2) Helper and role model; and 3) Dual role as consumer and provider. Within each, there was evidence that participants talked about this aspect of the PSW role in such a way that it seemed to evidently influence their recovery.

Six studies suggested the role positively impacted on participants' sense of self. Reference was made to personal 'growth' (2, 5, 7, 8) and enhanced self-esteem, self-confidence and self-concept, e.g.:

"... for a long time I looked at myself very negatively. And now I look at myself in a very positive way. And I also used to look at myself as somebody who's maybe not as good as other people, not as capable as other people, that, you know, I would have certain limitations because of this disability...and now I no longer see that because of the things I've been able to accomplish in my work." (Moran et al., 2012, p.308).

Participants in four studies (2, 3, 5, 9) made reference to no longer having to hide mental health problems and consequently experiencing increased self-acceptance. Disclosing personal stories of recovery was seen as an intrinsic part of the role, although participants differed in relation to how comfortable they felt about this aspect. For some, the sharing of their story was inherently connected to personal recovery and they progressed from telling an “illness story” to a “recovery story” because “when you share your recovery you’re kind of owning it in a new way. So, you know, kind of tending and pruning it” (Moran *et al.*, p.311).

Just one study (2) suggested that the role identity could impede recovery in and of itself:

“...there’s something about becoming a peer support worker (...) that bugs me, that you’re always going to be in that sick role (...) so I don’t know if people might see me as (...) always being “she was unwell once”, or something. So that always sits uncomfortable with me” (Dyble, 2012, p.127).

A key aspect of identity and development appeared to relate to the role as a ‘helper’ and ‘role model’ and either or both of these constructs were mentioned in all studies but one (3). The importance of being a role model (1, 2, 4, 5, 7) was related to helping others but goes beyond this; it related to embodying personal recovery in order to be “...the evidence” of recovery (Moran *et al.*, 2012, p.312) for others to emulate:

“ So, to me it is just something that I feel is important to be a role model and to be better. To live up to that expectation, to take care of myself.” (Moran *et al.*, 2012, p.312).

However, Moll *et al.* (2009) recognised that being a role model could bring pressures and challenges that would require negotiation.

A particularly challenging aspect of the role is the dual identity as both service consumer / user and service provider, which impacts on relationships and boundaries with both professional colleagues and clients. This resonated in all but two (5, 9) studies. Just one participant specifically highlighted the related risks to their personal recovery and the challenges of maintaining boundaries with clients:

“I need to be detached from people who have problems like mine because it tends to trigger my anger, which triggers my delusional thinking. I have difficulties keeping boundaries with these people because they’re so much like me”. (Mowbray *et al.*, 1996, p57).

Other participants did not seem to explicitly discuss whether dilemmas of the dual role specifically impacted on their personal recovery. However, there was a suggestion that such dilemmas could be a source of stress, which could be assumed to impact on recovery. This dual identity seemed to be especially difficult where PSWs were working within the team that currently or previously cared for them and when they had existing relationships with clients they were then assigned to work with.

Position within a professional team

Across all of the studies, connections were made between the participants’ position within a professional team and recovery, with three subthemes: 1) Clarity of the role and support to fulfil it; 2) Acceptance and belonging; 3) The value of the role.

All but one (10) of the studies made reference to the clarity of the role and support available to fulfil it. This was not always explicitly related to personal recovery, but was connected to the quality of the experience of the role, which would likely impact on recovery. Key issues centred on defining and establishing the role and expectations, including the level of autonomy. Training and information, transitional support into the role and supervision were seen as important to meet the challenges of the role. However, one study (8) found that despite participants making positive comments about supervisors, the content or process of supervision appeared superficial and that participants may not know how to make use of supervision.

The theme of acceptance and belonging was found in seven studies. The place of acceptance seemed to refer variably to working with other PSWs, clients or professionals in teams. Participants in some studies (2, 5, 10) felt accepted within their teams, e.g.:

"You don't have to remain anonymous here. There is safety in sharing that kind of stuff. It is a feeling of home, kind of like, so it's okay: brothers and sisters kind of stuff."
(Moran *et al.*, 2012, p.310).

Other participants had a very different experience; three studies (1, 3, 6) made reference to colleagues talking inappropriately or joking about people with mental health problems and in one case (3) peers were not invited to events where non-peer staff socialised and felt excluded from legitimate work activities. In one study, such a lack of acceptance appeared to have affect participants' perceptions of how to interact with other professionals:

"I'd better not act like a client...too emotional, or too dramatic, or too impulsive, or irresponsible". (Manning and Suire, 1996, p.940).

The value of the role was discussed in studies. For one participant, the role in itself offered empowerment "by being part of a movement that is exciting and energising" (Moran *et al.*, 2012, p.309), while another (8) described participants as 'hard-pressed to identify any perceived benefits to the larger mental health system' (Mowbray *et al.*, 1998, p.402).

There appeared to be mixed views regarding how valued individual participants felt within services, even within the same study. For example, Manning and Suire (1996) found that some participants saw themselves as 'cheap labour' while other felt they were well compensated. The issue of low pay arose in four studies (2, 3, 7, 8) but seemed to go beyond financial benefit to broader issues of the value of the role, e.g:

"...I think they may want to be using me as a dogsbody, er I've been called cheap labour [coughs] I've been called a fad. Er and a phase to phase out [coughs]." (Dyble, 2012, p. 135).

Although participants did not connect these issues to personal recovery, it is reasonable to suggest that a perception of a lack of value within teams could be detrimental to individuals' sense of self and recovery.

Impact of employment

All studies mentioned the impact of employment, relating to one or more of the subthemes: 1) Benefits of employment; 2) Challenges of employment; and 3) Moving on from the role.

Generalised benefits of employment were reported in five studies (5, 7, 8, 9, 10) and included the development of skills and abilities, being able to function better at work, improving communication, having improved financial freedom, having a schedule, experiencing teamwork and increased social networks.

Challenges of employment were discussed in all but one study (5). Only one study (9) reported participants enjoying being challenged by their work; more commonly, studies suggested the likely negative impact on recovery of general employment challenges such as the stresses and learning curve in beginning any job after a period of mental ill health (1, 3, 4, 10). Participants in one study (1) thought that team members did not necessarily appreciate how difficult it could be to get up in the morning and travel to work. There were also some 'unique' challenges because the role was distinct from other team members (4). These were not discussed in detail, but perhaps included the challenges of working with clients who did not respond or seem to recover, or who were even seen by PSWs as having 'failed' them (7).

Seven studies included the theme of moving on. For five (1, 5, 8, 9, 10) the role of peer support work was viewed as a stepping stone into further employment and career development as part of ongoing recovery, e.g.

"So I've been through a period of feeling inactivity, and I really needed to be doing something so ... maybe now I'm active again I need, need to move on and do something else."(Yuen and Fossey, 2003, p.60).

Discussion

This review aimed to synthesise existing qualitative accounts of PSWs' perspectives about how their role affects personal recovery. Four themes, with

subthemes, were identified that appear to affect personal recovery. Some of these were explicitly connected, while the influence of others appeared more implicit. It was evident that, even within individual studies, participants had a range of experiences and views in relation to each of the themes. In general each theme should be considered as capturing potentially contrasting experiences that can either promote or impede recovery.

There was clear evidence within the reviewed studies of benefits to PSWs of the role, in line with other literature (Repper and Carter, 2010; Davidson *et al.*, 2012). It appears that the most explicit connection between the PSW role and personal recovery is the increased knowledge about mental health and recovery. This has not been a dominant focus of previous research into the contribution that PSW roles can make to personal recovery and warrants further research. It perhaps also raises the question of what services can do to increase knowledge about mental health and recovery for all service users, including those who do not become PSWs. It could be argued that there are alternative means through which individuals could gain increased knowledge about mental health and recovery, without the potential detrimental effects of taking on PSW roles. This could include provision of education through initiatives such as 'Recovery Colleges', which have seen a growth within UK statutory mental health services (Perkins *et al.*, 2012).

The findings demonstrate that the PSW role offers opportunities to facilitate recovery by positively impacting on an individual's sense of self, in line with previous findings (Walker and Bryant, 2013). The helper-therapy principle (Reissman, 1965) seems to be a key mechanism by which this is achieved. However, the distinct

importance of being a role model appears to go further, by aiding motivation to practice the principles being taught. While these aspects of impact on sense of self have potential to aid personal recovery, they must be balanced against the challenges of negotiating and assimilating the complexities of dual roles as consumer and provider. PSWs should be offered appropriate support and supervision to achieve this.

The importance of incorporating PSWs into teams that are receptive to the value of individuals with lived experience of mental health problems seems clear. Both PSWs and teams are likely to require preparation for working together. The need for training (of PSWs and their colleagues), clear expectations and ongoing supervision was seen across the studies. This includes guidance about how to make use of supervision, for both supervisors and PSWs. There is a need for more rigorous research regarding how the team setting affected personal recovery before more specific recommendations could be made. Such research across a range of settings could highlight areas for consideration and offer examples of good practice, which could then be adapted to meet local needs.

Results suggest consideration must be given to the value of the role within services, both within and beyond the teams in which PSWs are located. While participants did not explicitly talk about the impact on their own recovery of perceptions that they were undervalued, it is reasonable to suggest this could be detrimental. The PSW role has the potential to hold value in terms of the general benefits of employment but goes beyond this in the application of recovery principles to one's own life. However, individuals are unlikely to remain within the role if they feel undervalued, particularly as they can seek alternative employment. Alternatives, which do not require

inherent disclosure of mental health difficulties, may become particularly appealing to individuals who wish to move beyond services. This would create a potential loss for the clients they would cease to work with.

There are several limitations of the process of review and the studies reviewed. It may be seen as a limitation that only qualitative studies were included, but this review sought to synthesise research into the experience and views of peer support workers, which would not be captured in detail by quantitative approaches. First person accounts offer an important aspect of the evidence for the relationship between PSW and personal recovery. However, it is recognised that quantitative studies that seek to measure this relationship could also offer a valuable component of the evidence base and be a focus of future research.

It is noted that although the quality appraisal tool used was expanded for the purposes of this review, it did not include evaluation of service user involvement in the studies. Recent publications (e.g. Gillard et al., 2014) have highlighted the importance of not only involving service users in research but in fact ‘coproducing’ research with service users whose lived experience can shape the scope and aims of a project, improve the design of interview schedules and enable data collection in ways that increase engagement. Future reviews may wish to include this as a criterion and future research projects could take this into consideration in both their design and reporting.

The quality of the studies was generally very poor. Whilst some authors advocate excluding papers on the basis of quality (Campbell *et al.*, 2003; Atkins *et al.*, 2008) others believe that all qualitative accounts could have value (Sandelowski *et al.*, 1997). Although not intended as part of the methodology, the present review tended to

rely more heavily on the higher quality papers for the synthesis because they tended to offer more clearly developed themes with supporting data. Lower quality papers tended to provide supporting evidence for themes identified by the synthesis, rather than offering new themes. Related to this, it is acknowledged that there is variability in the number of direct quotes drawn from papers to support the presented synthesis, which did not reflect any intentional aspect of the methodology. One paper in particular (Moran *et al.*, 2012), is more heavily represented than others in terms of direct quotes, simply because this paper included a higher number of longer quotes that were directly relevant to the aims of the review. Other papers (e.g. Doherty *et al.*, 2004) offered either very short quotes or few quotes at all and thus appear underrepresented. The reporting of future qualitative research projects may benefit from offering more supporting evidence for the themes developed, in the form of direct participant quotes.

There was also little focus within the studies on the potentially adverse effects of being a PSW; research typically asked questions around benefits and challenges. ‘Challenges’ found tended to relate to difficulties in integrating or developing the positions rather than specific focus on how PSWs were personally affected. Further research into how PSWs’ personal recovery may be affected by their role is warranted, although careful ethical consideration would have to be given to research that focused on individual persons, particularly given the possibility for research participation to impact on their views of the role. Further research is also needed into attitudes within mental health teams towards employing those with lived experience of mental health difficulty and the effects of this on PSWs. The quality appraisal criteria used in this review offers suggestions for how to enhance the standard of future research. For example,

Conclusion

Being employed as a PSW has the potential promote personal recovery, but this cannot be assumed to be the case for all PSWs. The role also has the potential to impede recovery. Evidence from the reviewed studies suggests this will be less likely if posts are thoughtfully established within supportive services with ongoing financial remuneration and support to manage the dilemmas inherent in the role. Further, high-quality research is warranted to gain a balanced perspective on the range of effects of employment as a PSW on personal recovery.

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JOURNAL PAPER¹

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Abstract

Purpose

Peer support workers are being employed at an increasing rate yet the evidence for their clinical and cost-effectiveness is uncertain. This may be due to the relatively low quality research conducted this far, and a lack of empirically validated studies exploring how peer support work may work. A number of psychological theories have been proposed to explain the mechanisms of peer support but these lack empirical validation and specificity to professional peer support. This research was an exploratory study developing a substantive interpretive grounded theory of service-users' experience of professional peer support work.

Methodology

Semi-structured qualitative interview were conducted with ten service-users who had engaged with a professional peer support worker. Constructivist grounded theory was used throughout the project.

Findings

¹ Written in preparation for submission to the Mental Health Review Journal and adheres to the publication guidelines provided at http://emeraldgroupublishing.com/products/journals/author_guidelines.htm?id=mhrj.

Three overarching themes were constructed from the data. 'The process of disclosure' describes how disclosure of mental health difficulties, experiences as a service-user and wider disclosure about life experiences, interests and values facilitate the development of a shared identity and an in-group identity with the peer support worker. 'The product of disclosure' highlights the sense of being understood that is the result of the disclosure and marks a deepening of the relationship. 'Dual roles' describes the tenuous position of holding relationships of both friend and professional with the service-user.

Research implications and limitations

Future research should seek to refine the theory developed through further study; to compare the effects of therapist self-disclosure with that found within peer support. There were several limitations within the study including limited diversity within the sample as well as difficulties within recruitment, each of which may be addressed by future studies.

Introduction

Peer support² has become an important part of the recovery movement within mental health (Repper & Carter, 2011) and locally within government policy and strategy (Gillard, Edwards, Gibson, Holley, & Owen, 2014). Peer support workers are now being recruited across many different services within the UK (Simpson, Quigley, Henry, & Hall, 2014) despite the equivocal evidence produced thus far (Gillard et al., 2014; Lloyd-Evans et al., 2014; Pitt et al., 2013). The theory behind peer support is poorly understood and yet is fundamental to measuring outcomes. Service-users' voices have been neglected within the literature (L. Davidson, personal communication, November 27, 2012), contradictory to the principles of personal recovery. Personal recovery within mental health moves away from the idea of treatment aiming to reduce symptomology. It refers to individuals being enabled to live satisfying, hopeful and meaningful lives despite the difficulties they still might experience (Anthony, 1993)³.

² Whilst there are a number of different forms of peer support, unless stated otherwise this shall refer to professional peer support

³ This section will be expanded within the extended paper

Peer support

Peer support is defined as “a process by which persons voluntarily come together to help each other address common problems or shared concerns” (Davidson et al., 1999, p.168). It “encompasses a personal understanding of the frustration with the mental health system and serves to reframe recovery as making sense of what has happened and moving on, rather than identifying and eradicating symptoms and dysfunction” (Repper et al., 2013, p.4).

The term peer support encompasses a number of approaches that utilise the lived experience of mental health difficulties. It is distinct however, from individuals with mental health difficulties who are working in health care settings, but are not actively disclosing their lived experience to a service-user in order to support and enable their recovery. The failure to distinguish between different types of peer support has led to the aggregation of findings for many consumer-provided services.

Types of peer support

Peer support has developed from individuals coming together of their own accord in order to resolve one another's difficulties. There are now a number of different types of peer support, including professional peer support workers who are employed by the National Health Service (NHS) (Repper & Carter, 2011). This is based on the premise that peer support is a valuable component of recovery-oriented best practice for rehabilitative services (Gates & Akabas, 2007).

Peer support has been described within the literature as forming three distinct parts (Davidson et al., 1999). Firstly, mutual support groups are the progenitor of formalised peer support and exemplified by Alcoholics Anonymous (AA). These groups have a flattened hierarchy with members thought to hold equal status and who work with one another in a mutually beneficial manner. The premise that each holds

equal status is in fact difficult to measure or maintain and describes a stable dynamic which may in fact fluctuate throughout the relationship.

The second type of peer support, peer-run services, is generally developed outside of statutory care and are run and delivered by individuals who have experience of mental health difficulties. This type of peer support is somewhat distinct from mutual support groups as there is a reduction in the degree of mutuality. It is not the intention for the service provider to receive care and support from those attending the groups, however with slightly more relaxed boundaries there is a degree of reciprocity present (Davidson et al., 1999).

Finally, professional peer support services are a relatively new introduction to mental health services (Repper & Carter, 2011). They involve individuals with lived experience of mental health difficulties being employed within the NHS. They are employed in order to use their experience in providing support to others who have been through similar difficulties. At the time of the present research, the Trust in which it was conducted employed peer support workers as supernumerary to multi-disciplinary teams (MDT). They worked in collaboration with community psychiatric nurses (CPNs), social workers, psychiatrists, clinical psychologists and other members of the MDT.

Evidence regarding peer support

Research examining peer support has tended to focus on the benefits and challenges to the system employing peer support workers (Gillard, Edwards, Gibson, Owen, & Wright, 2013), the benefits and challenges to peer support workers in terms of effects on personal recovery (Bailie & Tickle, 2015), and the effects on the recipients of peer support (Lloyd-Evans et al., 2014). The majority of research has been randomised controlled trials, quasi-experimental and experimental methods, as well as qualitative accounts. For the purposes of this article the research will focus on the effects on service-user receiving care from peer support workers. The overall quality of evidence

has been of low to moderate quality and subject to bias (Gillard et al., 2014; Lloyd-Evans et al., 2014). Randomised controlled trials have generally compared peer support workers to treatment as usual and findings generally point towards there being no significant difference between peer and non-peer staff on outcomes such as hospitalisation, employment, overall psychiatric symptoms, symptoms of psychosis, depression and anxiety, quality of life, self-rated recovery, hope, empowerment and satisfaction with services. It has therefore been concluded that peer support workers are able to perform equivalent roles to non-peer staff, despite the low quality of evidence that has been provided. In a review of the evidence, Davidson, Bellamy, Guy, and Miller (2012) identified studies that found reduced rates of hospitalisation, improved engagement of hard to reach clients and reduced substance misuse (Davidson, Stayner, & Chinman, 2000; Rowe et al., 2007; Solomon, Draine, & Delaney, 1995; Wexler, Davidson, Styron, & Strauss, 2008). Whilst there does appear to be the potential for peer support workers to make contributions above and beyond existing staff as noted above, the consistency of this evidence is lacking and the demonstrable evidence regarding peer support worker's effectiveness remains equivocal (Lloyd-Evans et al., 2014; Pitt et al., 2013). The breadth of interventions offered by peer support workers and the manner and services in which they are employed varies considerably, making comparisons between the interventions offered by peer support workers difficult (Lloyd-Evans et al., 2014).

There have been a number of qualitative studies exploring the benefits of peer support. However, there have been few looking at the potentially detrimental effect of peer support or when it has not been beneficial (Bailie & Tickle, 2015). Further evaluations of this nature would help provide a more balanced picture of the effects of peer support. Despite these limitations the conclusions of qualitative studies have identified a number of potential benefits including improved sense of empowerment, reduced perception of stigma (Ochocka, Nelson, Janzen, & Trainor, 2006), improved social support and social networking (Chinman et al., 2008; Davidson et al., 2001; Ochocka et al., 2006). Whilst there remains potential for beneficial effects of peer support work these have yet to be demonstrated consistently. There has been a failure to

adequately represent service-users voices within the literature and these qualitative accounts often relate to programmes that assume a similarity with professional peer support yet remain distinct⁴..

Mechanisms underlying peer support

In order to understand the effects of peer support, it would be useful to understand how peer support works. There has been very little research on this subject however, and researchers state that peer support lacks a theoretical underpinning and clarity with regard to expected outcomes (Lloyd-Evans et al., 2014).

It has been proposed that five theories account for the potential beneficial mechanisms of peer support Salzer et al. (2002). The proposed theories include: social learning theory (Bandura, 1971), the helper-therapy principle (Riessman, 1965), experiential knowledge (Borkman, 1999), social comparison theory (Festinger, 1954), and social support (Sarason, Levine, Basham, & Sarason, 1983). Solomon (2004) goes on to reference these same five theories but acknowledges they have no empirical support and are based on self-help groups. She claims that this is because of the difficulty in applying traditional research methods to the culture of self-help groups, but fails to specify why.

Whilst it may be a complex and entangled web to try to establish how peer support works, it is necessary in order to understand what outcomes we might expect from peer support and how best for it to be used within the NHS. These outcomes have yet to be demonstrated within research consistently because of the lack of continuity in the outcomes measures assessed. Qualitative studies have yet to explore service-users' accounts of professional peer support and there is an assumed similarity between

⁴ This section will be expanded in the extended paper

professional peer support and other modalities of peer support. Furthermore, these five theories account for all types of peer support yet clearly there are distinctions between professionally employed peer support workers and mutual support groups that must be made apparent⁵.

Social identity theory

Current literature regarding peer support fails to take into account group status. Throughout the process of data collection and analysis it became apparent that in-group and out-group status may be significant. Whilst no current peer support literature makes reference to this it would seem significant and important to introduce the idea to contextualise the reader to the constructed themes.

Social identity theory was developed by Tajfel and Turner (1979) and proposes that part of an individual's sense of who they are is determined by their membership within a particular group. It is also reported that people have a natural tendency to self-categorise into one or more in-groups, which serves to delineate boundaries from out-groups. This established in-group status gives individuals a sense of belonging in the social world but also establishes a sense of them and us, something commonly reported in mental health services (May, 2001).

Individuals may define their group status according to their profession such as mental health professionals; others may identify themselves as service-users. Indeed it was found that subjective higher in-group status predicts better mental health status (e.g. less depressive symptoms and higher well-being) (Sani, Elena, Scrignaro, & McCollum, 2010). Whilst it is interesting to look at the implications of in-group status, especially

⁵ This section will be expanded in extended introduction

within this population, there is no causal attribution made and no mechanism identified for how this might happen.

According to social identity theory individuals will positively discriminate towards their own in-group, enhancing perceived similarities and against the out-group, enhancing differences. What has failed to be taken into account is what happens when an individual is a member of two groups such as professional and service-user as is the case for peer support workers (Tajfel, 1981). Social identity theory suggests that group comparisons are made in order to maintain or enhance self-esteem however it makes a rather simplistic explanation of in-group out-group processes.

Aim of the project

The aim of this project was to explore and develop a substantive theory of service-user accounts of professional peer support work. It sought answers to the question: what are service-users accounts of professional peer support work and how might these accounts connect with existing theory? The specific objectives of this research project were to explore service-users' accounts of professional peer support work; to relate findings from these accounts to extant theory; and based on these findings the ultimate objective was to develop a theory that contributes to explaining the relationship developed within peer support work.

Methodology

A constructivist grounded theory methodology was employed according to the principles outlined by Charmaz (2014). Grounded theory is a means of systematically and inductively gathering, synthesising, analysing and conceptualising qualitative data to develop a theory (Charmaz, 2001). Constructivist grounded theory uses a flexible approach to the guidelines developed in earlier versions grounded theory (Bryant, 2002; Charmaz, 2006; Clarke, 2005). It seeks to inductively develop a substantive theory of

the studied phenomenon, in this instance service-users' experiences of peer support and their accounts of the relationship that developed. Substantive theory is local and modifiable, unlike formal theory which remains more general and has wider application to the studied phenomenon (Corbin & Strauss, 2014). The researcher moves between constructing themes from data (induction) and the consideration of how these themes fit with other data (deduction) (Charmaz, 2014; Corbin & Strauss, 2014). According to Ezzy (2002) the researcher also uses abduction in making imaginative leaps without having empirically demonstrating all the steps. These leaps are then confirmed by induction and deduction and form the working hypotheses within the analysis.

Current context

This research project was based within a Healthcare Trust where a number of peer support workers are employed. They are employed in a number of different contexts and within different teams across the county. At the time that the research was conducted, a large proportion of peer support workers were employed to support individuals' transition from inpatient services back to the community. Peer support workers were supernumerary to multidisciplinary teams (MDTs) but worked closely with other professionals such as nurses, psychiatrists, occupational therapists and clinical psychologists to provide support to clients. Their role remains broad in providing social, emotional and practical support and to help facilitate their client's achievement of their recovery goals. They also champion recovery within their teams and aim to inspire the hope that recovery is possible for their clients. Peer support workers begin working with clients within inpatient settings through self-referrals which allows people to make their own decisions about whether or not they would like a peer support worker. Referrals are also made through other professionals where they have identified people who might benefit from peer support.

Recruitment

The study was advertised through peer support workers themselves and used purposive sampling to identify individuals who had worked or were working with a

peer support worker within the last year and had been for at least four weeks. Purposive sampling is designed to enhance understandings of a particular group and for developing theories and concepts (Devers & Frankel, 2000). This may be achieved through selecting participants who are able to provide the greatest insight into the research question and for whom it is most relevant. Advertising posters (Appendix A) were placed within outpatient departments and involvement centres across Nottinghamshire Healthcare NHS Foundation Trust.

Procedure

Ethical approval was gained for the study through NHS research ethics committee (Appendix B) followed by Research and Development approval (Appendix C). Peer support workers made initial contact to assess their client's potential interest in the project. They were provided with an information sheet (Appendix D) and consent form (Appendix E) and the researcher's contact details in order to establish contact, discuss any further questions, and arrange a time and place most suitable to them to complete written consent, a socio-demographic sheet (Appendix F) and participate in the research. Semi-structured interviews were completed, audio-recorded and transcribed verbatim. An interview schedule (Appendix G-I) was utilised with non-directive, open ended questions and prompts in order to explore the participants' subjective experiences whilst trying to prevent imposing a set of pre-defined concepts. A single interview lasting between 30-60 minutes was conducted with the participant in a place of their choosing. The participants were offered a debrief regarding the study aims after concluding the interview. Whilst interviews are able to offer retrospective accounts of individual experiences they rely on recollection and the interpretation of the participant. Other sources of data can also be utilised such as observations or recorded sessions. However, constructivist grounded theory concerns itself with the construction of data between participants and researcher rather than an examination of a singular truth or perception of reality. For this reason interviews were the sole method of data collection.

Participants

Ten participants were recruited to take part in the study and are described in table 4. The first seven were recruited through the peer support workers and the last three were recruited through posters. This figure is considered appropriate to achieve theoretical sufficiency (Dey, 1999). Details of the participants can be seen in Table 4. One of the participants, Caroline, had been diagnosed with dissociative identity disorder (DID). Individuals diagnosed with this disorder are thought to have compartmentalised memories within different identities (Dorahy, 2001). Caroline explained that in order to get a full account of her experience of peer support it would be necessary to interview another of her identities, Eve. After consultation with research tutors, Eve was approached, gave written consent and was interviewed as another participant.

All participants were currently living independently or with family within the community and had current contact with mental health services. Six female and four male participants consented to be involved in the project and ranged in age from 19 to 53.

Participant Pseudonym	Ethnicity	Time working with current Peer support worker	Referred source	Referred for
Alice	White-British	8 months	CPN	Emotional and social support
Betty	Black-British	2 years	Social Worker	Practical Support and social support
Caroline	White-British	4 months	CPN	Emotional and social support
Denise	White-British	16 months	CPN	Emotional and social support
Eve	White-British	4 months	CPN	Emotional and social support
Faye	White-British	9 months	CPN	Practical and social support
Gavin	White-British	8 months	CPN	Emotional and social support
Harry	White-British	2 months	Crisis Team	Practical and social support
Ian	White-British	2 months	Self-referral	Practical and social support
Jim	White-British	5 months	Self-referral	Practical Support

Table 4: Participant information

As may be expected within a recovery-oriented model of care, whilst there were varying reasons for referral, over the course of the relationship these goals may have altered according to the needs and developing goals of the client. For example Jim was supported in accessing services within inpatient care at the start of his relationship with his peer support worker. As he transitioned to life back in the community this altered to

providing emotional and social support and accessing the community and developing interests and activities.

Analysis

Charmaz (2014) proposes flexibly applied guidelines on how to engage in constructivist grounded theory. The researcher engages in a cyclical process of data collection and analysis, allowing for the refinement of the interview schedule to further explore concepts and themes perceived to be salient to the research question. Initial is the first stage of analysis, involving the examination of each line of data and accompanied by labelling with short, specific descriptions of the data using the participants' own language (See Appendix J for example coding). Focused coding evolves from the constant comparative analysis of moving back and forth in order to find similarities and differences between emerging themes (Charmaz, 2014). This ensures the researcher does not just build up themes but also breaks them down (Willig, 2001). Having identified themes the researcher looks for negative cases, which may not fit with the emerging findings in order to add depth to the analysis. Abstraction to the theoretical level is an iterative process involving the movement back and forth from focused coding to more abstract concepts and developing links between them. Memo-writing was used throughout the research process in order to document this abstraction of data to the theoretical level.

Results

Three overarching themes were constructed through interviews and subsequent analysis of the data: 'The process of disclosure', 'The product of disclosure' and 'Dual roles'⁶.

The process of disclosure

The theme of 'the process of disclosure' describes how disclosure occurs within peer support relationships and is divided between 'disclosing', 'disclosing mental health experiences' and 'disclosure beyond mental health'. It also explores the degree of overlap between the disclosure wanted by service-user and that offered by the peer support worker. This theme also describes how disclosure tended to focus on issues related to mental health but was in no way limited to this. Indeed disclosure of non-mental health related experiences, values and interests was a common experience and one that would seem to play an important part in the development of the relationship.

Disclosing

Peer support workers are employed because of the shared experience of mental health difficulty they have in common with the service users with whom they work. This is reflected in the accounts of service-users as Alexa describes below.

"She's been there. She describes us as being both from the same mad planet." (Alexa).

⁶ These are highlighted below but further explored within the extended paper.

This statement from Alexa's peer support worker highlights the seemingly active identification with the service-user. The active component of this disclosure exemplifies the peer support worker appearing to seek common ground with the service-user, rather than holding a passive position and allowing the service-user to identify commonality. This helps to bridge the gulf between the current service-user in the midst of personal crisis and the potential to recover as demonstrated by the peer support worker in the paid position working for the health service in supporting others. The reference to the same planet positions them as being close to one another yet vastly different from those around them.

"...when she expanded on how it made her feel, and suddenly came up with things that I hadn't said to her that were the same as me, so, I mean, things weren't completely the same, they still had big differences, but the initial problem was the same" (Eve).

Eve describes here the matching of shared experience and the expansion beyond what had been already disclosed which seemed to demonstrate to her that the peer support worker had a genuine understanding of their common experience. In spite of the 'big differences', there was sufficient similarity established between the two for this to feel of value to her.

"He had had some difficulties ... he didn't go into detail ... but he'd had some difficult times in his life, and in telling me that, that encouraged me because it gave me hope for the future, because if he can do it then I can". (Jim).

The degree of disclosure between peer support worker and their client appeared to vary considerably but in each case was able to inspire hope for the

future in battling adversity. Jim articulates here that the limited disclosure he was offered, served to inspire hope in the potential of recovery.

Disclosure beyond mental health

Perhaps a natural assumption to make around peer support disclosure is that it would be limited to mental health. However, the service-users within this project reported disclosure in personal experiences, interests, values and perspectives.

“I was lucky with (PSW) that he had that interest in history ...because if somebody runs with something that you enjoy ... do you know what I mean? ... I think that you start trying to um ... I think you become more open to their interests as well”. (Ian).

Ian describes how the mutual interest in history with his peer support worker facilitated visits to historical sights and generated conversations that were of value to him. They were not saturated with discussing mental health but went beyond those boundaries that allowed Ian to be seen, and see himself, as a person not just a diagnosis. Ian also speaks of the expanding of his activities of interest and value which may serve to further develop the relationship.

Disclosing mental health experiences

Through disclosure between peer support worker and service-user, there is an interweaving of common experience of mental health difficulties and of being a service-user. This act serves to highlight similarities and develop a bond between the two. Harry highlights below the development of hope and inspiration through the narratives developed over time by the peer support workers in witnessing and recounting their recovery.

"I suppose when they tell their stories you look for little bits of positiveness from their stories, and it does help a great deal, far more than what I can probably convey in this conversation." (Harry).

All of the participants valued the disclosure they were privy to from their peer support worker but there remained a challenge of how much to disclose to the peer support worker and how to facilitate being able to ask about peer support workers' experiences which related to and is further explored in the theme of 'blurred roles'.

The product of disclosure

This theme describes the effects of disclosure and how this affects the peer support relationship. Whilst this theme will obviously make reference to disclosure it will be focused on the effects of this disclosure rather than the process. Service-users perceived their peer support workers as better able to understand them because of the shared lived experience. Whilst there is no way to objectively assess this understanding, it could be viewed as a product of disclosure and goes some way to enhance the working relationship between the two. This theme is rooted in the language of the service-user participants and offers insight into their perceptions of feeling understood by peer support workers. The disclosure of experience by peer support workers would appear to be the only method through which this understanding can be facilitated from the accounts within this study.

Through the establishment of shared mental health difficulties, personal experiences and mutual interests, a relationship built on commonality is developed. Through this a deep understanding or at least the perception of being understood is developed. Most participants made reference to the sense of feeling understood by their peer support workers.

"I think it's important, not only ... talking's very, very important, but not only just talking, it's talking to somebody that you can see clearly, and that understands". (Harry)

Harry highlights that it is not just the channel of communication being open and having someone available and willing to talk to and listen; it is the perception that they can understand your experiences and perspective. Alexa reflects this in struggling to understand her own experiences; her peer support worker is able to do this with her.

"Um, I dunno, if things come up she'll sort of, think, you know you say "Do you know what I'm talking about" and I say something that really does not make sense, she usually makes sense of it." (Alexa)

The sense of understanding that is a product of the sharing of experiences and perspectives is often held in contrast with service-users' experiences of working with other mental health professionals. Caroline's belief that her peer support worker understood her perspective was developed through the common experiences they have shared:

"You're like well how the hell do you know, what do you know about that really? Like, for example, with drug addicts, and they've got er Psychiatrists saying to them "You can do this" and it's "How do you know, it's not that easy, have you been on drugs"?" (Caroline)

Here, Caroline casts doubt over the legitimacy of professionals' understanding of a given area without having lived experience of it themselves. Having shared experiences and holding an identity as a service-user was seen to give the perception of being more understanding of the service-users' experiences.

"I've met people who have tried to give me advice. When you've left their company, you can tell that really it's from a training manual, you can tell, but when you know it's somebody who's been there and they've told you their story, and you realise what they've been through, I think that is the key difference." (Harry).

Harry speaks of the perceived book-learned knowledge accumulated by professionals in comparison to the peer support worker sharing personal insight and experience. For the majority of participants the latter knowledge and process of disclosing held great weight and value to them. This perception of enhanced understanding and experience of sharing experiences was described as therapeutic in its own right but also facilitated a stronger connection between participants and their PSW.

The theme 'the product of disclosure' reflects a sense of being deeply understood, often in contrast with other professionals they have worked with. Whilst the degree of disclosure varies between peer support worker and service-user, the perceived understanding that is a result of this always seemed to develop the relationship and be perceived as beneficial. It could be argued that role disclosure through the title 'Peer support worker' is sufficient to improve understanding and subsequent disclosure further enhances this⁷.

⁷ This section will be expanded in the extended paper

Dual roles

'Dual roles' highlights the unique position that peer support workers come to occupy as holding both professional relationships with their clients and being perceived as friends. This holds both potentially beneficial and challenging aspects that require negotiation and planning in order to manage and resolve successfully. The perceived 'friendship' between client and PSW is marked by a more relaxed relationship.

"You just feel so relaxed and I've never felt that under pressure about anything at all, I've just been myself." (Betty).

Betty recognises a lack of pressure she feels with her peer support worker, perhaps contrasting with other relationships she may have had. Allowing her to be herself engenders a more open and honest relationship with the peer support worker. This informality highlights the position of the peer support worker as being something akin to a friend.

Whilst informality might imply the content of conversations being superficial this was not found to be the case. Indeed, the flexibility to have both serious and less serious conversations allowed service-users to work at their own pace, over deeply personal content which may be difficult to conceptualise, articulate and acknowledge:

"I don't know, it's like quite relaxed and, like, and we can talk about serious things as well." (Alexa)

The relationship established between peer support worker and service-user was seen as somewhat closer to friendship than found in other professional relationships. All participants within the study made reference to the relationship being a friendship and viewed this as a positive thing.

“Not becoming their best friend, but becoming a friend but not their best friend” (Ian).

The relationship that develops may be conceptualised as a friendship by the service-users but there is an acknowledgement that the relationship is distinct and holds greater boundaries than a typical friendship.

“There’s only just so much you can talk to a friend about, isn’t there? And then again, there’s so much you can talk to a Peer Worker about, it’s all confidential.” (Betty).

Betty acknowledges the professional status of the peer support workers and the benefit this holds in relation to confidentiality. It would seem that the relaxing of boundaries would appear to be well received by service-users and perhaps why they perceive the relationship to be a friendship as opposed to a more typical professional relationship.

“She’s laid back, you know, Peer Support Workers, you know, they’re not like part of the Establishment, they’re more laid back and more friendlier.” (Faye).

Faye's reference to peer support workers not being part of the establishment highlights the dual position they hold. They are both professionally acknowledged through service-users' accounts of the knowledge and boundaries they establish yet somehow they are perceived to be outside of the traditional system. It would seem that the relationship that develops between service-users and peer support workers is distinct and provides something that other relationships are not able to. Yet there remain challenges to this relaxing of boundaries and the development of a more relaxed relationship.

"I felt really attached to her and um it felt more like she was my friend, really, and I just felt like it was really unfair that once we'd stopped working together we weren't allowed to be friends." (Eve).

Eve highlights here the difficulty in establishing and maintaining appropriate boundaries and holding the position of being a professional. For Eve the relationship that developed was a friendship represented by how close the two were and compounded by the absence of other relationships that may be perceived to be friendships.

"(Peer support worker) were very good in that she always made it very clear that she couldn't be our friend, she never made us think that like yeah maybe we could be friends one day, or anything like that. Whenever anything arised that were like out of the boundaries then she'd say "Oh I'm sorry but I'm a Peer Support Worker and that's as far as it goes". (Eve).

Eve highlights the conflict she found in the relationship. She recognises the boundaries set in place by the peer support worker yet expresses her dissatisfaction at them. Again there are comparisons made to current or previous relationships with

mental health professionals that serve to act as contextual markers for each participant, e.g.

“Yeah, you know for a fact that you’re seeing a professional and you pour your heart out to them but when you leave, you know you’re just on a conveyer belt when the next person walks in.” (Harry).

Here Harry identifies the lack of interpersonal connection and investment by the professionals he had seen. His description clearly indicates that the relationship is not one of friendship. This was clearly in contrast to how his peer support worker made him feel.. What is not clear is what exactly constitutes ‘too’ professional.

Whilst the friendship that appears to develop between service-user and peer support worker is perceived as being a positive step by all of the participants there are significant drawbacks such as when the relationship comes to an end, e.g.

“It was difficult, er, I mean I really missed him”. (Jim)

Jim spoke about the isolated position he had found himself in following his discharge from inpatient care. The support offered by his peer support worker had been well received and a strong relationship had developed. When Jim’s contact with the particular service within which his peer support worker was based ended his relationship with him had to finish as well. This proved particularly challenging for him and others in similar circumstances when there was a lack of other sources of social support.

Another area that was difficult to negotiate for service-users was when to discuss issues of that were potentially emotionally distressing with their peer support worker. This issue seems to have arisen because of the position of holding both professional and friendship roles. Several of the participants expressed concern about the welfare of the peer support worker should they disclose things of a personally distressing nature.

"I don't feel like I want to burden her." (Denise).

Denise feels conflicted with talking about her difficulties due to a concern about burdening her peer support worker. Whilst there had been significant disclosure within the relationship up until that point it remained a challenge, given the friendship that had developed to disclose more. This was not something articulated as being a problem with other professionals by any of the participants. There remain both opportunities and challenges to be negotiated by service-users and peer support workers because of the unique position occupied by the peer support worker.

'Dual roles' highlights the different position that peer support workers hold when comparing the relationship to that of friends and other professionals. It would appear to fulfil a role that others are not able to achieve, however doing so entails difficult negotiations with regard to enquiring about further disclosure, and managing endings. What 'dual roles' does is enable the peer support worker to be in a position that is intimately connected to the service-user whilst also holding professional boundaries.

Discussion

Within this section the findings will be summarised, integrated and related to the extant literature. Limitations of the study and opportunities for future research

that have been highlighted by this project will be recommended but explored in more detail in the extended paper. Further comment on the findings within this study and how they relate to those theories and models proposed by Salzer et al (2002) will be made in the extended results.

There were three themes constructed from the data; 'The process of disclosure', 'The product of disclosure' and 'Dual roles'. They highlight how disclosure encompasses mental health and wider lived experience, that disclosure would appear to lead to a sense of being understood by the peer support worker, and that the position of peer support worker is a tenuous balance between professional and friend that has some potentially beneficial points but also significant drawbacks. -

The findings relate most significantly to social identity theory (Tajfel & Turner, 1979) in combination with social comparison theory (Festinger, 1954). As previously stated, social comparison theory was proposed as one of the mechanisms underlying peer support by Salzer et al. (2002). According to this theory 'upward comparisons' are made with those deemed to be in a better position and these comparisons serve to inspire self-improvement and hope in the potential for recovery. Based on the accounts of service-users within this study upward comparisons may indeed be made with peer support workers, which may lead to the inspiration of hope and potential for recovery as described in the process of disclosure.

It would be important to consider whether every individual who may be perceived to be doing better than the service-user would be used within this upward comparison. Based on the accounts of service-users in this study the references that were frequently made about non-disclosing mental health professionals were through negative comparisons and how service-users struggled to relate to, connect

with and feel understood by these professionals. By comparison peer support workers are able to relate more easily having established commonality, a sense of being understood and an intimate connection through the informal relationship that has developed.

This raises questions regarding the selection process involved in making upward comparisons within this context. This is perhaps where social identity theory may be able to supplement social comparison theory. Social comparison theory (Festinger, 1954) would generalise those in a better position to be an aspirational figure but what seems to be evident from the constructed themes is that an in-group identity is developed through disclosure. According to social identity theory (Tajfel & Turner, 1979) individuals make self-categorisations to one or more group that serves to establish their sense of belonging in the social world. This establishment of an in-group also serves to establish out-groups. Based on the accounts of service-users within this project an in-group is developed through disclosure with the peer support worker. This is established by the identification of commonality, whether mental health difficulties, experiences as a service-user or more widely in life experience, interests or values. According to the theory there will also be the establishment of an out-group, which would appear to reflect non-disclosing professionals (Tajfel, 1981). Accordingly differences between these two groups may be exacerbated by in-group and out-group status being recognised. Whilst, according to the theory, there may be a benefit of service-users finding a sense of belonging socially and a resultant beneficial effect on their self-esteem, there may be drawbacks regarding the implications this has for relationships with other mental health professionals and would require further research to investigate. The model itself has several flaws including the failure to explain what may occur when an individual holds a position as peer support workers could be argued to. It also fails to explain the mechanism through which self-categorisation occurs.

The constructed themes from this research project pose significant questions for the position of peer support workers in relation to other health professionals. The ten essential shared capabilities (ESCs) are set out as best practice for all professionals working with service-users ((Brabban, McGonagle, & Brooker, 2006). These include 'working in partnership', 'promoting recovery', 'providing service user centred care', and 'making a difference'. Based on this research, peer support workers are perceived, through the process of disclosure, to understand the service users with whom they work more intimately than non-disclosing professionals. From this we might ask what peer support workers are able to provide beyond that described in ten essential capabilities, perhaps particularly in relation to 'working in partnership'. Given the potential for in-group and out-group differences to be exacerbated by the formation of this in-group identity the peer support workers might use their position of holding dual roles to identify similarities with mental health professionals. The professionalization of peer support workers may lead to a shift in alignment between other mental health professionals and service-users but is yet to be explored. Equally, non-disclosing professionals could be encouraged to find ways in which they may be able to establish similarity or common experience with the service-user in order to enhance the relationship. This would suit the peer support workers' current position of being embedded within MDTs and their role identified in previous studies for engaging 'hard to reach' individuals (Campbell & Leaver, 2003; Clay, 2005). It should be highlighted that any clinical implications would be tentative given the exploratory nature of this study and the local and situated theory that has been developed.

This research was evaluated using the guidelines described by Charmaz (2014) as to whether the constructed grounded theory could substantiate claims of credibility, originality, resonance and usefulness. This research provided an

interpretive substantive theory of the experience of professional peer support, however there are a number of limitations highlighted⁸.

One of the limitations of this study is based on the recruitment method. The peer support workers acting as gatekeepers to the study may have led to the perception of being personally evaluated and a concern only service-users with a good perception of peer support would be recruited. This was in spite of every reassurance to the contrary as well as efforts to circumvent the peer support worker and recruit individuals who may not have had as positive experiences of peer support through advertising at outpatient departments and involvement centres within the Trust. The reliance on recall from service-users is potentially a limitation of the study. Triangulation, which has many different definitions but for the purposes of this research will refer to the cross-referencing of different researcher's perceptions of the themes as a form of inter-rater reliability (Denzin, 1978). Whilst this is incongruent with the epistemological position of the author, a variety of sources that develop a rich and detailed explanation of the studied phenomenon would have been valuable. The clinical implications of this research are limited due to the situated nature of the findings in the experiences of a small sample. Whilst a small sample size is not a limitation in itself due to the objective being the attainment of theoretical sufficiency, the ability to generalise findings to wider settings is limited.

In conclusion this research highlighted the spectrum of disclosure from peer support workers that enables the service-user to feel understood. It offers a perspective on the tensions of holding dual roles being seen as both friend and professional and the informal approach that is apparent within peer support relationships. It highlights the central importance of disclosure as a means to

⁸ See extended discussion

establish in-group identity. This was a process identification study, which could simply be described as a means of exploring the underlying processes involved in the studied phenomenon which limited the potential clinical implications at this early stage. Whilst we would hesitate to make recommendations for changes in clinical practice or training, were the theory to find further support we may make a number of recommendations⁹. Support and supervision for peer support workers in managing their tenuous role should be highlighted as being significant. Further, high quality research is necessary to establish whether the theory developed within this research may be supported in other settings.

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⁹ See extended discussion

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EXTENDED PAPER

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Introduction

This section identifies key literature relevant to this study and moves from the broad topic of recovery in mental health, through general principles of peer support to professional peer support, which constitutes the area researched within this study. Also discussed is the evidence around peer support and the mechanisms that are reported to underpin it. During the study it became apparent that other theories were relevant to the project but had yet to be discussed within the literature and are therefore outlined here. This section concludes with the aims of the project in light of a gap within the literature around peer support.

Recovery

Recovery has become an important aspect of both UK (Leamy, Bird, Le Boutillier, Williams, & Slade, 2011) and US (Davidson & Roe, 2007) government policy. However the use of the term recovery within outcome research, service design and provision, system reform and personal narratives has led to confusion as to its definition (Davidson, O'Connell, Tondora, Lawless, & Evans, 2005; Jacobson & Greenley, 2001). It has received criticism and has been a contested concept for being blurred as both a process and an outcome (Roe, Rudnick, & Gill, 2007). This is due to the confusion between clinical recovery (an outcome) and personal recovery (a process).

As a measure used by clinicians it can be outcome-oriented and has been described as dichotomous in nature; either you have recovered or you have not. According to Slade (2009) clinical recovery identifies change as observable, is rated by the clinician not the service-user and the definition is invariant. However, this account of clinical recovery does not account for outcome measures completed by service-users yet interpreted by the clinician.. Clinical recovery has been described as the amelioration of symptoms and deficits to a significant degree so that they no longer interfere with social, vocational and personal activities and functioning (Davidson et al., 2005). One may argue however that if clinical recovery is dichotomous the degree to which one recovers is irrelevant, either you have or you

have not. This incongruence highlights differing accounts of clinical recovery within research and clinical practice. Other factors that may be included in clinical recovery could be a return to full or part-time work or education, independent living, having friends to share activities with and this being sustained for two years (Lieberman & Kopelowicz, 2005; Lieberman, Kopelowicz, Ventura, & Gutkind, 2002).

Personal recovery¹⁰ was born out of a service-user movement in the 1970's involving service-users acting as advocates and champions for living a life of value and substance whilst still being defined under diagnostic themes (Davidson & Roe, 2007). Deinstitutionalisation was also a significant period for recovery advocates where rehabilitation shifted to include treating the consequences of an illness not just its symptoms such as unemployment, addressing stigma, social networks etc. (Anthony, 1993).

Recovery has been defined as “a deeply personal, unique process of changing one’s attitudes, values, feelings, goals, skills and/or roles...a way of living a satisfying life even with the limitations caused by the illness” (Anthony, 1993, p. 17). This type of recovery does not necessarily involve an absence of symptoms but involves the active management of the difficulties one faces and “living one’s life, pursuing one’s hopes and aspirations, with dignity and autonomy, in the face of the on-going presence of the illness” (Davidson & Roe, 2007, p. 464). Recovery does not change the fact that the experience has occurred, that the consequences may still be experienced and that an individual’s life has changed forever (Anthony, 1993). Recovery acknowledges mental health difficulties as one aspect of an otherwise whole person (Davidson et al., 2005). The development of these other, often neglected, aspects of the individual are of central importance to recovery principles.

¹⁰ Future reference to recovery within this work will refer to recovery as opposed to clinical recovery unless stated otherwise.

Recovery may also include recovery from being a mental health patient including poverty, housing issue, isolation, unemployment, loss of valued social roles and identity, loss of a sense of self and purpose as well as addressing the iatrogenic effects of involuntary treatments from mental health services (Davidson et al., 2005).

Recovery may also means different things to different people (Davidson et al., 2005; Slade, 2010). Goals and outcomes vary significantly between individuals and require services and those supporting the individual to be able to provide a diverse breadth of interventions and means of support to facilitate the individual to recover in a way that is personally significant to them. This means that the measurement and assessment of recovery using traditional research methodologies is particularly difficult (Onken, Craig, Ridgway, Ralph, & Cook, 2007).

For some people recovery to a pre-illness state is impossible and indeed for others it is not wanted (Jacobson & Greenley, 2001). If one does not want to simply recover to a pre-illness state the outcome includes growth and expansion beyond what was previously achieved (Davidson et al., 2005). However, how growth may be measured as an achievable outcome is somewhat less clear.

There are a number of authors who propose central tenets to recovery-oriented practice. Dihoff and Weaver (2012) reference ten different factors that have been identified through a consensus statement to be important for recovery: a) the individual being self-directed, having choice available to them and taking control of their own recovery b) an individualised and person centred approach c) active participation in one's own recovery d) a holistic approach to recovery involving multiple aspects of an individual's life and well-being e) the approach should be

strength based as opposed to deficit reducing, building on an individual's capacities
f) acknowledgement that recovery is non-linear g) peer support and the sharing of
experiential knowledge h) respect, acceptance and appreciation from those around
the individual i) an individual taking responsibility for his or her own self-care and
recovery j) the instillation of hope

Mead and Copeland (2000) identify only five overarching factors involved in recovery; hope, an individual taking responsibility for their own recovery, education, the practice of advocating for oneself and peer support. Whilst there is a degree of overlap between different conceptualisations there is also considerable difference. This makes comparison more complex especially when measuring and comparing change in outcomes. For a thorough review of the recovery literature see (Davidson et al., 2005; Slade, 2009).

Peer support

Many authors including those cited above have identified peer support as being a central component of recovery-oriented practice. Peer support is defined as being "based on the belief that people who have faced, endured, and overcome adversity can offer support, encouragement, hope and perhaps mentorship to others facing similar situations" (Davidson, Chinman, Sells, & Rowe, 2006, p. 443). Peer support is also based on the premise that "people who have like experiences can better relate and can consequently offer more authentic empathy and validation" (Mead & MacNeil, 2006, p. 30). One may question how you would measure the authenticity of empathy; it is surely the perception of empathy from the recipient's perspective that is of significance.

It has been reported that there are twice the number of services run by and for people and families affected by mental health difficulty than traditional, professionally run mental health services in the USA (Goldstrom et al., 2006). The assumption might be that this growth based on success but this remains unclear. The

growth of peer support in all its many forms has been the focus of significant research efforts in the USA (Davidson et al., 2012) and across many other countries such as Brazil, Israel and the Netherlands (Weingarten, 2012), the UK (Bradstreet & Pratt, 2010), Australia (Lawn, Smith, & Hunter, 2008) and Canada (Grant, 2010) to name but a few. Peer support has been acknowledged within addiction, trauma and cancer as being of value yet there remains a stigma for those experiencing mental health difficulties (Davidson et al., 2006).

Peer support is an umbrella term for a number of approaches utilising lived experience of mental health difficulties. There are a number of different and distinct forms of peer support but the dissemination of research findings has often failed to make these distinctions (Bailie & Tickle, 2015).

Types of peer support

Three distinct categories of peer support will be reviewed below; mutual support groups, consumer-run services, and professional (intentional) peer support (Bradstreet, 2006; Davidson et al., 1999; Repper et al., 2013). There are a number of types of relationship described by Davidson et al (2006) that are positioned along a continuum from one-directional to reciprocal. The example given of one-directional is within psychotherapy and the example of reciprocal is friendship. It could be argued that neither of these could be considered static relationships and no relationship considered truly one-directional as therapists will learn from the clients they work with and gain something from the relationship. Professional peer support is thought to fall somewhere close to the centre of this continuum. A brief overview of each category of peer support will be discussed.

‘Informal’ mutual support groups

Mutual support is a process by which people voluntarily come together to help each other address shared concerns or difficulties. The impact of this type of support became evident during the deinstitutionalisation of hospital services and a

move towards care in the community. This highlighted that hospitals, and the communities that were developed within them, served to function as a source of social support for service-users. The premise upon which mutual support is built is that by sharing life experiences with others, a person can improve their understanding of their difficulties and improve their social support (Davidson et al., 1999). This process of using one's experiences to help others is a socially valuable role. It also challenges the perception that service-users are passive and beholden to mental health services, and this process has been coined the helper-therapy principle (Riessman, 1965).

Mutual support is distinct from naturally occurring peer support found between individuals due to its set procedures and ways in which difficulties are addressed. This is typically learning new behaviours or ways in which difficulties can be managed as well as being exposed to role models who are further along in their journey of recovery (Davidson et al., 1999). Examples of mutual support groups are alcoholics anonymous and the hearing voices network.

Consumer-run services

Consumer run drop-in centres and residential, outreach and vocational programmes are another form of peer support (Chamberlin, 1990). Like mutual support consumer run services involve a voluntary and intentional effort by the individual to take advantage of the support available by their peers. The difference between the two concerns the lack of mutuality, with the service provider not seeking or gaining support from the individuals involved in the project. Whilst peer support may be mutual between members this is not the case for workers. However as these types of services lie outside of typical professional and therapeutic boundaries there have been questions raised about the degree to which these are mutual as opposed to one directional. There also tends to be more structured activities and interactions, and a consistency that may be lacking in mutual support groups (Davidson et al., 1999).

Professional (Intentional) peer support

It is important to note that within the peer support literature there are a number of terms that are used in reference to peer support that are again quite distinct. In some studies the term consumer-provider may be used and may well refer to intentional peer support as described in this project, but may also apply to individuals who have experienced a mental health difficulty that now work within the mental health system. Whilst they are both effectively providing a service the intentional peer support is defined by the use of one's lived experiences to support others with similar difficulties. This confusion has led to the aggregation of studies that use the terms synonymously, when in fact they are quite different (Bailie & Tickle, 2015; Davidson et al., 2006).

The first reports of professional peer support workers were during the early 90's where individuals who had experienced mental health difficulties were employed as case managers (somewhat equivalent to care coordinators in the UK) or case manager aides (Nikkel, Smith, & Edwards, 1992; Sherman & Porter, 1991). This type of peer support differs from consumer run services and mutual support groups, as the nature of the relationship is not reciprocal. It is a one-directional relationship with one provider and one recipient of care (Davidson et al., 2006). Consistent with positive psychology and recovery principles utilising the peer's lived experience this type of work promotes a wellness model, as opposed to an illness model, which promotes strengths and positive aspects of an individual's life (Seligman, Steen, Park, & Peterson, 2005). Peer support workers use their lived experience to help others in similar circumstances overcome the difficulties they are facing (Repper & Carter, 2011). According to Repper and Carter (2011) there is still a degree of reciprocity within peer working that goes some way to avoid the power imbalance that typifies staff-patient relationships found in statutory care (Mead, Hilton, & Curtis, 2001).

The role of peer support worker

There has been little emphasis within the literature with regards to the specific role of professional peer support workers. Davidson et al. (2006) identified functions for peer support workers including developing acceptance, expressing empathy which may lead to increased hope, improving self-efficacy and willingness to take personal responsibility for one's recovery, offering understanding, role modelling, providing practical information, support to access community facilities, development of coping strategies and problem solving skills. There is considerable overlap with recovery principles in the potential functions of peer support worker. The peer support worker role can also challenge stigma, discrimination and bias and emphasise socially inclusive practices and a holistic view of mental health difficulties (Mowbray, Moxley, Jasper, & Howell, 1997). It is clear that the breadth of work potentially encompassed by peer support worker is profound. With such a broad range of functions the potential benefits for service-users are numerous and one of the reasons it has been incorporated into health policy. However there are also a number of challenges for services and peer support workers themselves. As stated previously the potential detrimental effects of peer support work on service-users has yet to be explored specifically but no study has thus far determined a potential risk. Challenges to peer support workers include low pay and hours, lack of social inclusion within teams, negative and rejecting attitudes from non-peer staff, managing relationships as provider of care and friend to service-users (Walker & Bryant, 2013).

Peer support and health policy

According to Bradstreet (2006) recovery principles within clinical practice are most advanced in New Zealand and the US. However as an active part of the recovery agenda within government and local service policy peer roles are actively being recruited within mental health trusts across the UK. This is in order to address issues of service quality and costs for health service providers (Gillard et al., 2014). It has been identified that peer support worker may address health policy relating to self-care (Department of Health, 2006), personalisation (Department of Health, 2009) and recovery (Department of Health, 2011). There is however, a tenuous link

to these potential outcomes due to a lack of high quality evidence (Lloyd-Evans et al., 2014; Pitt et al., 2013).

The cost-improvement implications would appear to be a driving force behind peer support worker recruitment and this is supposed to be achieved through adjusting the skill mix of frontline staff, namely the addition of peer support workers supplementing or replacing existing staff (Department of Health, 2009). In a time of austerity mental health trusts are faced with making significant cost improvements for which the employment of peer support workers, typically employed at band three of the agenda for change pay scheme, instead of existing staff may be an attractive opportunity (Hutchinson et al., 2006). However, the cost-effectiveness of peer support workers has yet to be evidenced (Gillard et al., 2014).

There is a specific remit within a relatively new mental health strategy focused specifically on developing and demonstrating new peer support worker roles (Department of Health, 2011). However, questions have been raised about policy and service development outpacing the research to support it (Bailie & Tickle, 2015; Gillard et al., 2014). According to the Medical Research Council's (MRC) guidance for evaluation of complex interventions, sufficient theoretical, modelling and piloting work needs to be completed in relation to complex organisational or service level interventions before they are incorporated into clinical practice (Medical Research Council, 2000). Whilst there certainly has been some theoretical and piloting work there is a question as to whether this would constitute 'sufficient'.

Peer support: What does the evidence say?

With such broad mechanisms can research effectively measure change? There has been research conducted on the effects of peer support on the peer support worker themselves, and for the service in which they are employed, but for the purposes of this study the findings will be confined to the effects of peer support

worker on the recipient of that care. Research on these other outcomes can be reviewed elsewhere (Bailie & Tickle, 2015; Gillard et al., 2013; Repper & Carter, 2011).

The effects of peer support work

It is important to consider what effects one might expect to see from peer support worker. Whilst aspects of clinical recovery are typically measured within studies evaluating peer support workers, it is perhaps unlikely that these might change dramatically given recovery-oriented interventions focus on living a life with a difficulty not ameliorating symptoms. As discussed previously there are a number of different functions that peer support workers may perform such as increasing hope, improving social support etc. These are perhaps measures one would more realistically expect to change.

A Cochrane review (Pitt et al., 2013) highlighted a small amount of low to moderate evidence from three studies that there is no significant difference between consumer-providers and non-peer staff on quality of life, function or social relations after 12 months of case management (Rivera, Sullivan, & Valenti, 2007; Sells, Davidson, Jewell, Falzer, & Rowe, 2006; Solomon & Draine, 1995). No significant differences were found in measuring group Cognitive Behaviour Therapy (CBT) administered by peer compared to non-peer staff on measures of depressive symptoms (Bright, Baker, & Neimeyer, 1999; Solomon & Draine, 1995). Two low to moderate quality studies found no significant difference in patient satisfaction of peer compared to non-peer staff. Two low to moderate quality studies found a small but significant reduction in use of crisis services in peer intervention compared to non-peer but no change in hospital admissions (Clarke et al., 2000; Solomon & Draine, 1995). It is unclear the reasons why crisis services were utilised less and appears to be open to a number of interpretations. There was no difference in uptake of mental health services (Rivera et al., 2007; Solomon & Draine, 1995) or attrition (Bright et al., 1999; Sells et al., 2006; Solomon & Draine, 1995) when comparing peer delivered interventions with non-peer.

There is limited evidence from two low to moderate quality studies that the addition of peers to mental health services did not have an impact on psychosocial outcomes such as quality of life, function and social relations (Craig, Doherty, Jamieson-Craig, Boocock, & Attafua, 2004; O'Donnell et al., 1999). Both of these studies provided only limited training to peers who had never performed this type of role before. Results indicated that there was no significant impact on service-user satisfaction.

The conclusions of the Cochrane review highlight that peer staff can perform an equivalent role to non-peers with limited training and experience. It is consistent with the conclusions of Davidson et al. (2012) who reviewed the same research and dubbed them feasibility studies for the inclusion of peer workers within mental health services. Davidson et al. (2012) go on to highlight four studies that the authors believe leads to consistently beneficial effects on engaging difficult to reach service-users, reducing rates of hospitalisation and days spent as an inpatient, and decreased substance use beyond that achieved by non-peer staff (Davidson et al., 2000; Rowe et al., 2007; Solomon et al., 1995; Wexler et al., 2008).

The most recent systematic review and meta-analysis of randomised controlled trials (RCT) concluded that there was little current evidence for peer support worker in any of its three forms. The results were marred by poor quality studies at serious risk of bias of factors such as blinding of participants, selectively reporting outcomes, and incomplete data. The only positive aspect that was identified was the limited evidence for improvements in recovery-oriented processes such as hope, empowerment and self-rated recovery although these results were inconsistent and again influenced by bias (Lloyd-Evans et al., 2014). The overall low quality of studies incorporated within the reviews highlights a need to remain critical of findings and for increased high quality research within the field.

The conclusions of authors who evaluate the same studies appear to be inconsistent in reference to the effectiveness of peer support.

Whilst there remains an absence of high quality RCTs to examine the effects of peer support worker there is some evidence available from qualitative studies (Repper & Carter, 2011). The derived themes and issues identified within qualitative studies are not intended to be generalised to wider groups and should be seen as local and time specific. There have been reports of an improved sense of empowerment, reduced perception of stigma (Ochocka et al., 2006), bonding through experiential knowledge, improved sense of understanding (Coatsworth - Puspoky, Forchuk, & Ward - Griffin, 2006), better rapport compared to non-peer staff (Doherty, Craig, Attafua, Boocock, & Jamieson-Craig, 2004; Paulson et al., 1999) and social support and social networks (Chinman et al., 2008; Davidson et al., 2001; Ochocka et al., 2006). Furthermore, peer support worker can be perceived as role models by their service-users (Chinman et al., 2008; Doherty et al., 2004; Moll, Holmes, Geronimo, & Sherman, 2009; Mowbray, Moxley, Thrasher, Bybee, & Harris, 1996). Qualitative research has failed to investigate the potential detrimental or challenging aspects of peer support work for both clients and peer support workers to any degree and there is a tendency to place a positive spin whilst highlighting the potential benefits.

Challenges of employing peer support workers

Whilst we have restricted the literature contained within this work to the effects on the recipients of peer support work during the course of the research there appeared to be issues emerging that may have overlap with previous research and have contextual relevance. Whilst this is not a systematic review it highlights key issues relevant to the themes constructed within this research.

Issues of concern around confidentiality and the potential for peer support workers to compromise confidentiality give the potential for there to be pre-existing networks of relationships with service-users (Gates & Akabas, 2007). There has

however not been published concerns regarding the peer support worker's ability to work within confidentiality policies.

Fox and Hilton (1994) identified there being conflict relating to the employment of peer support workers and the dual roles they held as friends and professionals. There were concerns raised regarding working relationships between peers and service-users where there was a pre-existing friendship and how this may influence the work they undertook and how the peer would manage this conflict.

There has also been a concern raised by peer support workers regarding their position. It was highlighted that training leading towards professionalism detracts from the advantage of being a peer (Dixon, Krauss & Lehman, 1994). In this way the peers involved in this study actively wanted a position that was distinct from other professionals and set them apart. The research highlighted within this section is in places twenty years old and the evolution of peer support programmes has moved on significantly during this time, therefore caution should be given when interpreting the information provided.

So how might peer support work?

The broad variety of possible mechanisms identified earlier and the variability in measures used to assess the effectiveness of peer support worker draw us back to the question of how peer support actually works. There has been relatively little research conducted in this area but shall be summarised below.

The most frequently referenced text in identifying mechanisms underpinning peer support proposed five theories that may contribute to peer support worker (Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002). These authors do not specify which type of peer support they apply their proposed theories to and appear to aggregate peer support into a homogenous group. These theories will be briefly reviewed here.

Social comparison theory

Originally developed by Festinger (1954) this theory states that individuals use social comparisons to determine social and personal worth. Individuals therefore make constant self and other evaluations across a variety of domains. When applied to this population, individuals seek out others with similar illnesses in order to normalise their experiences through positive comparisons (Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002). Comparisons made between individuals and tend to be upward or downward. Upward comparisons are essentially aspirational. They are made with those who are perceived to be doing better, in this case in their recovery, and these comparisons motivate individuals to increase self-improvement skills. These comparisons also serve to increase hope by having achievable goals to measure. Interactions and comparisons with those less fortunate (downward comparisons) serve to maintain self-esteem and maintain affect by recognising how bad things could be. The validity of this explanatory theory has yet to be evidenced within peer support worker or as having mental health difficulty as a comparative domain. Social comparison theory has received criticism as individuals are also reported to actively seek those they do not easily compare to in order to make social comparisons, which cannot be accounted for by this theory (Deutsch & Krauss, 1965). This theory has also received criticism for the lack of clarification regarding which characteristics individuals choose to compare themselves with (Goethals & Darley, 1977).

Social Learning Theory

Bandura (1971), amongst others, proposes that a change in behaviour may result from interactions with peers who act as more credible role models than non-peers. peer support workers in recovery provide examples of individuals coping with the challenge of mental health difficulties (Solomon, 2004) and could therefore be perceived as credible role models. Social learning theory relates specifically to educational aspects of the relationship and role-modelling self-care. The influence a role model has over one learning from them is dependent on certain characteristics, the attributes of the observer and the perceived consequences of adopting the

behaviour (Bandura, 1977). The peer support worker must be perceived to have high status within the peer group in order for the service-user to be motivated to adopt their demonstrated behaviour (Turner & Shepherd, 1999). There is an assumption that the service-user will prejudice the status of being a mental health peer over any other characteristics in order for them to be assumed a credible role model. What would happen if they shared the status of service-user but held substantially different experiences, values, attributes etc.? service-user's would also need to be able to observe the peer support worker practising the positive health behaviour.

Interactions with peer support workers are proposed to increase self-efficacy, which in turn increases optimism and enforces positive treatment-related behaviour (Solomon, 2004) however this linear argument lacks specificity of how this might be achieved. If we are to assume that a peer is a more credible it highlights the question of who exactly is a peer. The only research conducted on who constitutes a peer found considerable disagreement as to similarities in which characteristics constituted a peer including that of gender, ethnicity, culture, diagnosis, age, sexual orientation, faith etc. (Faulkner & Kalathil, 2012).

Social support

Social isolation has a well-established relationship with mental well-being (Kawachi & Berkman, 2001; Thoits, 2011). Indeed social support has been attributed with buffering the effects of stress (Cohen, 2004; Dean & Lin, 1977). Social support is a very broad term that has been defined as the “process of interaction in relationships which improves coping, esteem, belonging, and competence through actual or perceived exchanges of physical or psychosocial resources” (Gottlieb, 2000, p. 28). However there are varied interpretations of what social support actually means and these have been used “loosely and interchangeably” (Berkman, Glass, Brissette, & Seeman, 2000, p. 844). Peer support is reported to include emotional support by providing someone to confide in who provides esteem, reassurance, attachment and intimacy. Instrumental (services,

money, transportation etc.) and informational support (advice, guidance, problem-solving etc.) are included as well as companionship and validation (Salzer & Mental Health Association of Southeastern Pennsylvania Best Practices Team, 2002). It is reported that social support is especially important in mutual support groups (Solomon, 2004). This may play a less significant role in individual support found within professional peer support worker relationships but there is no empirical evidence of this.

Experiential knowledge

It is proposed that experiential knowledge is held in contrast with professional knowledge acquired by mental health professionals (Borkman, 1999). Experiential knowledge is distinguished from professional knowledge by the pragmatic rather than scientific approach, oriented to the here and now as opposed to the long-term accumulation of knowledge and holistic rather than segmented. This is perhaps an unfair description of knowledge accrued by mental health professionals which includes recovery oriented processes that are holistic (Slade, 2009). Because the said knowledge has been abstracted through inference and experience in working with individuals, or through education and training does not mean that it is any less legitimate than that acquired by a service-user. Indeed the heterogeneity of experiences that encompass mental health difficulties highlight the potential lack of generalizability of a service-user's knowledge based on their own experiences. It could be argued that professional knowledge can be both pragmatic and scientific, focused on the here and now (especially in reference to psychological therapies such as CBT and Solution Focused Brief Therapy (SFBT)).

Borkman (1999) bases his theory on mutual support groups but this may have application to peer support worker relationships as well. These views may offer alternative worldviews or ideologies to the traditional mental health system. According to Borkman (1999) this is an antidote to passivity that is an iatrogenic effect of mental health services. It is argued that "experiential knowledge promotes choice and self-determination that enhances empowerment" Salzer et al. (2002, p.

6). Surely it is the application of this knowledge and the approach taken to the service-user that would determine whether choice, self-determinism and empowerment are encouraged not the means by which knowledge was acquired.

Helper-therapy principle

As mentioned earlier the helper-therapy principle (Riessman, 1965) has been proposed as a benefit of one individual helping another. Riessman (1990) believes that the iatrogenic effects of being helped under traditional mental health services can be addressed by a more reciprocal role where both may mutually benefit. Whilst this may make reasonable sense there is a certain ethical dilemma when one of those who will mutually benefit is a state employed professional. Is it the service-user's responsibility to support or care for a professional? It is believed that the helper-therapy principle results from an increased sense of interpersonal competence by making an impact on another's life, the development of a sense of equality by giving and taking between two individuals, gaining new personally relevant knowledge through helping, and social approval from the person they help (Solomon, 2004). This theory has clear application within mutually supportive relationships but is less convincing when applied to the less reciprocal relationships found between professional peer supports and service-users.

Proudfoot et al. (2012) conducted a study as an adjunct to an RCT using qualitative methods to explore whether four of the proposed theories were useful in explaining effective peer support in service-users newly diagnosed with bipolar disorder. Social learning theory was not included within the study and no explanation given as to its absence, however this could be due to the support offered via email-exchanges rather than face-to-face contact. The study examined whether examples of these four theories (social comparison theory, social support, experiential knowledge and the helper-therapy principle) were present during email exchanges between 44 service-users and their informed supporters (an equivalent role to peer support worker). The authors report that a selection of the emails were collated and analysed yet give no explanation as to why all emails were not

analysed or how these emails were selected. The informed supporters within the study were also invited to take part in an interview conducted by a medical student supervised by the first author. Both email exchanges and interview transcripts were analysed using content analysis, in this way making the analysis a purely deductive process without room for further explanation of other processes involved in peer support. It was deemed that if either participant or informed supporter gave examples that applied directly to these theories this was an indication of the theories value within peer support. The helper-therapy principle applied only to the informed supporter not from the service-user's perspective. The number of emails exchanged ranged from one to 15. There were a number of examples from both informed supporters and service-users that demonstrated clear links with each of the proposed theories, however the reliance on a deductive method prevented the exploration of how other theories or processes may be involved.

In summary, there is coherence of each individual theory and logic as to how they would be applied to professional peer support with the exception of the helper-therapy principle, however there is a failure to integrate these theories into a coherent model. Solomon (2004) who references Salzer et al. (2002) identifies that these five theories have been inferred within the area of mutual support rather than being empirically evidenced. She believes this is due to the difficulty in applying traditional research methods to this particular culture. She supports the proposed theories as explanatory theories of peer support whilst acknowledging their lack of evidence. This paper has often been referenced as giving an explanatory account (Davidson et al., 2012; Rogers et al., 2007) and yet there is little empirical evidence to support this.

Overarching Explanations

Davidson et al. (2012) utilise these five theories and incorporates them into their explanation alongside other literature (Davidson, 2003; Davidson, Weingarten, & Steiner, 1997; Mead et al., 2001), but there remain only tentative links with

empirical accounts. Davidson et al. (2012) report three basic contributions of peer support that would be unique to or well suited for peer staff.

The first of these is the instillation of hope through positive self-disclosure, demonstrating the ability to gain control over one's life. One may question why disclosure used by professionals could not fulfil the same function. The second expands role modelling to include self-care and exploring experiential knowledge of peer support workers to manage their life, not limited to symptoms but including issues around housing, finances and stigma. The third contribution is the use of empathy which when paired with conditional regard (described as the ability to "read" the service-user) allows them to place greater demands on their service-users, believing that it is possible to recover with hard work. One could also argue that a professional who held a strong therapeutic relationship with a client may be able to read their client. Empathy holds a central place within therapeutic relationships and it could be challenged that this is a role unique to peer support workers.

Supplementary Theories

Whilst these principles appear to be rooted in the experience of service-users and have a coherence that makes them plausible, they lack transparency in moving from the source data to the conclusions. During the course of this study further literature was considered significant and will be discussed here.

Professional disclosure

It is somewhat surprising that given the role of peer support workers involve an implicit assumption that disclosure of some kind will be offered, that there has been no mention of the professional disclosure literature. This focuses on disclosure within therapy and it is estimated that 90% of therapists will disclose at some point (Edwards & Murdock, 1994) and 3.5% of interventions offered by therapists are disclosures (Hill & Knox, 2001). These are somewhat misleading statistics to the casual reader as there are many types of disclosure. Therapist self-disclosure (therapist-self-disclosure) has been defined as "behaviours, either verbal or non-

verbal that reveal personal information about therapists themselves to their clients” (Constantine & Kwan, 2003, p. 582). Henretty and Levitt (2010) described five different types of disclosure in their guidelines: demographics (education, marital status, age etc.), feelings/thoughts about the client or relationship, therapy mistakes (repairing ruptures), relevant past struggles that have successfully been resolved, and similarities between client and therapist. Each of these may have relevance to peer support but the last two perhaps appear more pertinent.

Therapist self-disclosure would appear to vary according to the training and theoretical orientation of the therapist. Traditionally psycho-analytic therapists view themselves as the blank canvas for client’s to project their transference distortions onto (Henretty & Levitt, 2010) yet more recently therapists of this model have paid more attention to the potential value of disclosure (Knox & Hill, 2003). Rogerians were reported to be the first to adopt the practice of therapist-self-disclosure (Farber, 2006) modelling openness, strength, vulnerability and the sharing of intense feelings. It was thought that this would cultivate trust, perceived similarity, credibility and empathic understanding (Henretty & Levitt, 2010). It is also reported that realness and authenticity are vital in encouraging service-user’s own openness, intimacy, trust, self-understanding and change (Rogers, 1951). Lane and Hull (1990) believe therapist-self-disclosure normalises human struggles, and makes the therapist appear more humane and enables them to serve as role models. This may also act to equalise power in the relationship (Jourard, 1971). Despite these mechanisms appearing logical and coherent there is a lack of empirical evidence to support this. There is no clear description of how therapist-self-disclosure achieves these goals. There would however, appear to be considerable overlap in the proposed mechanisms of therapist-self-disclosure and the aims of peer support and recovery principles.

The evidence around disclosure is contradictory and is somewhat confused due to differing theoretical conceptualisations of what constitutes disclosure.

Therapists receive little training and there are very limited guidelines which may leave therapists vulnerable and anxious about self-disclosure (Hill & Knox, 2001; Knox & Hill, 2003). Empirical findings rely mainly on analogue methodologies essentially involving participants rating the usefulness of disclosures within vignettes. The ecological validity of these studies is somewhat questionable given participants are not in therapy and there is no therapeutic relationship established. The evidence is arguably in favour of therapist-self-disclosure though it may also be deemed detrimental (Knox & Hill, 2003). The specifics of when, what and how to disclose are aggregated amongst the different types of therapist-self-disclosure confusing already vague guidelines.

Not all researchers and therapists are proponents of therapist-self-disclosure however and it has raised questions about the incongruence between therapist-self-disclosure and the therapist role (Barnett, 1998). Indeed it is believed inappropriate disclosure may prevent the therapists' role from being clinically effective or even in role reversal (Lazarus & Zur, 2002). It is believed that appropriate therapeutic boundaries provide a framework that guides the service-user's expectations about therapy and distinguishes it from other social experiences (Smith & Fitzpatrick, 1995). It could therefore be argued that providing therapeutic boundaries are maintained appropriate therapist-self-disclosure could be a beneficial strategy.

Supportive relationships

It would appear that the relationship between the peer support worker and service-user is central to the focus of peer support worker yet there remains little research examining this relationship. There are a number of therapeutic relationships that may display some similarities to the peer support worker relationship and will be discussed below.

Nurse-patient relationship

The nurse-patient relationship has received a great deal of attention over the years and there have been a number of authors who have made a substantial contribution to our understanding of the theoretical aspects of this relationship.

Peplau (1988) spoke of the nurse-patient relationship as a significant therapeutic interpersonal process. Whilst Peplau speaks of nursing as a whole and psychiatric nursing being quite distinct from other fields this sentiment remains valid. The nurse-patient relationship has also been described as being “an interpersonal, transactional process that aims to affect a positive change” (Cameron, Kapur, & Campbell, 2005, p. 64).

These relationships have been described in linear terms, evolving through stages, taking time to develop trust and is viewed as the primary vehicle of change and key to successful health outcomes (Hagerty & Patusky, 2003). This relationship has been described as having three parts; collaborative tasks that have been mutually understood, bonds that encompass a sense of compatibility, trust, respect and caring, and goals that are mutually derived based on service-user readiness (Shattell, Starr, & Thomas, 2007).

Nurses form a core part of current mental health practice and their positions within inpatient and community settings often involve being care coordinators. This position and current clinical practice enable nurses to have frequent contact time with their service-users, enabling them to utilise this relationship. The current demands on nurses’ time and high caseloads may not allow nurses to make best use of this. Indeed research suggests that time spent talking to patients by nurses is minimal and are neither purposely therapeutic nor theoretically informed (Whittington & McLaughlin, 2000).

In a study of service-users’ perceptions of what constitutes an excellent mental health nurse the focus remained on being treated holistically and with a human touch. Interestingly none of the participants focused on the clinical knowledge, technical skill and textbook communication techniques that are seen as core aspects of the role. Compassion, attentiveness and engagement were prized by participants alongside the instillation of hope in recovery (Gunasekara, Pentland,

Rodgers, & Patterson, 2014). In this way the specifics of the nursing role would appear to be less important than the relationship in general.

Therapeutic relationships

Therapeutic relationships have received an enormous amount of attention within research and there are a number of terms that are used synonymously such as working alliance or therapeutic alliance (Lasky, Taylor, & Weist, 2012). Whilst there is an argument for distinguishing between them, for the purposes of this research the term therapeutic relationship will be used. This has been described as the relationship between health professionals trained to provide treatment to those that require it (McCabe & Priebe, 2004). Consistent with the literature surrounding relationships within mental health settings the therapeutic relationship has a central role in helping to bring about recovery (Borg & Kristiansen, 2004). As has been described relatively consistently the therapeutic relationship is viewed to be a reliable predictor of service-user outcomes in psychiatric care (McCabe & Priebe, 2004). The perceptions of service-users have also confirmed that the therapeutic relationship can help or obstruct recovery (Green et al., 2008; Schön, Denhov, & Topor, 2009; Topor, Borg, Di Girolamo, & Davidson, 2011; Topor et al., 2006).

This relationship is described as a connection between two people including a bond, trust, warmth, mutual positive regard, feeling allied and a positive working relationship alongside shared goals (Lasky et al., 2012). Rogers (1965) investigated the process of therapeutic relationships and concluded that there are six fundamental principles that underpin this. These have been more recently referred to as the triad of therapist offered conditions of empathy, genuineness and unconditional positive regard (Josefowitz & Myran, 2005).

Helping relationships

Helping relationships refer to relationships between two or more individuals that are less concerned with the profession of those involved. Indeed these may apply to fellow service-users, friends or family members. It has been reported that social support from family and friends, professionals and service-users is a decisive

factor in recovery (Borg & Kristiansen, 2004; Davidson, 2003; Topor et al., 2006). In their analysis of helping relationships within psychiatric services Topor and Denhov (2012) found service-users valued the continuity of a fixed and stable relationship, the interpersonal fit of service-user and professional, having a conversational partner and having available time to meet their needs.

Indeed time appears to be a consistent factor in facilitating helping relationships. Time has many aspects and implications on the relationship. It includes the time taken to get to know someone and establish trust, time within sessions for service-users to be able to talk about the difficulties they are experiencing, the flexibility to go beyond the limits of the session, intensive time where service-users need more time more often on occasions, contact time between sessions, coming into contact with services at the right time for change, and focused and undisturbed time to highlight the service-user's importance to the professional (Topor & Denhov, 2012).

Despite it being reported that professionals have typically offered little hope to people with severe mental health difficulties (Borg & Kristiansen, 2004), service-users' appreciated professionals who could convey hope, who shared their professional power and were available when needed. Furthermore they valued professionals who were flexible regarding the methods that helped and were willing to break the rules for what is considered professional behaviour (Topor, 2001).

Helpful relationships consist of equality and collaboration. Most helpful in therapeutic relationships were demonstrations of empathy, respect and a person-to-person investment (Borg & Kristiansen, 2004). In their study of professional friendship, Berggren and Gunnarsson (2010) found the personal ombudsman (PO) (somewhat equivalent in role to care coordinator in the UK) were perceived by service-users to be like a professional friend. The relationship was described as

reciprocal, the professional always being available, like a friend. Despite this, boundaries were apparent and well maintained. This reciprocal nature did not appear to apply to sharing experiences of mental health difficulties but did involve sharing other personal experiences, shortcomings and happy moments with one another. There is a considerable degree of overlap between the ways of working between POs and peer support workers including a more relaxed and informal setting, discussing symptoms to develop coping strategies as well as the above mentioned reciprocal sharing. These relationships with POs were perceived to be more beneficial than relationships with other types of professionals. Berggren and Gunnarsson conclude with highlighting the need for reinterpretation of professionalism in light of these findings. Whilst these remain interesting findings it would seem appropriate to conduct more high quality research within the field before moving towards radical changes in practice.

In conclusion there would appear to be several theories that may have application to peer support worker relationships yet have not been empirically investigated. It is difficult to conclude if these theories account for all of the factors within peer support due to the lack of continuity in what peer support workers do, and the lack of research and predicted outcomes in this field.

Extended Paper

Aims

The aim of this project is to explore and develop a substantive theory of service-user accounts of professional peer support work. A research question that has yet to be asked by the literature is what are service-users accounts of professional peer support work and how might these accounts connect with existing theory. The specific objectives of this research project are to explore service-users' accounts of professional peer support work; to relate findings from these accounts to extant theory; and based on these findings the ultimate objective was to develop a theory that contributes to explaining the relationship developed within peer support work.

Methodology

Study Rationale

Ontology and epistemology

Ontology refers to the nature and form of reality and what can be known about it, whereas epistemology refers to the relationship of the researcher with this knowledge (Guba & Lincoln, 1994). The two are inextricably linked as the ontological position will invariably influence the epistemological position.

The traditional position within the social sciences is that of positivism, which would argue that reality is universal, objective and quantifiable. Reality is shared by all and through the application of science we can observe this reality (Darlaston-Jones, 2007). The post-modern perspective opposes this, one aspect of which is social constructivism. This position asserts reality is socially constructed by and between the people experiencing it (Gergen, 1999). There can be multiple realities, each of which may be different and is dependent on our unique understanding of the world and our experience within it (Darlaston-Jones, 2007). The researcher and the researched construct the data, influenced by their positions and experiences (Charmaz, 2008).

It has been argued that it is essential for the researcher to choose a paradigm that is congruent with their beliefs about the nature of reality and truth (Mills, Bonner, & Francis, 2006). My beliefs are consistent with the social constructionist perspective that knowledge is constructed through language between individuals and will be the position taken within this research project (Burr, 2003).

Rationale for a qualitative methodology

Whilst quantitative methodologies remain dominant within the social sciences there has been an increase in interest in and utilisation of qualitative methodologies (Hayes, 1997). There are a number of differences and similarities between the two

that are described elsewhere (Barker, Pistrang, & Elliott, 2002; Hayes, 2000; Marks & Yardley, 2004). It is therefore useful to highlight the rationale for using a qualitative methodology within this research project. Primarily, this relates to qualitative researchers' interest in the meaning particular events and experiences hold for their participants. They are interested in quality and texture of experience (Willig, 2001).

Quantitative methodologies seek to isolate and control all variables that are deemed relevant to the research question a priori in an attempt to generate objective and reliable knowledge. Questions as to whether this is truly possible have been well articulated previously (Danziger, 1994; Sherrard, 1998). It is essential for the research question to match the methodology used. The research question of this project aims to explore the perceptions of service-users regarding the psychological processes involved in professional peer support. This project is an exploratory investigation, interested specifically in how participants understand and make sense of their experience of peer support, making a qualitative methodology most appropriate.

Researcher Position

Contextualism is the position that all knowledge is local, provisional and situation dependent (Jaeger & Rosnow, 1988). In this way the data constructed within the research process will vary according to the context in which the data was collected. All views, including those of the researcher and participant, are inherently subjective and therefore are not invalidated by contradictory perspectives. In order to remain as transparent as possible, the following section describes particular experiences and attitudes of the researcher that may have influenced the research process. This is not an attempt to remain objective or discount this bias but to acknowledge it and give the reader a better picture of the lens through which this research was constructed.

My personal experiences have a considerable bearing on this research process. My epistemological position and chosen methodology place considerable emphasis on the role of the researcher in all aspects of the research, from formulation of the research question to data collection, analysis and write-up. I have a great deal of interest in recovery principles (Anthony, 1993) that currently are being developed and delivered within local and international policy and practice. I also hold a particular interest in the value that lived experience of mental health difficulties can have in informing professional clinical practice. Having been a service-user within the mental health system myself, I feel that these experiences have fundamentally affected the way in which I view and interact with others within my clinical capacity. Whilst I may value lived experience of mental health difficulties for clinicians who have experienced it I feel that it is important to state this does not mean I am necessarily pro-peer support work per se. I am interested in this area as it explicitly utilises lived experience of mental health difficulties and I feel that it is important to ensure that the research-practice links are fundamentally sound and well established in this rapidly growing field.

Grounded Theory

Kidder and Fine (1987) distinguish between ‘big Q’ and ‘small q’ in qualitative research, where small q refers to the analysis of data that is not numerical such as open text options given within questionnaires. Small q does not seek to engage with the data to develop new insight into the ways participants construct meaning (Willig, 2001). Big Q on the other hand refers to open ended, inductive research methods that seek to develop theories and explore meanings. This study aims to explore service-users’ experiences of peer support work and will therefore utilise big Q methodology.

One particular big Q methodology is that of grounded theory. Grounded theory is a set of guidelines for the collecting, organising, analysing and conceptualising qualitative data in order to construct theory (Charmaz, 2001). It was

developed as a post-positivist response to hypothetico-deductive models of inquiry that were dominant at the time (Charmaz, 2003).

The methodology has evolved since its inception by Glaser and Strauss (1965) and there are differing versions of grounded theory (Mills et al., 2006). The split focuses on the process of induction, whether data is constructed or uncovered, and objectivist versus subjectivist perspectives (Annells, 1996). Corbin and Strauss (2014) have developed a prescriptive step-by-step guide to using grounded theory. They include specific coding parameters to look at predefined themes such as gender, race, class etc. This prescriptive element alters the epistemological position of the research to closer with an objectivist position (Willig, 2008). However, not all researchers ascribe to this methodology and attempt to avoid using predetermined variables to be assessed.

The original version of grounded theory was said to involve the discovery of theory from data, suggesting the researcher finds something that already exists. Some authors such as Charmaz (2003) and Clarke (2005) believe that the researchers' beliefs and attitudes as well as their interactions with the participants shape the collection and analysis of the data. Indeed Pidgeon and Henwood (1997) identified four different factors which influence the way that knowledge is produced within qualitative research:

- The understanding of the participants.
- The interpretations made by the researcher.
- The cultural systems of meaning for both researcher and participant.
- The acts of judging particular interpretations as valid by the scientific community.

These same authors describe how the researcher and the participants are involved in the conduct of a human relationship, and participants are not just subjects under the gaze of researchers. Within grounded theory there is a

commitment to local contextual theory and reflecting the participants' and researchers' co-construction of the data. This co-construction of data is at the core of constructionist interpretations of grounded theory (Charmaz, 2014).

In choosing a methodology that is in line with my own epistemological and ontological views, a social constructionist version of grounded theory has been developed and refined by Charmaz (2006, 2014). The guidelines developed will be used as throughout this research process (Charmaz, 2006; Charmaz, 2014).

Critique of grounded theory

Grounded theory has been acknowledged as being a widely used qualitative interpretive framework within the social sciences (Denzin, 1994; Miller & Fredericks, 1999) but, as with any methodology, there has been considerable critique of grounded theory approaches (Haig, 1995; Layder, 1993; Robrecht, 1995) and are eloquently described in Thomas and James (2006). Whilst the authors lay their criticisms at the feet of social constructionist grounded theory their critiques refer also to the classic grounded theory as conceptualised by Glaser and Strauss (1967). The differences between these two approaches to grounded theory are considerable and well described within the Breckenridge, Jones, Elliott, and Nicol (2012) article. One criticism that has been levelled at grounded theory that applies specifically to the constructionist version is the question of what constitutes a theory.

Positivist ideas of theory dominate thinking in psychological research and focus on seeking causes, looking for explanations and emphasise generality and universality (Charmaz, 2014). However, there is considerable value in interpretive definitions of theory. An interpretive definition of theory assumes emergent and multiple realities, with truth as provisional, local and subjective (Charmaz, 2006). It also gives greater priority to abstract understanding than to explanation. Researchers using this approach seek to understand meanings and actions and how people

construct them (Charmaz, 2014). From this perspective, theories are deconstructions of how we construct realities and social processes and ourselves as participants in those realities (Alasuutari, 1996). Interpretive theory also seeks patterns and connections as opposed to linear reasoning between variables (Charmaz, 2006).

One may distinguish between formal and substantive theory. Substantive theory is the product of empirical investigation and interpretive enquiry, whereas formal theory is the product of theoretical or conceptual work. In this instance in relation to constructivist grounded theory it incorporates the experiences, perceptions and values of the researcher within the construction of data and is rooted in time and place. The inclusion of the researcher's position differentiates this from other interpretations of data. According to Gasson (2003, p. 84):

A formal theory can only emerge from sufficient data analysis, in sufficient cases, for the researcher to be sure that they are not merely describing the case in a single situation. A single grounded theory research study would not be expected to generate formal theory.

Another criticism of grounded theory is that it is not scientific in its use of inductive rather than deductive methods. Constructivist grounded theory uses both inductive and deductive processes and it has been argued that all human reasoning holds this balance (Simon, 1957). It is the subjective nature of the researcher's reasoning that would appear to be at the core of this criticism, but Strauss and Corbin (1998) argue that the use of the constant comparative method is utilised in order to validate the constructs and addresses this criticism.

Alternative Qualitative Approaches

In utilising grounded theory it is important to acknowledge other methodologies and outline why these may be less well suited to the research question of this study.

Thematic analysis

Thematic analysis is a means by which researchers can identify, analyse and report themes from qualitative data. Boyatzis (1998) argues that this is a generic skill found across a range of qualitative methodologies. Braun and Clarke (2006) responded to this by stating that thematic analysis should be recognised as a methodology in its own right and set out guidelines for its use. Thematic analysis is a flexible approach that can be used from differing epistemological positions. The general steps by which one conducts thematic analysis are very similar to grounded theory. The main difference in the analysis and interpretive stage is the overarching development of a theory that makes links between differing themes. Another notable difference in grounded theory is the emphasis on negative case analysis and constant comparison. This emphasis on analysing alongside data collection allows a greater degree of flexibility to focus the data collection on issues that are particularly pertinent and to shape future interview schedules to match this. I feel that these differences have allowed data collection and analysis to be more responsive to the emerging themes.

Interpretative phenomenological analysis (IPA)

IPA is an exploratory and inductive means of investigating an individual's interpretation of an event or experience (Smith, 2011). IPA highlights that it is not possible to directly capture an individual's experience directly but is subject to the double hermeneutic; the participants' make interpretations of their experience and the researcher interprets their account of the experience (Smith, Flowers, & Larkin, 2009). It therefore acknowledges that the researcher's opinions and experiences will influence the resulting analysis. Whilst the current research is interested in individuals' experiences and acknowledges that the researcher's experiences and opinions will influence the research process, IPA does not seek to generate a coherent theory making connections between themes as grounded theory does. IPA takes a critical realist position in terms of epistemology that is inconsistent with my own constructionist perspective. IPA also tends to focus on the experiences of fewer participants, whereas grounded theory sets no limits on the number to be included.

Discourse analysis

Discourse analysis is based within a constructionist epistemology that endeavours to understand how the research participants construct dialogue around a topic in a particular context (Potter, 1996). Discourse analysis refutes the assumption that talk is a route to cognition, instead proposing that social reality is constructed (White, 2004). Whilst investigations into how participants discuss their experiences of peer support work or who would constitute a peer are valid and interesting research questions this is not the aim of this research project. The study hopes to generate a coherent substantive theory regarding the service-users' experience of peer support. This research aim does not match the aims of discourse analysis and is therefore inappropriate for the purposes of this research.

Participants

Purposive sampling was used to identify participants for whom the research topic was relevant in order to allow rich and detailed data to be constructed within the interviews. Each participant had worked with a peer support worker for at least four weeks within the last year. Negative case analysis is an approach to refining themes and concepts. This involves looking for cases that do not fit with the emerging theory. This allows the researcher to qualify and elaborate the emerging theory (Charmaz, 2014). Attempts were made to gain a variety of perspectives in order to challenge the emergent theories, especially in the latter stages of the recruitment process.

Theoretical saturation

According to (Charmaz, 2014) theoretical sampling takes place until theoretical saturation is achieved. This is where the addition of new data into the analysis results in no new themes being defined. Pidgeon and Henwood (1997) believe that theoretical saturation is impossible to achieve for a small-scale study. Whilst theoretical saturation may not be possible for this project, the use of theoretical sufficiency is. This is achieved when themes cope adequately with additional data without requiring modification (Dey, 1999).

Sample size

Determining the sample size for grounded theory projects is different than that of other methodologies. As discussed earlier theoretical sampling seeks to achieve theoretical sufficiency (Dey, 1999) where any further data collection does not enhance existing themes. However there are published examples of grounded theory studies including ten participants (Coniglio, Hancock, & Ellis, 2012; Edwards & Jones, 2009; Kylmä, Vehviläinen-Julkunen, & Lähdevirta, 2001).

Inclusion criteria

There are several inclusion criteria in order for individuals to be able to participate in the study:

- Are deemed by the researcher to have mental capacity to give informed consent as defined by the Mental Capacity Act 2005. The author has completed appropriate Trust training in order to make this assessment.
- At least 18 years old with no upper age limit.
- Are currently or were previously engaging in peer support work for at least four weeks within the last year.
- English speaking

Ethical Considerations

Approval was sought from the University of Nottingham as sponsor for the research. Once granted ethical approval was sought and gained from the East Midlands NHS Research Ethics Committee and the Nottinghamshire Healthcare Trust Research and Development department. Due to significant difficulties in identifying participants for the study a substantial amendment was made and approved (See appendix L) in order recruit participants who were no longer in contact with their peer support workers, through posters placed with psychiatric outpatient departments and 'involvement centres'. These centres are established to allow individuals who wish to have input into individual care and strategic planning as well as receiving news about developments within the Trust.

Participant Recruitment

Procedure

After gaining ethical approval participants were approached by their peer support workers in order to introduce the study. They were provided with information sheets and consent forms and the authors contact details should they express an interest in participating in the project. The participants then made contact with the author in order to further discuss the study and to answer any questions or concerns they might have. A time and place of the participants choosing was then agreed to conduct the interview if they were willing. Written consent was gained at the interview after verbal consent had already been given over the phone.

All peer support workers and their manager were approached to see if they would be interested in helping to recruit for the study. It was acknowledged that this was voluntary and that the choice to be involved was solely theirs. The peer support workers were asked to approach the service-users that they were currently working with to discuss the possibility of being involved in the study.

A socio-demographic sheet which included contact details for professionals in the event issues relating to clinical risk were raised in keeping with the requirements of the ethics committee were completed along with the consent forms. A debrief period was used at the end of each interview in order to ensure the wellbeing of the participants. It must be acknowledged that using the peer support workers as gatekeepers had both benefits and drawbacks. Whilst it allowed the prospective participant to be approached by someone they were familiar with, enhancing the potential for recruitment to the study, it also had the potential for the peer support workers to cherry pick their service-users for those who would give favourable opinions. To attempt to address this and broaden the participant pool a substantial amendment was made to the study ethics after one month of recruitment to allow individuals not currently working with a mental health professional to participate.

Posters advertising the study were placed within local mental health outpatient departments and involvement centres within Nottinghamshire Healthcare Trust in order to attract service-users who may not have been approached by their peer support worker or who had already finished working with them. Three participants were recruited through the posters (Harry, Ian and Jim); for the remaining seven the participants had been approached by their peer support workers. There did not appear to be any significant variation in the data constructed with those individuals recruited through different means. In order to ensure transparency the names of those recruited through different means are identified within the methodology section. Whilst it is unclear why some individuals may choose not to take part in this research it may have included concerns about confidentiality and the care they may receive, the perception their views may not have an effect on the service or wider aspects of peer support.

It is worth considering the implications of two identities of one individual with DID participating separately as opposed to one account. Whilst Caroline and Eve are identities within the same body and the data constructed from interviews with both could conceivably be integrated as two parts of one whole in order to remain respectful of their individual identities they will be analysed as separate participants. Whilst there are similarities between accounts there are also considerable differences. Eve recalls accounts with all three of the peer support workers she had relationships with whereas Caroline only commented on the most recent two. The data constructed with Caroline and Eve are clearly identified within the results section which leaves the reader in the position to interpret the information as they see fit.

Prior to the commencement of each interview details were given of the participants GP, care-coordinator and peer support worker (if appropriate). This was to ensure that if participants experienced any distress during the interview, they would receive the care and support they might need afterwards. Whilst this was a necessary safety precaution, none of the participants experienced distress and this

information was not used to contact any mental health professionals involved in their care.

There were three individuals who worked with more than one peer support worker. Caroline and Eve both held accounts of the same two peer support workers. Both spoke of the differing ways in which they had been supported by the different peer support worker. One, who also experienced similar difficulties and was diagnosed with DID helped both to understand and come to terms with their difficulties as well as advocating on her behalf with the mental health team. They also developed shared coping strategies that were mutually beneficial. The other peer support worker helped provide emotional and social support and helped to facilitate communication between the two identities. Eve also spoke of her first experience with a peer support worker which was not satisfactory. This was exemplified by the lack of communication, openness and disclosure which was present with the other two peer support workers. Denise also worked with more than one peer support. She had a primary relationship with her allocated peer support worker as well as fleeting contact with a peer support worker who facilitated a course she attended at the recovery college. From Denise's account both peer support workers were able to provide information and pass on knowledge without assuming an expert role.

Participant withdrawal

Participants were given an opportunity to withdraw from the study at any point without having to give a reason. This information was detailed in the information sheet and discussed on initial meeting, during and after the interview. Participants were also made aware that this would not affect their future care. Participants were informed that that should they withdraw their consent to participate within 72 hours their data would not be included in the analysis. None of the participants chose to withdraw from the study.

Data Collection

Semi-structured interviews

Grounded theory can use the same forms of data as other qualitative methodologies such as interviews, observations or texts (Corbin & Strauss, 1990). The use of semi-structured interviews allows for the grounded theory principle of data collection and analysis occurring at the same time. It also lends itself to exploring issues in more depth and fosters each participant discussing their interpretations, and therefore is useful in interpretative inquiry (Charmaz, 2006). An interview goes beyond the scope and depth of a normal conversation as well as allowing the researcher to shift the focus or direct the focus as necessary (Charmaz, 2006). Charmaz (2014) believes that interviewing fits grounded theory methods particularly well. This involves the gently guided exploration of an individual's experiences that relate to the research topic, in this case their experience of working with a peer support worker. It is considered the best means of securing the personal and private concerns of the participants (Chenitz & Swanson, 1986). Indeed the discourses generated through interviewing can be multiple, fragmented and contradictory as well as coherent and consistent. Interviews can be used by participants to find, piece together or reconstruct discourses consistent with the social constructionist version of grounded theory of co-construction of data between the interviewer and participant (Charmaz, 2014).

Each interview was audio-recorded and subsequently transcribed and coded before the next interview took place allowing the constant comparative analysis, the development and refining of theory and to find examples of negative cases in order to challenge the themes identified. The interview schedule was therefore refined a number of times in order to pursue emerging themes within the data. All interviews were conducted in a private and undisturbed space and lasted up to 60 minutes.

Analysis

The process of analysis begins during the interviews as the researcher identifies areas of interest that require further investigation. Once the data was

transcribed verbatim initial coding began. Coding is the process of defining what the data is about by applying tentative labels that summarise the data. These labels are reported to be the pivotal link between collecting data and developing an emergent theory (Charmaz, 2014). These initial codes are not definitive and are described by Star (2007) as transitional objects which connect fragments of data with analytic abstraction. They are subject to revision and reinterpretation through the stages of analysis.

There are several ways in which to conduct initial coding, word-by-word, line-by-line or incident-by-incident. The interviews within this study were a combination of line-by-line coding and incident-by-incident in order to allow easier comparison between data both within interviews and across different interviews. The codes are constructed as the researcher seeks to find the best fit for the data (Charmaz, 2006). This best fit is not an attempt at objective truth knowing or to ensure complete accuracy but as a recognisable description of the data (Charmaz, 2014). There is an attempt to seek diversity and multiple facets of the particular concept (Pidgeon & Henwood, 1997).

In making initial codes I sought to avoid using pre-existing themes and attempted to code actions within the text. It is however unrealistic to expect that I would not have some prior ideas and experiences that will guide the coding. As Dey (1999, p.251) reports “there is a difference between an open mind and an empty head”. The researcher needs some theoretical resources in order to begin the process of interpretation (Riessman, 1993) and they are not expected to be a tabula rasa (Glaser & Strauss, 1967) despite some claims to the contrary as described by Urquhart (2002). Pidgeon and Henwood (1997) describe the flip-flop process of inserting new discourses within old systems of meaning.

One of the most important aspects of an inductive approach and one that I was keen to utilise within this project was the ability to adapt the interview schedule and interviews in light of new and emerging information and themes. In order to do this the process of constant comparison that is inherent but not exclusive to grounded theory was particularly useful. Grounded theory describes how, as incidents are noted, they are compared and contrasted with incidents within the same corpus of data and across other participants (Corbin & Strauss, 1990). This is used to not only aid and refine the research process but to challenge researcher bias in questioning what has been done already. If comprehensive process notes are also taken this also adds another layer of transparency to the research process.

Analysis moves from initial coding to focused coding, where the most compelling codes are identified (Tweed & Charmaz, 2012). There is a necessary decision making process to determine which initial codes make most analytic sense to abstract to focused codes (Charmaz, 2014). The goal of focused coding is to check the adequacy and conceptual strength of initial codes and allows preconceptions about topics to be challenged (Charmaz, 2014).

From focused coding analysis then moves to theoretical coding, the final stage of analysis according to Charmaz (2014). This attempts to establish how the focused codes relate to one another as hypotheses to be integrated into a theory (Glaser, 1978). Theoretical coding helps to specify relationships between themes that have been developed during focused coding and allows the telling of a coherent analytic story (Charmaz, 2014).

Quality Assurance Methods

Audit trail

In order to counter claims regarding subjectivity and researcher bias, it is helpful for qualitative researchers to illustrate the trustworthiness of their findings (Bowen, 2009). An audit trail was used to document systematically what was done,

how it was done and how the interpretations were arrived at. This allows an objective party to assess the steps taken in the research process in order to evaluate scientific rigour.

Throughout the research process the researcher records how the theory is developed. One such method that was used within this research was to keep a reflexive journal in order to record the dilemmas, directions and decisions, thus enabling transparency and as a further method of analysing and challenging existing themes and concepts.

The memo writing (See Appendix M for example) process is what Charmaz (2014) identifies as the pivotal intermediate step between data collection and the writing of drafts (See extended discussion for example). Memo writing is an essential part of grounded theory that not only allows for further analysis but is a means of tracing interpretations made during different stages of analysis. This is especially true given that coding is subject to change as codes and themes are developed to best fit the data. Memo writing involves writing descriptions and definitions of the concepts and themes and justifying the labels chosen for them. As with much of the analysis with constructionist grounded theory initial efforts are deemed to be partial, preliminary and provisional (Charmaz, 2014). Memo writing also involves commenting on how themes are refined and when and why they are changed.

Member checking

Member checking is an attempt to seek feedback from the participants in order to check that the conversation was captured accurately (Lincoln & Guba, 1985). This aims to improve the accuracy of the research process by ensuring that the findings reflected the views and opinions of the participant. This method assumes a singular truth or reality that contrasts with the multiple truth or reality so essential in socially constructed grounded theory. There is a large degree of

interpretation involved in constructionist grounded theory that precludes the utility of member checking. The interpretations made by the researcher may well differ from the interpretations of the participant. This in no way defines a 'right' or 'wrong' version to be corroborated. For this reason member checking was not used within this research project.

Triangulation

Whilst there are a number of definitions of triangulation in this instance it refers to the cross-referencing of different researcher's perceptions of the themes as a form of inter-rater reliability (Denzin, 1978)) Triangulation has been deemed to be tried and tested method of establishing credibility for qualitative research (Bowen, 2009). It is a means of corroboration which allows the researcher to be more confident of the study conclusions (Padgett, 1998). However this method for assessing quality control again assumes a singular truth or reality which contrasts with the social constructed grounded theory. Again, for this reason, it was not utilised within the research process.

Supervision

I utilised regular supervision with both of my academic supervisors throughout the research process. This enabled me to reflect on the themes and codes being developed in a more critical manner and ask questions of the data I had overlooked. Whilst I acknowledge the lack of a single truth or reality it was useful to check that the codes and themes that were developed were plausible and supervision facilitated this.

Evaluation

Evaluation of research within the social sciences can be conducted in a number of ways according to the methodologies utilised and the epistemological and ontological position of the researchers. Charmaz (2014) developed criteria for evaluating the quality of a study and are used within this research project that are credibility, originality, resonance and usefulness (See Appendix K).

Results

From the analysis, as described in the journal paper, three overarching themes were constructed from the data: 'The process of disclosure', 'The product of disclosure' and 'Dual roles'.

The process of disclosure

As discussed within the journal paper 'the process of disclosure' explores the central process that disclosure plays within the peer support relationship. It describes the ways in which disclosure is achieved through the identification of commonality, the discussion of experiences of mental health difficulties, of being a service-user and of finding other experiences, values and activities of interest that the two share.

Disclosing

Disclosure is an integral part of peer support in its many forms, something which when in reference to mental health difficulties, is rare from other mental health professionals. It is the mutual experience of mental health difficulties or identity as a service-user, when disclosed, that bonds the two individuals together. The process of disclosure is a joint participation in establishing common experience but varies significantly between individuals and often stands in stark contrast to the lack of disclosure offered by mental health professionals.

"She mostly seemed to pick um up on if I was experiencing something that she felt was similar to something that she had experienced." (Eve).

This focus on identifying commonality rather than the reciting of a personal narrative helped to highlight similarity rather than difference and allowed the individuals to reduce their sense of isolation. It also made the disclosure specific to the service-user and functional in its attempts to meet the needs of the service-user.

"By telling me her experience, we've realized we know people with similar age, and it's nice knowing ... I don't know of her, but it's nice knowing that she does normal and she's just living a normal, you know, life". (Denise)

Denise and her peer support worker talked about their lives and experiences and have identified similarities. These similarities help to foster hope about the potential for recovery, and is demonstrated through the embodied recovery of the peer support worker. They also act as a normalising process that was missing prior to her contact with her peer support worker. Ian was able to articulate what he wouldn't want from a peer support worker in disclosing their experiences:

"(I wouldn't want them to) tell me a story about their own Mental Health at that time, or, when we're both feeling okay say "Oh yeah I suffered this, I suffered that". That can add to it but when you're not feeling good, somebody like saying to you "Oh I had that" that can make it feel like they've had it worse or you know that bit of condescending "Oh well I've had it, I got through it"." (Ian).

Ian recognises that hearing a narrative from a peer support worker could lead to negative evaluations of one's own recovery or unrealistic comparisons between the two. What peer support workers seem to have been able to do is highlight similarity and shared experience rather than recounting a personal narrative. This interweaving of commonality serves to enhance the bond between the two. Ian was the only individual to highlight the potential for PSWs to disclose in a manner that didn't meet the needs of the service-user. This was a hypothetical position rather than a reflection on his experiences.

For one individual, the shared identity of being a service-user without any further disclosure was sufficient information about the nature of individual's personal difficulties to create a sense of solidarity demonstrated throughout the remainder of the interview.

"Interviewer: Did (peer support worker) talk about the problems she'd been through?"

Faye: No, no, she listened to my problems."

Faye identifies the lack of reciprocal process in discussing her experiences rather than the mutual sharing of experiences. This appeared to be all the disclosure that Faye required in order to feel that she had something in common and could therefore be understood.

"My previous co-ordinator introduced me to Gemma...for someone to talk to because, you know, we were in the same situation, with Mental Health problems, to know what it's like to understand Mental Health problems." (Faye)

For Faye the experience of having any mental health difficulty is sufficient to render an understanding of her perspective. In this way the acknowledgement of the title 'peer' would grant her an sense of being understood that other professionals were unable to achieve. The degree of disclosure that service-users were privy to seemed to vary considerably. For most this seemed to match the disclosure they expected or needed but for some such as Gavin this was something that wasn't achieved.

“Well she hasn’t been quite open with me, I haven’t ... I don’t like to ask, I’m not a person who likes to prod, to be nosey into other people’s business.”
(Gavin).

During the interview Gavin had identified that he valued the disclosure that was offered by the peer support worker but here acknowledges the difficulty in encouraging further disclosure. Three other participants echoed this. It highlights a problem to be negotiated by the peer support worker and service-user if the disclosure is going to meet the needs of the service-user. This may relate to the nature of the informal relationship as discussed with ‘dual roles’ sitting somewhere between friendship and professional status.

“I think you just get a chance to bond more, I think it’s purely the fact that they’re allowed to tell you about their experiences whereas, correct me if I’m wrong, but I don’t think that Psychologists and CPNs are actually meant to put forward anything that they’ve experienced, just that they’re meant to give advice.” (Caroline).

Caroline’s perception of mental health professionals is that they aren’t allowed to talk about their experiences. It remains unclear whether this relates purely to mental health or wider disclosure but highlights the lack of sharing that has taken place with others thus far. In reflecting on interactions with mental health professionals Eve highlights the lack of disclosure from other mental health professionals.

“They’d never offer anything that’s personal to them”. (Eve)

Eve expresses her dissatisfaction during this conversation that there was a purely professional relationship with no crossover into the personal. This lack of reciprocity to any degree is clearly unsatisfactory for her and is a common experience amongst other participants. There may be very good reason to hold distinctly professional boundaries within relationships with service-users but what can be highlighted here is that the lack of disclosure of any kind may prevent the development of the relationship between professional and service-user highlighted again by Harry below:

“I’ve had experiences up at (Mental health service) that have tried to give me advice, and talk about all sorts of things in life to help me feel better, and I’ve asked them of their experiences, most of them won’t tell you”.

Whilst Harry highlights that most won’t speak of their experiences he alludes to others that do; even limited disclosure may be beneficial. For Harry this lack of a reciprocal process of any kind made the relationship more challenging and unequal. Whilst this lack of disclosure may be more common in relationships with more traditional mental health professionals this can also be found with peer support workers as Eve points out. She discusses her first experience of working with a peer support worker, which she didn’t find helpful, and attributes this in part to a lack of disclosure:

“I found that my first peer support worker was quite closed and I don’t think I ever even ... I did work with her for quite a while and I don’t think I even found out if she’d been in Hospital or not”. (Eve).

This failure to disclose or find commonality is in contrast to her subsequent experiences and the difference this had on their relationship was clearly significant:

"If I asked any questions she just seemed to evade it, and then that put me off from asking any more questions, because she made it obvious that she really didn't want to tell me." (Eve).

It would seem quite apparent that this relationship was not well received and the openness, commonality and relaxed relationship were not established here. This was the only example of a poorly received peer support relationship but is also the only example where the needs for disclosure and personal connection were not met to any degree.

It became apparent throughout the construction of data that the degree of disclosure offered by peer support workers varied considerably. The ability to match the offered disclosure with that desired by the service-user was a delicate balance to retain. In most instances it would appear to have met the needs of the service-user but in some instances it did not meet this threshold.

"He disclosed a bit, but, um I ... because I was like um the Patient, as it was I didn't want to pry too much". (Jim).

Jim clearly valued the insight developed through disclosure from his peer support worker but also acknowledged this was a difficult dialogue to encourage. The service-users appear to be sensitive to the needs of the peer support workers and are conflicted perhaps by their friendship and informal relationship as described in more detail in dual roles.

Disclosing mental health experience

Throughout the data collection it became apparent that experience within mental health services and of mental health difficulties that were shared between service-user and peer support worker were fundamental to the process of peer support. This mutual experience came in various forms and the experiences overlapped on a spectrum of similarity but all served to establish common ground between the peer support worker and service-user.

“It’s strange, it sounds, sitting here today, that’s made me realise how important it is, that the people dealing with the people suffering from mental health issues, the difference it makes if they’ve suffered from something themselves, and gained that experience through life.” (Harry).

Harry highlights that the shared lived experience sets the peer support worker apart from other mental health professionals and that this changes perhaps both the perspective of the peer support worker and of the service-users’ view of them. For many individuals the experience of mental health difficulties set them apart from others and made them feel isolated and alone. Addressing this sense of isolation by having another individual who had shared this experience seems to have touched many of the participants. To have someone else validating his or her experiences seems to be liberating.

*“I just didn’t know anyone else who had had anything like that, and it made me feel very isolated and like I was a weirdo, and then all of a sudden I’ve got this person in front of me saying “Oh that’s exactly what’s happened to me”.
(Eve)*

Eve highlights how different and alone she felt, but having others with similar experiences normalises them and helps her feel more connected to those around her. Whilst these experiences might not be exactly the same this helps to distinguish her experiences as less different than she originally believed. Seven of the participants mentioned the sense of isolation they had experienced as a result of their mental health difficulties. This may have been physical isolation from others or loneliness from feeling different to those around you and society more generally. Being exposed to others who had been through something similar had challenged this isolation.

Harry not only mentions peer support workers challenging the isolation he experienced but he was incorporated into the group identity of being a service-user. This exposure of others with mutual experience highlighted the potential that they and he could achieve, demonstrated through the lived experience of the peer support worker and those other service-users he came into contact with.

"I think it's just the fact that it sort of felt like, I sort of look at it like he's still one of us, like a service-user... when you mix with other Services Users it just makes you feel different inside, like you've still got a role to play, or a part to play, you feel worthy, rather than being on your own and all sorts are going through your mind".

Harry's identification with an "us" is in contrast to an unstated 'them'. It is unclear who 'them' is but may refer to mental health professionals or non-service-users or indeed those not able or willing to disclose personal experiences that have been challenging.

For some individuals the identity as a service-user was sufficient to create a bond but for others this was improved by having other similarities such as a shared diagnosis or even shared experience of misdiagnosis.

“Because my diagnosis is quite rare, so it’s not understood as much and there’s not always a good way to treat it, so by comparing how we coped with things, it sort of helped us both really.” (Eve).

Eve highlights the mutual experience of living with a particular diagnosis. Not only that, she highlights how rare her diagnosis is and how misunderstood it can be. To have another individual that has shared this diagnosis and the lack of clarity and consensus over treatment appears to have been valuable for her. Eve was the only individual to highlight the reciprocal process of helping one another so commonplace in mutual support groups.

Whilst it may be useful to have similar diagnoses between peer support worker and service-user this is not always possible or necessary. Mental health diagnoses can involve nebulous clusters of symptoms that leave little overlap between those with the same diagnosis. Denise shares her diagnosis with her peer support worker but highlights there are differences.

“We’ve both got Bipolar obviously, er no, er, that’s where we do differ. She’s been extremely manic and I...is it the Hypomania?”

This difference did not appear to affect the development of their relationship and the majority of individuals in the study reflected this.

The mutual experience of mental health was not limited to the difficulties themselves but also what happened as a product of being in receipt of support from statutory services. Whilst there was considerable variety between participants it would appear that the establishment of common experience served to develop a sense of group identity thereby reducing isolation and fostered hope for the future through the lived experience of the peer support worker. It would appear that the establishment of mutual experience is beneficial; this is the product of disclosure between peer support worker and service-user.

It is not just the peer support workers that offer disclosure however. The service-users discussed within this project how having the opportunity to talk about their difficulties was a valuable tool for them.

"Because (with peer support worker), you can really tell her how you feeling as your peer support worker, yeah." (Faye).

Faye describes the honesty with which she can speak to her peer support worker, something she feels she is not able to do to other professionals. This opportunity to offload the difficulties she is experiencing is facilitated through the trust that has developed.

"But (CPN) more like get things sort of in place, to sort things out, and whereas, that's maybe fine but with (peer support worker) I can talk to her about how like I actually feel and that's good. (Alexa).

Alexa speaks about the contrast between the practical support offered by her CPN and the emotional support offered by her peer support worker. It is unclear whether it is simply a matter of time available that the CPN is not available for this emotional support or whether other issues may play a part. Regardless the opportunity to unburden themselves of their troubles is clearly of value. Whilst peer support is often framed as service-users providing inside knowledge regarding a particular mental health difficulty this was seldom found within this study. There was in fact only two references to this and was contextualised by the service-user and peer support worker sharing a rare disorder that is poorly understood and remains difficult to manage.

“When you’ve got someone else who confirms “Oh yeah I thought that too” and especially if they say “and I did this and that helped”, then that can be really helpful.” (Caroline).

“She would explain to me how she coped and things like that and she’d always say “I’m not actually telling you to do it, that’s just your own choice, but this is how I approached it”.“ (Eve).

The more focused sharing of learned coping strategies was less frequent amongst the participants and appeared to be dependent on the degree of overlap between the difficulties experienced. This was only evident in two of the participants’ accounts.

Disclosure beyond mental health

Through the analysis it was evident that peer support workers not only seek commonality with the experience of mental health difficulty and receiving care, but also actively seek to identify common interest in experiences, values and interests

that go beyond the realm of mental health. This distinct and active identification with their service-users beyond mental health further develops the growing bond between the two individuals.

“He also looked up information on his computer about activities, er, you know, things like walking, model railway because I’ve got a big model railway and er and other things”

Jim talks here about how his peer support worker invested time in finding things that may be of interest to both of them so that they could enjoy them together. This accompaniment serves to address the isolation that Jim had discussed and allowed him to feel more connected with both the peer support worker and the outside community. This was a common experience for all of the participants interviewed. Having other things in common such as age and the way people think was also helpful for some of the participants:

“She noticed that I was nervous and then she was like, she basically said, “Are you nervous” and I said yeah, and she said “Is it because you’re meeting new people” and I said “Yeah” and she said “Yeah me too”. So she was like rather than with the psychiatrist, she actually said that she was nervous about meeting new people as well, and it was just like we were in the same sort of position.” (Alexa)

This act of both reflecting what Alexa was experiencing and acknowledging this was what she experienced also was a bonding experience. It normalises the experience of anxiety and that the peer support worker could relate to Alexa and had experienced the same thing. This may appear a seemingly small disclosure but served its purpose in developing the relationship and facilitating further dialogue.

“I’ve got personal things in common with Ellie, a certain way that we think and um her reactions to certain things are very similar to mine” (Eve)

Eve talks of having similarities in the way they think that again serves to function as a connection between the two. This revolves less around the peer support worker acknowledging similarity but would not be possible without an active dialogue with the peer support worker. However, this is not always the case as Eve talks about her first experience of peer support:

“If I’m honest, I didn’t really find it that helpful, because we didn’t seem to have much in common”.

This absence of commonality was central to the relationship not developing further, whether personal or in regard to mental health. Gavin also reported that his peer support worker actively identified with how he felt in particular circumstances that left him feeling less isolated:

“Yeah, there’s some common things ... you know, related in a common way”.

An exception to the general theme of disclosure being exclusive to peer support workers, and professionals standing in stark contrast to this is when Denise identified that her CPN was able to identify commonality between them. This ability to identify similarity serves to make the individual more accessible and relatable:

“(She) doesn’t talk about obviously Mental Health problems, but she’ll relate ... I mean I think that ... I identify quite a lot with (CPN), um, again she’s a little bit older than me but we kind of like similar things.”(Denise).

This was the only instance of participants talking about discussions held with mental health professionals that went beyond the boundaries of their mental health. For Denise her CPN’s ability to relate to her improved her relationship. Given the time pressures within current services this is perhaps unsurprising but highlights the potential benefit of relating in a personal manner to service-users.

This sub-theme has highlighted that the similarities established between service-user and peer support worker are not exclusive to mental health or service use but incorporate personal interests, values and experiences. This move beyond mental health serves to highlight that their mental health is one aspect of a whole individual and that this is an important aspect to their recovery and connection to others. This discussion outside of mental health is not exclusive and other mental health professionals may choose to do this but from this sample of participants it seems to be very limited. The reasons for this are unclear and go beyond the scope of this project but is interesting none the less.

The theme of ‘ the process of disclosure’ has discussed the mutual personal and mental health experiences and the disclosure necessary to identify this. The peer support workers that worked with the participants in this study disclosed to varying degrees and seemingly according to the needs of the service-users. This was in contrast to the lack of disclosure from other mental health professionals. Service-users identified a number of different benefits to the disclosure, however there were difficulties identified with peer support workers not disclosing as much as service-users would like and how difficult that was to cultivate. This difficulty may arise

from developing a dual role relationship as both friend and professional discussed later.

The product of disclosure

There is an assumption that because of the identified shared experiences the peer support worker is better able to relate to and understand the service-user. This understanding is both an indicator of the success of the disclosure and enhances the relationship. This is in spite of a broad spectrum of disclosure by the peer support worker to the service-user and variability in overlapping experiences. As reported above some service-users knew very little of their peer support workers experiences beyond their status as a service-user. This appears to be sufficient to create the perception that they are better understood.

“That does really help because it ... you know that they know exactly where you’re coming from”. (Caroline).

Caroline goes on to question non-disclosing mental health professionals’ understanding having not lived through mental health difficulties and being the recipient of care. These mental health professionals may indeed have had their own experiences that simply are not articulated but it is clear the sharing of this fact is an integral part of the perception of feeling understood.

“I don’t think anyone will quite ever understand that, unless they’ve been there themselves.” (Caroline).

Faye speaks below about her perception of what it would be like to work with a peer support worker prior to doing so. Throughout their work together there was

no disclosure between the peer support worker and Faye about the peer support worker's mental health experiences beyond the status of being a peer support worker. However this appeared to be sufficient for Faye to feel better understood.

"I just thought it would just be seeing, like, a Social Worker, yeah, yeah but it's not, it's seeing somebody who has been through the same thing I've been through. Because you can get a bit more ... you can understand people then you see." (Faye).

This perception of being understood allows the service-user to explore their experiences, thoughts and feelings further as Alexa explains.

"I don't know, because if I'd said something and she just sort of stayed quiet and I think, it would be just like awkward. And it makes me feel...when she does say, "I know what you mean", and then it's like sort of I can carry on talking about it. And not have to worry." (Alexa).

The simple statement "I know what you mean" would appear to be something that anyone could say, but it is the perception of being understood that distinguishes this from a statement made by anyone. Gavin felt that he was introduced to a peer support worker for that very reason, that a peer support worker could understand his position where someone without lived experience may struggle.

"My previous co-ordinator introduced me to Gemma...for someone to talk to because, you know, we were in the same situation, with Mental Health problems, to know what it's like to understand Mental Health problems."
(Gavin)

This distinction creates or highlights a gap in perceived understanding between professional and service-user that a peer support worker may be able to bridge; someone who understands yet has a professional status and responsibility for providing care. An interesting question to ask would be whether this is truly a failure of mental health professionals to understand the experiences, thoughts and feelings of the service-user's or the perception that they can be understood by someone who's experiences shares more similarity than that of mental health professionals.

Harry spoke of how he feels that the experience of having mental health difficulties fundamentally changes an individual's understanding and care towards others with similar difficulties.

"Somebody who's been there and they've told you their story, and you realise what they've been through, I think that is the key difference, it does make a lot of difference, I think it changes the person to make them more understanding and caring, because they realise what the person's needs are, they understand what they're going through and I think it's massive".

Harry focuses on the peer support worker's understanding, that lived experience fundamentally changes an individual and the way in which they perceive the world. This is something that may be difficult to establish from the service-user's perspective as there is no before and after measurement. They may reflect on their own experiences and project this onto the peer support worker in feeling fundamentally changed but this is difficult if not impossible to assess. What may indeed have changed is in the perception of the service-user that they better understand the experiences of their peer support worker through the mutuality of

having lived through mental health difficulties. This stands in contrast with the perception of many of the service-users within this project who doubted the understanding and knowledge of the professionals they had worked with.

"I've met people who have tried to give me advice. When you've left their company, you can tell that really it's from a training manual, you can tell, but when you know it's somebody who's been there and they've told you their story, and you realise what they've been through, I think that is the key difference." (Harry).

There are clearly contrasting views regarding the legitimacy and privilege given to knowledge from peer support worker or mental health professional depending on the individual and understandably on their history with mental health services. What is clear is that peer support workers were positioned in a potentially useful but tenuous position, being neither in the distinct position of professional or friend.

"Just that I think a lot of people's view on mental health professionals is they ain't got a clue really, they just read it all out of a text book and they're just going on like statistics and things like that." (Caroline).

This text from Caroline represents the opinion of several of the participants within this study that value the knowledge gained through lived experience and challenge the legitimacy of knowledge and understanding gleaned through professional or academic endeavours. The knowledge and training that peer support workers have may be cast into doubt however because of their informal approach or status as a service-user.

“There’s still things I have to ask (CPN), because there’s some things, that when we’ve gone to the peer support Group together, that I found out and I thought “That’s a really good idea, I’ll just run it past (CPN) And (CPN)’s gone and asked Doctors and you know and they’ve said “no not at the moment”.” (Denise)

Denise was the only individual who voiced doubts about the credibility of her peer support worker’s knowledge. This may be related to her job as a mental health professional but cannot be definitively concluded. Giving privilege to one individual’s knowledge over another is not unexpected especially where information may be contradictory. These contradictions may however prove a difficult situation for the service-user, especially given the friend-like relationship between the peer support worker and service-user.

When there is a connection between the service-user and peer support worker through shared experience there would appear to be an implicit understanding between the two that negates the need for talking.

“I don’t know it’s just sort of like I can talk to her like easier, because I don’t really have to explain too much.” (Alexa).

“I was talking to him quite a bit, and he was empathising and he said one or two things and then he just said “Oh we’ll leave it at that, let’s not talk any more”. And I thought to myself “Yeah, yeah, you’re right, let’s not talk any more about it”. I think there’s just that understanding that being supportive is.” (Ian)

Both Ian and Alexa mention an implicit understanding that moves beyond having to speak about their experiences. In contrast to what others have said Ian challenged the notion of having to have lived experience to empathise effectively and even challenged the premise of peer support worker being based on an experience of mental health difficulty.

"I don't think necessarily a peer support worker has to have had serious Mental Health issues, for me I think ... or serious illnesses. I think for me the more important thing is like, um, empathy...". (Ian)

All of the participants expressed feeling well understood by their peer support worker and most attributed this to the lived experience of mental health difficulty. This ability to empathise is drawn from an experience that is somewhat similar to the service-user's experience and therefore supports this perception. However, the heterogeneity of lived experience of mental health difficulty means that even if two individuals have the same diagnosis their reactions to it, experiences, thoughts and feelings may not overlap with the peer support worker. What is important is the perception of being understood based on common experience. Ian challenges that position and acknowledges that the lived experience is unnecessary to establish empathy. However Ian did not identify others in his life that he felt exemplified this empathy without lived experience and was the only individual to challenge this.

'The product of disclosure' has highlighted how, through peer support workers' disclosure, service-users are able to identify commonality. This identification of commonality leads to a sense of being understood, and indeed often being better understood than those who have not or are not able to disclose. Given the sometimes limited nature of disclosure the perception of being understood is most important and the ability to relate having common experiences that draws the two individuals closer together.

Dual Roles

'Dual roles' illustrates how peer support workers hold a position of both friend and professional to the service-user. This role is both beneficial and challenging to maintain for peer support worker and service-user alike. This is perhaps due to the informal approach they have with service-users.

All of the participants commented on the relaxed and informal nature of the relationship with their peer support worker. Informality appeared to be the product of less formal settings such as an individual's house or coffee shop, the activities they undertook being distinct from clinical tasks, and the approach taken by the peer support worker which was not always centred on task oriented goals, instead focusing on process, and reflecting the meandering journey of recovery in achieving this despite not necessarily taking a straight path there.

"I met her at (Hospital), went across the road for a drink, felt quite relaxed, like I'd actually known her for a long time, for a period of time in general, which was good." (Betty).

This comment refers to the informality but views this as positive in providing a more accessible and relatable professional, by allowing more and less serious topics of conversation to emerge depending on the needs of the service-user, and by providing contrast to the more clinical settings and attitudes of other experiences within statutory care.

Denise, a mental health professional as well as a service-user compares her own practice with that of the peer support worker she works with.

"So I know when I go to somebody's house I like to get straight into the Assessment, and we don't have a drink unless I'm desperate. (CPN's) very much like that ... they're very different (Laugh). (peer support worker) always has a drink, she always chats to me while I'm making it, um, and I always think "Oh she's finding out quite a lot about me now" because I'm relaxed and saying more." (Denise)

This more relaxed approach, perhaps in combination with the shared identity, creates an informality that facilitates more open dialogue. This approach is echoed by Eve's reflections on her interactions with her peer support worker, particularly at the start of their meetings.

"Just start off talking about general thing...,and um, I suppose just to make me feel comfortable rather than jumping in with "What's going on with this in your life". (Eve)

Eve goes on to compare the conversations she has with her peer support worker with those she has with mental health professionals:

"I think it's the way that they talk, you can tell that they've been taught how to sound professional, and they've been taught the way that they should ask things, whereas with the peer support worker it just seems more like a chat." (Eve).

This perception that they were just having a chat was consistent across all of the participants and reflects the natural dialogue developed between two individuals but possible in the context of the professional relationship because of the dual roles

held. What they perceive to be a 'chat' as opposed to anything else remains unclear but it clearly signifies a relaxed and informal discussion, perhaps between peers, without agenda.

"But it just seems ... it gives a nice human touch to the care, having a Peer Worker." (Jim).

This identification of humanness that is perhaps lacking in other relationships may well relate to the caring relationship discussed earlier, with a genuine interest in their lives beyond their mental health. This may in part be due to the time available for peer support workers to discuss this rather than the task focused approach undertaken by other mental health professionals discussed later.

All of the participants made reference to the relationship bearing a resemblance to that of a friendship. This would appear to be a natural comparison given the shared identity of the individuals, the deeper understanding and the more informal and relaxed approach.

"She does feel more like a friend, um, a friend with lots of knowledge." (Denise).

This distinction for Denise sets the relationship beyond that of friendship with the imparting of knowledge largely relating to mental health.

"It is like friendship. I mean you have to have boundaries but, you know, it's a lot more person, you know it's got a personal touch". (Jim).

The personal touch that Jim emphasises is within the boundaries of a professional relationship and highlights the dual roles the peer support worker holds. Jim's reference to boundaries is a significant one. These relationships are not the same as naturally occurring peer support found within other settings but have the professional aspect to them that positions the peer support worker somewhere between the two.

"While they've got to work within the system, that's a given, but sort of more sitting on the fence as it were, sort of thing." (Ian).

Ian speaks of peer support workers working within the health care system but remaining impartial and not beholden to either service-user or service provider.

"Well a friend ... I don't think I'd be able to open up to a friend." (Faye).

For lots of people the idea of talking to a friend about their difficulties would feel natural, safe and supportive. For some of the participants however, they have had challenging and distressing experiences with friendships that would rule them out as a means of unburdening themselves.

"I have had some dreadful experiences with friendships and relationships, you know, right up to recently, and that has been a real issue for me, and I think it was (peer support worker) that fixed me up with a Course at the (Mental Health Service) on friendships and relationships." (Jim).

Jim has highlighted his difficult history with friendships, something that could otherwise have been a source of support for him. The peer support worker has then found a way to begin to address with a course and is able to model a positive experience of friendship through their work together. This professional aspect to the relationship serves to protect the service-users from potential abuse and exploitation and provide safe and consistent boundaries for the relationship.

"It's good that it feels confidential, except knowing that if you become ill, and he can see you becoming ill, um ... what I mean by that is not for a particularly long period, but if he's given me that extra thirty seconds to a minute to see where it's going, sort of thing, then if he susses out that the signs are there, then he's ... that is, you know that should never be kept a secret, that should always be sent straight to the Clinical Team because that's vital" (Ian).

"He would do nothing to take advantage of me". (Jim).

Both Jim and Ian highlight the advantages to the professional aspects of the relationship in ensuring their safety through risk management and liaising with other health mental health professionals and preventing them from being exploited.

Endings proved a challenge for a number of the participants and this may in part be due to the informal and friendly relationship that had developed.

"It was really hard, as I felt really attached to her and um it felt more like she was my friend, really, and I just felt like it was really unfair that once we'd stopped working together we weren't allowed to be friends". (Eve)

It is perhaps a positive sign that the relationship is or will be missed by the service-user but highlights the need for careful management and preparation. When the peer support worker is providing a substantial portion of the social support available to the service-user or is indeed the only social contact this appears to be more challenging for the service-user. This reliance on the peer support worker for social contacts could move towards dependence which is then challenging to negotiate given the time-limited nature of the relationship. This time limit would appear to depend on the service within which the peer support worker is working but regardless of which service at some point there is inevitably going to be an ending. Endings were negotiated by some which were perceived to be positive and reflected well on the significance of the relationship that had developed. This was in some cases mediated by preparation done by the peer support worker and service-user:

"I think we had a nice trip out to the country and had a picnic, and we had a nice special day together." (Jim).

In contrast to several of the peer support workers who found the endings a challenge Denise framed her ending as a positive thing. This perhaps reflects the establishment of other sources of social support within her life.

"It's a positive thing, because it shows I'm getting better." (Denise).

Denise was the only individual to actively frame the ending as being positive but there would appear to be a continuum on which individuals found endings more or less challenging. This was perhaps related to the degree to which the service-user

depended on the peer support worker as a source of support especially if they have a limited number of other sources of social support and had poor experiences of working with health mental health professionals but this would require further research to examine.

Whilst it is acknowledged above the professional aspect to the peer support worker relationship was valued as boundaried and containing, there was still a degree of informality that served to distinguish this relationship from other mental health professionals. Ian also mentions the uneven nature of the professional relationships being a positive thing; that the service-user is not burdened with the difficulties of their peer.

"I didn't think it would be right for me to become his carer." (Ian).

In mutual support the reciprocal nature of the relationship is one of its distinct qualities but this seems to contrast with professional peer support worker. Ian highlights above that he did not expect to be dealing with his peer support worker's difficulties and this distinctly one-sided relationship fits with more traditional relationships with mental health professionals.

"With a friend who's going through tough times I would feel that I've got no right to even think about putting my problems, but it's as if Ellie's signed something to say "I'll take that for you". "(Eve).

Eve highlights the fact that this is a job for the peer support worker and that they are employed with a capacity to cope with the emotional distress of their

service-users. But this is not an easy boundary to manage and poses significant difficulties in negotiating.

"I think it's that bridge in between the Clinical side." (Ian)

Ian recognises the position that peer support workers hold in sitting between service-users and professionals. This also reflects the tension that they hold in being both friend and professional to the service-user. The acknowledgement of peer support workers' professional status and the responsibilities this has is significant, especially in regards to managing the safety of their service-users. It moves the relationship from a mutual relationship where each has equal status to one with different roles and responsibilities that need to be managed by the peer support worker and service-user alike.

The informal nature of this professional relationship and the similarity to friendship means that for several of the participants they questioned whether they were able to divulge information to their peer support worker due to a concern over how the peer support worker may handle this potentially distressing information.

*"I think the main thing I were worried about were that it could upset her."
(Caroline).*

It is interesting to note that no-one made reference to feeling concerned about talking to other mental health professionals but individuals are concerned about upsetting or burdening their peer support worker. This perhaps reflects the nature of the relationship holding similarities to friendship for the service-user.

"But sometimes I do relate myself and do think "OK (peer support worker)'s been through situations and she is supporting me, listening to all my stuff and what's going on around me, and she has other people to support as well, and sometimes I look at it and I think "I wonder how stressful that must be?"... I'm going to stand back, sign myself off because I'm sure there will be someone else out there who will need help, you know." (Betty).

Betty went so far as to think that she may need to discharge herself from the service due to the perception her peer support worker's time and emotional energy is limited and others are perhaps more deserving.

"Because I thought to myself like "I don't want to bring up old things for him, you know what I mean, because like I didn't want to go deep into something." (Ian).

Ian highlights the challenge of discussing issues that may resonate with the peer support worker who by their very nature has lived through something (to some degree) similar to them. These issues serve to act as barriers to disclosure and discussion that may not otherwise be present with mental health professionals and indeed no participants identified similar challenges when discussing their difficulties with other members of staff, however this was not explored in detail.

'Dual roles', where peer support workers are positioned as both friends and mental health professionals is a tenuous but potentially rewarding and useful position as described above. This position is challenging for both individuals and services to manage as has been highlighted above. Whilst this has not been

discussed here the challenges and benefits of integrating peer support workers into traditional mental health teams have been well documented and can be reviewed elsewhere (Gillard et al., 2013). 'Dual roles' positions peer support workers to provide a service that is distinct from traditional services, not through the specific techniques, but their unique position and the relationship developed through disclosure, perceived understanding and common experience.

Discussion

Section Introduction

In this section there will be theoretical, clinical and research implications as well as the relevance of this project to clinical psychology. There will then follow an evaluation of the research project as a whole, and concluding with a critical reflective section.

Theoretical implications

As noted within the introduction the only theorising that have taken place with regard to the processes underlying peer support was by Salzer et al. (2002). They highlighted five theories and models that may contribute to peer support. These will briefly be discussed in relation to the constructed themes within this study.

It was described in the journal article that social identity theory (Tajfel & Turner, 1979) and social comparison theory Festinger (1954) would appear, when integrated, to help to explain the constructed themes. The disclosure offered by peer support workers would seem to facilitate the development of a group identity, that could serve to enhance self-esteem and develop the service-user's sense of who and where they are in the social world. Through the interactions and relationship developed with the peer support worker the service-user potentially gains access to a broader identity, serving to address the social isolation experienced by so many. This appears to happen in concert with the more immediate social support offered on a day to day basis by the peer support worker and described in the theme dual roles.

The theme of dual roles describes the peer support worker being both a friend and a professional to the service-user, and both the value and challenges this holds. The role of friendship could be described as fitting with the broad sphere of social support, one of the significant factors that are "positively and causally related to

mental health, physical, health and longevity” (Thoits, 2011, p. 145). Whilst social support has been demonstrated as being important the reasons for this are still poorly understood (Berkman, 2009) and mirrors the participants’ difficulties in articulating exactly what it is about friendship that was of such value. Social support is one of the theories proposed as a mechanism through which peer support works (Salzer et al., 2002) and this would be consistent with the constructed themes within this project. Whilst participants seemed to struggle articulating what it was about the status of friendship that was important to them, they did highlight the position of sitting between professional and friend and holding the characteristics of each. They described the informality and the expression of care and interest, which often contrasted with other professional relationships. The value would appear to be placed in gaining the social support from the friendship whilst being maintained within the safety of professional boundaries. The position of sitting between two groups is an important one when considering the integration of social identity theory (Tajfel & Turner, 1979) and social comparison theory (Festinger, 1954).

The peer support worker sits in a role as both professional and friend, yet service-users have identified struggling to relate to some professionals. An important distinction needs to be made; the out-group are not all mental health professionals. The out-group would appear to be those individuals unwilling or unable to find ways to relate to the service-user, and the divide in life experience and perspective would seem incompatible. A description of the in-group would appear to be those individuals who are able to find ways to relate to the service-user in establishing commonality. For some this would be through mutual experience of peer support and for others it may be other challenging aspects of life.

Whilst service-user accounts have pointed towards peer support workers acting as role models in inspiring recovery, there was no mention of modelling positive health behaviours explicitly. Social learning theory (Bandura, 1977) was proposed by Salzer et al. (2002) but does not appear to match the accounts of service-users within this project. Borkman’s (1999) experiential theory is somewhat related to social learning theory according to Solomon (2004), and there were several accounts of practical support offered by peer support workers in using

their lived experience to make recommendations to service-users. One particular example of this was when Eve described how she and her peer support worker shared coping strategies they had found useful. Indeed this was the only example that would match the helper-therapy principle (Riessman, 1965) where Eve felt a sense of satisfaction for this reciprocal process. Whilst there has been much attention within the literature to the reciprocal processes involved in peer support neither the accounts of service users nor data reflected this.

Within grounded theory there is significant attention given to 'negative cases', those individuals or aspects of the data constructed that contradict the prevailing narrative within the themes or theory as a whole. There were no individuals with whom data was constructed with that contradicted the theory presented as a whole. There were a number of individuals whose accounts did contradict particular aspects of a theme such as Faye's peer support worker not disclosing anything beyond her role, Denise highlighting that her CPN disclosed personal information, and Ian even challenging the premise that peer support workers need to have lived experience of mental health difficulties at all.

Clinical Implications

As a process identification study the clinical implications of this research are limited. As stated in the journal paper, whilst we would be reticent to make recommendations based on a single study, should the theory developed within this research find further support, the following implications might be made.

According to social identity theory the establishment of an in-group may lead to an exacerbation in the perceived differences with the out-group. Whilst we have described this out-group as not all professionals but the professionals who fail to find ways to relate to the service-user and establish commonality, it is possible that service-users may generalise this to all mental health professionals. This would be detrimental to the relationships that exist and lead to a broadening of the 'them and us' divide. The potential here for the peer support relationship to be detrimental to other relationships with mental health teams and professional could be considerable.

This is a clinical implication in itself, however the peer support workers may be in a useful position within their dual role to highlight shared experience as someone who holds a professional role, works alongside other mental health professionals and who can embody the recovery they hope to inspire. Peer support workers may also be able to work within teams in highlighting this 'in-group out-group' dynamic that has been demonstrated within this research.

From the participants' perspective within this study, disclosure was viewed positively and was often contrasted with the lack of disclosure offered by professionals. Whilst disclosure has been documented as a therapeutic intervention in itself as highlighted within the introduction it is used very rarely within therapy (Hill & Knox, 2001). Whilst there may be significant difference between therapists and peer support workers, due to the absence of theory and research relating to disclosure within peer support relationships we draw on that established within therapist self-disclosure literature. Within the therapist self-disclosure literature it has been argued that the infrequency with which it is used makes the disclosure so powerful. However the constructed themes from this study would allude to a larger degree of disclosure instead focused on similarities and relevance for the service-user. There may indeed be more that therapists and other professionals are able to offer in terms of disclosure, that did not compromise their practice, but which could further develop the relationships as it appeared to do within this study.

Given the complex position that peer support workers hold as exemplified within the theme dual roles it would seem that appropriate support and supervision are necessary to ensure that professional boundaries are maintained, and the peer support workers are adequately supported within this challenging position. This is especially true given the concerns already raised from Fox and Hilton (1994) regarding the management of existing relationships and the motivations of some peer support workers to be positioned outside of holding a more traditional professional status (Dixon, Krauss & Lehman, 1994). It should be highlighted that whilst service-users may have perceived the relationship as that of a friendship there

is no evidence that peers reciprocated this sentiment. It is worth considering how this tension should be managed within teams, by peer support workers and within clinical supervision.

The ten essential shared capabilities are considered core to the professional activity of all health professionals (Brabban et al., 2006). They describe ten capabilities that act as best practice to be aspired to by all health professionals working with service-users. The most relevant for the findings of this research project would appear to be that of 'promoting recovery' and 'working in partnership'. Principles of personal recovery have been described within the introduction; in relation to the ten essential shared capabilities refers to service-user activism and the sharing of stories and experiences. It also refers to service-users holding decision making powers within professional relationships. This collaborative work highlights the central importance of the relationship. The close working relationships that are akin to friendships seem to have been both beneficial but at the same time challenging. This has previously been highlighted as a difficult conflict to manage for peer support workers (Dyble & Tickle, 2014; Gates & Akabas, 2007). This highlights the need for further exploration and training relating to this dynamic and the potential consequences of it for all individuals involved.

It would seem that there are unique qualities around professional peer support that make it distinct from other forms of peer support. Currently research findings are aggregated and the implications then disseminated into clinical practice. It would be a recommendation, based on the findings of this research that distinctions are made between the types of peer support and the theoretical mechanisms that underpin them. This would enable the training of peer support workers to more accurately focus on those aspects that uniquely apply to their position and are viewed as valuable by service-users.

There are considerable difficulties negotiating the dual roles of both professional and friend, and have potential negative connotations for both peer support worker and service-user. From the accounts of participants, the peer support workers had developed boundaries in order to help manage this but there still appeared to difficulties around endings and disclosing to them for fear of burdening them. This seemed most prevalent for those participants who reported lacking other sources of social support. In this way further training and support could be offered to peer support workers in order to help negotiate this challenge. Developing social support for those individuals lacking it, beyond that provided by the peer support workers may be of value in reducing the dependence service-users may feel towards them. However this would require further investigation.

Future Research

There are a number of different research implications from this study and are highlighted below:

- In order to move from substantive theory to formal theory it is necessary that the grounded theory developed be elaborated and evolved (Suddaby, 2006) through further application within wider study populations. Therefore the grounded theory developed within this study should be applied to wider range of settings and groups in order to further refine the theory.
- Direct comparisons made between professional peer support and other forms of peer support should be made in order to evaluate the difference that peer support worker may be able to offer.
- To compare and contrast peer support worker disclosure with that of other professionals in order further develop our understanding of its value.
- High quality research evaluating peer support within differing settings to determine where it is of most value.
- To identify service-user perceptions of the functions of peer support workers especially in relation to comparisons with other mental health professionals.

- To explore peer support roles in relation to team functions within current health service provision.

Relevance to Clinical Psychology

Clinical psychology has evolved in recent years to move beyond that of therapy. Clinical psychologists are moving towards positions of consultation, service development, training and leadership. In this position it is important for clinical psychologists to be involved in the development and evaluation of service level initiatives in order to provide the most effective care for service-users.

Peer support is an established part of government policy but there is a need for further high quality research to determine its value, effectiveness and unique contributions for peer support workers, service-users and services (Gillard et al., 2014; Pitt et al., 2013). Clinical psychologists have significant research skills and training that could contribute to this process.

Clinical psychologists work within multi-disciplinary teams including peer support workers. In order to best understand how the team as a whole can work towards supporting the needs of the clients they should have an understanding of the roles of each member of the team. Where clinical psychologists work independently they frequently signpost to alternative services and must thus be aware of what services are available, what these might be able to provide and how this might be achieved.

There is much that clinical psychologists and any other professionals, like myself, who hold a dual identity as service-user and clinician may gain from this research in considering how disclosure may be used. Indeed, as we have seen from this research, disclosure is not limited to mental health difficulties and there may be ways in which clinical psychologists can utilise different forms of disclosure in order to achieve positive therapy outcomes.

Evaluation of Research

In line with the methodology utilised within the research project, the developed grounded theory will be evaluated the criteria set out by Charmaz (2014, p. 337) as highlighted within the methodology section. This includes the sub-sections credibility, originality, resonance and usefulness described below. The issue of theoretical sufficiency (Dey, 1999) will also be evaluated within this section.

Credibility

This research has achieved 'intimate familiarity' with service-users' accounts of the relationship that developed within professional peer support work. This has been achieved iterative process of data collection and analysis. The audio-recordings of the interviews were transcribed verbatim and the process of analysis moved through initial and focused coding before moving to theoretical coding. This process allowed the researcher to become engrossed in the data.

The claims of the research are modest based on its small sample size and lack of generalizability due to its epistemological and ontological foundations. This could be improved by accessing a greater number of individuals who had less positive experiences with their peer support worker. The claims made by the research are however supported by the data. The process of constant comparative analysis allowed the researcher to make systematic comparisons between the emerging themes and the corpus of data at all stages.

Throughout the results the themes that were developed are supported by extracts from the interviews. This allows the reader to establish the plausibility of the claims made by the researcher. A research supervisor checked the themes for their plausibility. It is important to note this is not member checking or a form of

triangulation to seek validity of the findings but to assert whether the findings appear logical based on the data used to support them.

Originality

This research is the first of its kind within the peer support literature in seeking to explore the experiences of service-users in their interactions with peer support workers. This research offers a fresh and insightful perspective on experiencing professional peer support.

The research does offer a new conceptual rendering of the data based on comparison with existing literature. Whilst the local theoretical reflection did highlight similarities to those theories proposed to be critical to peer support it also demonstrated some substantial differences.

The theoretical significance of the study may be modest due to its exploratory nature and lack of generalizability it provides valuable insight into the experiences of service-users, something distinctly lacking within the current literature of peer support. It provides a starting point for further research to expand on and highlights differences to the assumed processes involved in peer support.

Resonance

The research findings portray the full experience of peer support work. Due to the breadth of work and interventions covered by peer support worker and the heterogeneity of individual experience it would be unrealistic to report all of the individual experiences. What is captured within this research is the core experience of peer support work, with negative case analysis highlighting where experiences contradicted the emergent theory. During the process of theoretical coding and discussion of findings the 'taken for granted' meanings were explored, placing the theory within a wider cultural context. (Henwood and Pidgeon, 2003).

The research made links between individual experiences and wider collectivities or institutions such as the comparisons made with relationships with other mental health professionals, with the wider recovery focused movement within the NHS and internationally and applicability of peer support within government policy. This research project did not seek to incorporate the views of the participants as a means of triangulation and member checking due to inconsistencies with the epistemological position of this research. As stated previously this research is based on a social constructionist epistemology and the findings represent the co-construction of data between participant and researcher. The participant could therefore not attest to the truthfulness of this co-construction.

Usefulness

This research has implications for clinical practice and future research. Whilst the findings do not assert generalizability they highlight questions that may be asked about shared experience, disclosure, working relationships and the development of peer support services and provision of training and support from psychologists. The research has highlighted core experiences of service-users utilising professional peer support, but this remains limited to the individuals that participated within the research the research does not imply this would be the case for all but could be a starting point for further research. There are significant research implications which have been highlighted elsewhere. The contribution of this paper to the knowledge base around peer support is modest but original. It challenges current proposed mechanisms and has implications for future research on peer support worker.

Theoretical sufficiency

As stated within the methodology this research project sought to achieve theoretical sufficiency as opposed to theoretical saturation (Dey, 1999). Theoretical sufficiency is achieved when existing themes cope adequately with new data without the requirement of extension or modification. As analysis occurs at the

same time as data collection the developed themes are revised with each subsequent episode of data collection. By the tenth interview it was felt that the constructed data could fit within the developed themes without it being necessary to further develop or modify the theory.

The recruitment for the study was a difficult process and is explored in more detail in the extended methodology. It was not always possible to explore every avenue fully due to time constraints and the researcher's ability to identify key issues at the point of interview. However, the interview schedules were adapted after analysis in order to pick up on interesting and important areas. By the last interview, no new themes were developed and the existing themes coped sufficiently with the new data. For this reason an argument can be made for achieving theoretical sufficiency. The author acknowledges however that were all lines of inquiry explored extensively it is possible that new themes could have been constructed.

The theory

One of the frequent criticisms levelled at constructivist grounded theory is surrounding that of theory and whether the author has successfully developed a grounded theory. As mentioned earlier there are considerable differences between interpretive and positive definitions of theory.

“One problem that still occurs is treating positivism and its versions of theory and method as interchangeable with science and scientific method. Positivism represents one rather than all ways of accomplishing scientific work”
(Charmaz, 2014, p. 230).

This study did not seek to develop a formal theory as a positivist theory might, rather it sought to develop an interpretive understanding of the service-users' accounts (Pidgeon & Henwood, 2004). This theory is situated within time and space and is a subjective interpretation that acknowledges multiple realities. The theory developed is consistent with the epistemological and ontological assumptions of constructivist grounded theory.

Limitations

Sampling

The sampling for this study could be perceived as a limitation. The sampling strategy in utilising the peer support workers to introduce the project to their service-users perhaps limited the individuals to be recruited to this study. The initial response rate was very low and contact with the peer support workers was difficult despite the best efforts of the author and field supervisor. Despite the early indications from peer support workers and service leads that there would be no shortage of participants these failed to appear. It is perhaps due to the developmental stages of peer support worker and the perception that peer support workers were being evaluated themselves rather than the process of peer working. This may have led to cherry-picking of service-users or a failure to advertise the study to prospective participants who may not have held as positive views about peer support.

These difficulties were attempted to be mediated in the substantial amendment by circumventing the peer support workers and advertising to individuals who may be current or previous recipients of care of peer support workers by posters and staff contacts at outpatients departments and involvement centres within the Trust. This led to an increase in response rate but there was no measure of where the participants were recruited from when they contacted the researcher. In order to address these difficulties in future research a recruitment method could be to contact all individuals who have been in contact with a peer support worker for sufficient time through service records.

Sample diversity

It could be argued that the sample size of ten is a limitation of this study. The aim of this project however was not to recruit a large sample size, it was to achieve theoretical sufficiency. As discussed earlier this was achieved however it was acknowledged that with further exploration of each relevant theme it could be possible to have developed further themes or expand existing ones. In order to address this it may be useful to gain consent from the individuals participating to be involved in a second interview after the initial interview had been analysed to further develop areas of interest. This research did not aim to create a formal theory or hold a representative sample of individuals from a particular population. An argument could be made to increase the diversity or sample size but this is incongruent with the aims of the research.

Conclusions

This research has offered a unique and original contribution to the knowledge base around professional peer support. It highlights the central importance of disclosure as a means to establish in-group identity. This in-group identity posed particular importance for individuals who described themselves as isolated with limited social support. There is considerable overlap between psychological literature around therapist-self-disclosure and that proposed within peer support, as well as that around therapeutic and other helping relationships. These could be used to help describe and explain the processes involved in peer support. The dual roles occupied by peer support workers are a potentially useful but challenging position to be in for all involved. The findings of this research highlight the interventions, and engagement with service-users, offered by peer support workers is consistent with the principles of recovery-oriented practice and is a means by which recovery-oriented practice can be further developed. The clinical implications are limited due to the aims of the project and the use of a constructivist methodology. However the

identification of process within peer support has led to areas of potential further research.

Critical reflective component

As a researcher I was engaged in a reflective process from the outset of research design through to analysis and write up. I utilised a reflective diary and memo writing in order to aid this and excerpts will be presented below. This section highlights some of the scientific, ethical and theoretical issues identified during the research process. Also included are challenges identified and decision-making processes that aided the resolution of these.

Researcher positioning

Reflexivity is commonly viewed as a process of “continual internal dialogue and critical self-evaluation of researcher’s positionality as well as active acknowledgement and explicit recognition that this position may affect the research process and outcome” (Berger, 2013, p. 2). It is also acknowledged that there is interdependence of the researcher and the researched (Pidgeon & Henwood, 1997) and this has been utilised as a measure of quality control within qualitative research projects (Lietz, Langer, & Furman, 2006).

An example of this positionality and interdependence between the researcher and the researched was in my struggles with how some staff conceptualise service-user experiences to the exclusion of all else. I have a strong attachment to recovery-oriented principles and the way in their mental health difficulties are one part of a much larger individual with strengths, values, interests and relationships. This position I have found is often in conflict with the medical model which dominates healthcare within the UK. When listening to accounts of service-users experiences where they viewed exclusively by their diagnosis I struggled to disentangle my

disagreement on the reliance of the medical model with poor clinical practice. The extract below from my reflective diary after an interview exemplifies this

“Having just spent an hour listening to the accounts of a service-user, I am immediately drawn to their experience of care within the health service and how poorly received it is. The reliance on the medical model leads to the distancing of professionals from those they profess to care for. Where is the care in healthcare? Having spent time thinking about this my thoughts turn to my own biases and preference for recovery oriented practice. It is entirely possible that professionals utilising a recovery-oriented position could treat the service-users they are working with in the same manner. In fact it is not the orientation of the clinician that is important it is a fundamental respect for those you care for and an integrity to treat others as they should be.”

I was pleased that I was able to reflect on this whilst the data collection and analysis were taking place. I discussed this within supervision and reanalysed transcripts in order to make sure that my bias against poor practice rather than the medical model apparent.

Researcher or clinician?

A particular challenge that I found difficult to manage across the research process was disentangling the clinician from the researcher. The statements I would make would inevitably shape the conversation and line of enquiry within the research that held considerable difficulties for me when an aspect of my role of trainee clinical psychologist is the provision of psychological therapy. In each of the individuals I met there was a degree of emotional distress displayed currently or in reflecting on past experiences. I had considerable struggles, especially at first with refraining from being a therapist instead of a researcher. My primary aim in the research capacity is one of curious enquiry about the phenomenon under

investigation, however I found myself slipping into the role of clinician when faced with emotional distress from the participants. My actions in responding to the emotional distress exhibited by my participants perhaps curtailed or prevented the exploration of a line of enquiry further. The challenge of working as a therapist researcher has received some attention in research methodologies literature (Arber, 2006; McNair, Taft, & Hegarty, 2008).

One example of my impact on the research process was during an interview with a participant who expressed some concern over speaking badly about a professional she was working with. I responded by attempting to normalise her experiences in highlighting lots of individuals having poor experiences with mental health professionals. Whilst this may have alleviated some of the discomfort she felt about disclosing these feelings it limited my exploration of why this would be such a bad thing and what this actually meant to her. My attempts to validate feelings and experiences shaped the research process and limited my exploration of the phenomenon. This was discussed within research supervision and I made efforts to refrain from attempting to alleviate a participant's distress in future interviews, supported by further supervision. A challenge that took several interviews to improve upon but thereafter appeared to open dialogue and allow further discussion.

Memo writing

Memo writing is an essential element to grounded theory studies and forms and indeed Charmaz (2006, p. 72) believes this to be the “pivotal intermediate step between data collection and writing drafts”. Memo writing involves capturing thoughts, questions and reflections to describe what is happening or not happening within the data. It is a means by which emerging themes can be described and compared and routes for further analysis or investigation are discovered. My overwhelming sense of memo writing was that I was constantly in a process of writing and re-writing memos. Whilst this is useful in demonstrating transparency through an audit trail I found that more questions were raised than necessarily

answered. The constructivist position of multiple realities and no single truth left me wondering what the 'right' answer was. This was where the grounding supervision from more experienced professionals allowed me to vent my frustrations and reflect on the opportunity presented by so many different realities.

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Appendices



Study: Service users' perceptions of professional peer support work

For more information on what would be involved in this study or to find out how you can take part please contact the principal investigator, Alistair Bailie, using the details below

Phone: 07583-052-258 for the purposes

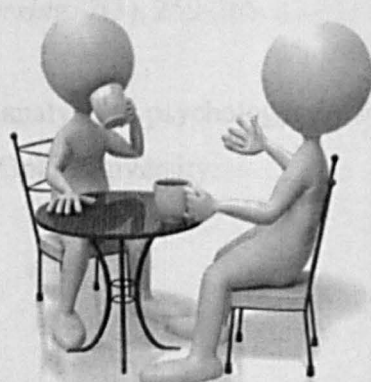
of the study only

E-mail:

lwshab@exmail.nottingham.ac.uk

NHS R&D and
Leicester Research
Ethics Committee approved study no:
14/EM/0042

Final version 2:
05/03/2014



- Have you worked with a peer support worker on a 1:1 basis in the last 12 months?
- Would you like the chance to share your views and experiences in order to help shape service provision?
- A study is currently taking place looking at the experiences of those who have received support from peer support work-

Appendix B

NHS
Health Research Authority

NRES Committee East Midlands - Leicester

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FS

Telephone 0115 883 9425

21 February 2014

Professor Thomas Schroder
Co-Director Trent Doctorate in Clinical Psychology
University of Nottingham
YANG Fujia Building
Jubilee Campus, Wollaton Road,
Nottingham,
NG81BB

Dear Professor Schroder

Study title:	A grounded theory study of service users' perceptions of professional peer support work
REC reference:	14/EM/0042
Protocol number:	13145
IRAS project ID:	139218

Thank you for your letter of 18 February 2014, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information has been considered on behalf of the Committee by the Chair.

We plan to publish your research summary wording for the above study on the HRA website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the REC Manager Ms Wendy Rees, NRESCommittee.EastMidlands-Leicester@nhs.net

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the conditions specified below.

Ethical review of research sites

NHS sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see

"Conditions of the favourable opinion" below).

Non-NHS sites

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

Management permission ("R&D approval") should be sought from all NHS organisations involved in the study in accordance with NHS research governance arrangements.

Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at <http://www.rdforum.nhs.uk>.

Where a NHS organisation's role in the study is limited to identifying and referring potential participants to research sites ("participant identification centre"), guidance should be sought from the R&D office on the information it requires to give permission for this activity.

For non-NHS sites, site management permission should be obtained in accordance with the procedures of the relevant host organisation.

Sponsors are not required to notify the Committee of approvals from host organisations

Registration of Clinical Trials

All clinical trials (defined as the first four categories on the IRAS filter page) must be registered on a publically accessible database within 6 weeks of recruitment of the first participant (for medical device studies, within the timeline determined by the current registration and publication trees).

There is no requirement to separately notify the REC but you should do so at the earliest opportunity e.g when submitting an amendment. We will audit the registration details as part of the annual progress reporting process.

To ensure transparency in research, we strongly recommend that all research is registered but for non clinical trials this is not currently mandatory.

If a sponsor wishes to contest the need for registration they should contact Catherine Blewett (catherineblewett@nhs.net), the HRA does not, however, expect exceptions to be made. Guidance on where to register is provided within IRAS.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Evidence of insurance or indemnity	Henderson	31 July 2013
Interview Schedules/Topic Guides		06 January 2014
Investigator CV	Thomas Schroder	17 February 2013
Letter from Sponsor		08 January 2013
Other: CV - Hugh Alistair Baillie		
Other: CV - Dr Anna Tickle		
Other: CV - Michael Rennoldson		
Other: Poster	1	06 January 2014
Other: Demographic and clinical information	2.0	18 February 2014
Participant Consent Form	1.0	06 January 2014
Participant Information Sheet	2.0	18 February 2014
Protocol	1.0	06 January 2014
REC application	139218/549507/1/189	13 January 2014
Response to Request for Further Information		18 February 2014

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Reporting requirements

The attached document "*After ethical review – guidance for researchers*" gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Notification of serious breaches of the protocol
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

Feedback

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

Further information is available at National Research Ethics Service website > After Review

14/EM/0042

Please quote this number on all correspondence

We are pleased to welcome researchers and R & D staff at our NRES committee members' training days – see details at <http://www.hra.nhs.uk/hra-training/>

With the Committee's best wishes for the success of this project.

Yours sincerely



Professor Geoff Dickens
Chair

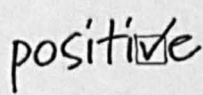
Email: NRESCommittee.EastMidlands-Leicester@nhs.net

Enclosures: "After ethical review – guidance for researchers"

Copy to: Mr Paul Cartledge

Shirley Mitchell, Institute of Mental Health

Appendix C



Nottinghamshire Healthcare 
NHS Trust
Positive about integrated healthcare

Research Support Services
Institute of Mental Health
University of Nottingham Innovation Park
Triumph Road
Nottingham
NG7 2TU

E-mail: Shirley.mitchell@nottshc.nhs.uk
Direct Line: 0115 748 4321

Date of NHS Permission: 3 March 2014

Professor Thomas Schroder
Co-Director Trent Doctorate in Clinical Psychology
University of Nottingham
YANG Fujia Building, Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Professor Schroder

Study Title: A grounded theory study of service users' perceptions of professional peer support work
IRAS ID/REC Ref.: 139218/14/EM/0042
Sponsor: University of Nottingham
Principal Investigator: Hugh Baillie

Thank you for submitting your project to the Nottinghamshire Healthcare NHS Trust's R&D Department. The project has now been given NHS permission for PIC activity on behalf of:

Dr Gopi Krishnan: R & D Director, on behalf of Nottinghamshire Healthcare NHS Trust.

NHS permission for the above research has been granted on the basis described in the application form, study protocol and supporting documentation. The following documents were reviewed:

Document	Version	Date
Interview Schedules/Topic Guides		06/01/14
Participant Information Sheet	2	18/02/14
Participant Consent Form	1	06/01/14
Other: Poster	1	06/01/14
Other: Demographic and clinical information	2	18/02/14
Study Protocol	1	06/01/14

Permission is granted on the understanding that the study is conducted in accordance with the Research Governance Framework, ICH GCP [ONLY if applicable], and NHS Trust policies and procedures available <http://www.nottinghamshirehealthcare.nhs.uk/contact-us/freedom-of-information/policies-and-procedures/>

The research sponsor or the Chief Investigator, or the local Principal Investigator at a research site, may take appropriate urgent safety measures in order to protect research participants against any

Resource, Duncan Macmillan House, Porchester Road, Nottingham NG3 6AA
Chair: Dean Fathers, Chief Executive: Professor Mike Cooke CBE



Appendix D

Participant Information Sheet

(Final version 2.0: 18/02/2014)

Title of Study: Service-users' perceptions of professional peer support

Name of Researcher(s): Alistair Bailie

We would like to invite you to take part in a research study. Before you decide we would like you to understand why the research is being done and what it would involve for you. I will go through the information sheet with you and answer any questions you have. Talk to others about the study if you wish. Ask us if there is anything that is not clear.

What is the study about?

This project aims to ask service-users what they think about peer support work. This is to help us better understand the work of peer support workers. Other professionals may also learn from this. This study will also be a chance for people who have worked with peer support workers to have their views heard.

Why have I been invited?

You are being invited to take part because you have worked with a peer support worker within Nottinghamshire Healthcare Trust. We are inviting between 15 to 20 participants like you to take part.

Do I have to take part?

It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form. If you decide to take part you can change your mind and withdraw and without giving a reason at any time until 72 hours after you are interviewed for the study. This would not affect your legal rights or the services that you receive.

What will happen to me if I take part?

If you decide to take part in this study you will be interviewed once for between 60-90 minutes and complete a socio-demographic information sheet (Final Version 1.0 17/01/2014). This can be at a time and place that is convenient to you. I will ask some questions to prompt a conversation about your experience of peer support work.

If you consent for the study to keep your contact details you will be sent an information sheet with the main findings of the study when the final analysis is complete in 2014.

Expenses and payments

You will not be paid to participate in the study. Travel expenses will be offered for any visits incurred as a result of participation.

What are the possible disadvantages and risks of taking part?

There are not expected to be any risks associated with taking part in this study. You may find it upsetting to talk about personal experiences. If there are any questions that you do not want to answer, you can just tell me without having to explain. If you need to have a break or stop the interview, you can do this at any time, without having to explain.

What are the possible benefits of taking part?

We cannot promise the study will help you, but you might find it useful to talk about your work with your peer support worker in a private setting. The information we get from this study may help to develop peer support work in the future.

What happens when the research study stops?

After the interview, you will not be asked to do anything else for the study. If you consent to your contact details being stored until the end of the study, I will send you an information sheet with the main findings of the study.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak to the researchers. The researchers' contact details are given at the end of this information sheet. If you remain unhappy and wish to complain formally, you can do this by contacting NHS Complaints. Details are given at the end of this sheet.

Will my taking part in the study be kept confidential?

We will follow ethical and legal practice and all information about you will be handled in confidence in line with the requirement of the Data Protection Act 1998.

All information which is collected about you during the course of the research will be kept **strictly confidential**, stored in a secure and locked office, and on a password protected database.

The audio files of the interview will be transcribed either by the principal investigator or by a transcription service. The transcription service will sign a confidentiality agreement as part of their work and will not retain any copies of the audio file or transcribed interview.

Your personal data (address, telephone number) will be kept until November 2014, after the end of the study, so that we are able to contact you about the findings of the study (unless you advise us that you do not wish to be contacted). All other data (research data) will be kept securely for 7 years. After this time your data will be disposed of securely. During this time all precautions will be taken by all those involved to maintain your confidentiality, only members of the research team will have access to your personal data.

When I write about the research, I would like to use quotes from the interview. I will not use your real name or include any other information that could be used to identify you.

If you join the study, some parts of the data collected for the study will be looked at by authorised persons from the University of Nottingham who are organising the research. They may also be looked at by authorised people to check that the study is being carried out correctly. All will have a duty of confidentiality to you as a research participant and we will do our best to meet this duty.

If you let me know during the interview that you or anybody else was at risk of harm or told me about a crime, I may have to breach confidentiality. This is because I have a duty of care to act on this information. This may include contacting your care coordinator, GP or other appropriate professional. If this does occur you will be kept informed of what is happening and why.

In the event that you become distressed during the interview I will contact your GP, care coordinator (if applicable) and peer support worker in order to ensure you have appropriate support available. I will use the contact details you have provided in the socio-demographic form you will complete at the start of the interview.

What will happen if I don't want to carry on with the study?

Your participation is voluntary and you are free to withdraw at any time, without giving any reason, and without your legal rights being affected. You have 72 hours after completing the interview to withdraw your data from the study, in which case all information will be removed from the study and destroyed. If you decide after 72 hours that you wish to withdraw then the information collected so far cannot be erased and this information may still be used in the project analysis.

Involvement of the General Practitioner/Family doctor (GP)

Your GP will not be contacted as a routine part of this study and no information exchanged.

What will happen to the results of the research study?

The research will also be submitted as part requirement of fulfilment of the Trent Doctorate in Clinical Psychology. It is hoped that the results of the study will be published in a journal. The journal article is likely to be submitted for publication by January 2015.

Who is organising and funding the research?

This research is being organised and funded by the University of Nottingham.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee, to protect your interests. This study has been reviewed and given favourable opinion by the University of Nottingham Research Ethics Committee and the NRES Committee East Midlands - Leicester.

Further information and contact details

The principal investigator is Alistair Bailie, Trainee Clinical Psychologist. All enquiries should be directed to him. He is contactable through the administration department of the Trent Doctorate in Clinical Psychology. Telephone number: 07583 052258 or by email lwshab@exmail.nottingham.ac.uk. The project supervisor, Dr Anna Tickle can also be contacted on the same number or by email on lwaat@exmail.nottingham.ac.uk.

Complaints contacts

To write:

Samantha Eagling

Service Liaison Manager

Service Liaison Department

Moorgreen House

Highbury Hospital

NG6 9DR

Email: complaints@nottshc.nhs.uk

Tel: 0115 993 4542

Appendix E

CONSENT FORM

(Final version 1: 06/01/2014)

Title of Study: Grounded theory study of clients perceptions of the psychological processes underlying professional peer support

REC ref: *(to be added after approval given)*

Name of Researcher: Alistair Bailie

Please initial box

1. I confirm that I have read and understand the information sheet final version 1.0 06/01/2014 for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my medical care or legal rights being affected. I understand that should I withdraw then the information collected can only be erased within 72 hours of the interview taking place. If I withdraw after 72 hours the information I have provided may still be used in the project analysis. ☐
3. I understand that relevant sections of the data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐

4. I understand that the interview will be recorded and that anonymous direct quotes from the interview may be used in the study reports. ☐
5. **OPTIONAL:** I agree to my contact details being kept until the final analysis is complete in 2014 so that I may receive an information sheet with the main findings of the study. ☐
6. I agree to take part in the above study. ☐

Name of Participant

Date

Signature

Name of Person taking consent

Date

Signature

Appendix F

Demographic and clinical information

Interviews will begin with completing a demographics and clinical information sheet

Name

Age

I would describe my ethnic origin as: (please tick)		
Asian <input type="checkbox"/> Bangladeshi <input type="checkbox"/> Indian <input type="checkbox"/> Pakistani <input type="checkbox"/> Any other Asian background Black <input type="checkbox"/> African <input type="checkbox"/> Caribbean <input type="checkbox"/> Any other Black	Mixed <input type="checkbox"/> Asian & White <input type="checkbox"/> Black African & White <input type="checkbox"/> Black Caribbean & White <input type="checkbox"/> Any other mixed background Other Ethnic Group <input type="checkbox"/> Chinese <input type="checkbox"/> Any other ethnic group	Undisclosed <input type="checkbox"/> I do not wish to disclose my ethnic origin White <input type="checkbox"/> British <input type="checkbox"/> Irish <input type="checkbox"/> Any other White background

background		
------------	--	--

Gender (please tick) Male ☐ Female ☐

Approximate date started with peer support worker

Please describe any previous contact with peer support workers

General Practitioner (GP) address:
.....
.....
.....
.....
.....

GP Phone number:

Name of care coordinator (if applicable):
.....

Care coordinator Team
.....

Care coordinator Telephone number

.....

Peer support worker name:

.....

Peer support worker telephone number:

.....

Appendix G

Interview schedule (Draft version 1 05/12/2013):

1. Could you tell me about how you started working with a peer support worker?
 - a. What prompted you to begin the work?
2. Could you tell me about the type of work you do together?
 - a. What's does a typical session consist of?
 - b. Has it changed since you started and if so how?
 - c. How did you organise your time/sessions together?
3. Do you think the work you have done has been useful?
 - a. Why?
 - b. How?
 - c. Is it different to what you expected, if so how?
 - d. Has your relationship changed since beginning work together and if so how?

- e. Has your perception of peer support work changed since you began work together and if so how?
4. How would you compare your relationship with other professionals (current or previous)?
 - a. What's different/similar compared to working with your CPN/Psychiatrist/Psychologist etc?
 - b. What's different compared to a friend or family member?
5. Did your peer support worker disclose their experiences of mental health difficulty?
 - a. How did you find this?
 - b. Have any other professionals made this type of disclosure and if so how do they compare?
 - c. How did the disclosure effect your relationship/work together
6. What sources of support do you have?
 - a. Friends, family, professionals
 - b. How does peer support work compare?
 - c. Is there anything that peer support brings that couldn't be provided by someone else?

This is not an exhaustive list of questions and is likely to change with the inductive nature of grounded theory research.

Appendix H

Interview schedule (Final version 2 25/06/2014):

1. Could you tell me about how you started working with a peer support worker?
 - a. What prompted you to begin the work?
2. Could you tell me about the type of work you do together?
 - a. What's does a typical session consist of?
 - b. Has it changed since you started and if so how?
 - c. How did you organise your time/sessions together?
3. What did you think of the peer in peer support worker?
 - a. What did you know about peers
 - b. Did your opinions change through your experience with them
4. Did they share their experiences with you?
 - a. Why/Why not?

- b. What was that like?
 - c. What insight did you get from their experience
 - d. Did you feel you gave them anything
 - e. What was that like
 - f. Does it matter how close your experiences are
 - g. Would you know they has been through services without them telling you?
- 5. How do you think peer support works
 - a. What's different about it?
 - b. What's similar to working with other professionals
- 6. Do you think the work you have done has been useful?
 - a. Why?
 - b. How?
 - c. Is it different to what you expected, if so how?
 - d. Has your relationship changed since beginning work together and if so how?
 - e. Has your perception of peer support work changed since you began work together and if so how?
- 7. How would you compare your relationship with other professionals (current or previous)?
 - a. What's different/similar compared to working with your CPN/Psychiatrist/Psychologist etc?
 - b. What's different compared to a friend or family member?
 - c. How did you find this?
 - d. Have any other professionals made this type of disclosure and if so how do they compare?
 - e. How did the disclosure effect your relationship/work together
- 8. What sources of support do you have?
 - a. Friends, family, professionals
 - b. How does peer support work compare?
 - c. Is there anything that peer support brings that couldn't be provided by someone else?

This is not an exhaustive list of questions and is likely to change with the inductive nature of grounded theory research.

Appendix I

Interview schedule (Final version 3 10/09/2014):

1. Could you tell me about how you started working with a peer support worker?
 - a. What prompted you to begin the work?
2. Could you tell me about the type of work you do together?
 - a. What's does a typical session consist of?
 - b. Has it changed since you started and if so how?
 - c. How did you organise your time/sessions together?
3. How would you compare your relationship with other professionals (current or previous)?
 - a. What's different/similar compared to working with your CPN/Psychiatrist/Psychologist etc?
 - b. Can you compare the type of work you do with different professionals
 - c. What's different compared to a friend or family member?

- d. How did you find this?
 - e. Have any other professionals made this type of disclosure and if so how do they compare?
 - f. How did the disclosure effect your relationship/work together
- 4. What did you hope to achieve from seeing a peer support worker
 - a. Have you achieved this
 - b. How/ Why not
- 5. Did they share their experiences with you?
 - a. What insight did you get from their experience
 - b. Did you feel you gave them anything
 - c. What was that like
 - d. Does it matter how close your experiences are same dx/life experiences
- 6. How do you think peer support works
 - a. What's different about it?
 - b. What's similar to working with other professionals
- 7. Do you think the work you have done has been useful?
 - a. Why?
 - b. How do you know
 - c. What is different for you now since working with a psw?
 - i. Is that related to working with a psw
 - ii. How have they contributed to your recovery
 - d. Is it different to what you expected, if so how?
 - e. Has your relationship changed since beginning work together and if so how?
 - f. Has your perception of peer support work changed since you began work together and if so how?
- 8. What sources of support do you have?
 - a. Friends, family, professionals
 - b. How does peer support work compare?
 - c. Is there anything that peer support brings that couldn't be provided by someone else?
- 9. Are there boundaries within the work you do together
 - a. What
 - b. Are these useful
 - c. Are there any challenges in this

10. Have you talked about ending?
 - a. How has that been managed
 - b. How do you think you will manage this transition

This is not an exhaustive list of questions and is likely to change with the inductive nature of grounded theory research.

Appendix J

Interview 10				
I(nterviewer)			Initial Coding	Focused coding
P(articipant)				
I		So I suppose firstly, how did you get started with your Peer Support Worker?		
P		<i>Well I was ... I had a serious attack of Mental Health problems as I suffer from Schizo-Affective Disorder and the Police and Ambulance came to my house and I found myself on a Section 3 at</i>		

		<i>... shall I say the Ward?</i>		
I		You can say it if you want, or you don't have to.		
P		<i>Well it was (Hospital), and, er, it was a fairly frightening experience, and then after a short period (PSW) took me on and he was very good with me.</i>		
I		So how were those kind of introductions made? How did you first meet him? Was it just kind of around the Ward or did the Nurses introduce you, or ...		
P		<i>It was around the Ward, er, I mean I was too seriously poorly to be introduced to him to start with, but as I got better (PSW) generally introduced himself on the Ward as he did his rounds.</i>	<i>Met around the ward</i> <i>Introduced as started to get better</i>	
I		Okay. And how did you start, kind of, doing stuff together?		
P		<i>Er, well it's a bit difficult to remember, but I think when I was on the Ward (PSW) introduced me to Occupational Therapy and the Spiritual Centre which meant a lot to me...</i>	<i>Made introductions</i> <i>Valued input</i>	<i>Signposting</i>
I		Oh right.		

P		... being a Christian you know and, er, that was very helpful. Then after three months of this I was discharged, and (PSW) picked up my case and, er, he would either visit me every fortnight or weekly. And that was ... I didn't particularly have any other support apart from my Care Co-Ordinator, so I wasn't able to do any nice activities with anybody else, and that's where (psw) stepped in, and things like that.	<p>Faith important to him</p> <p>Limited support</p> <p>No activities with anyone</p> <p>Isolated</p> <p>Psw intervened</p>	<p>Input based on client's needs</p> <p>Socially isolated</p> <p>PSw as a means of Social inclusion</p>
I		And what sort of things ... what would be like a typical ... or is there a typical session with (psw)?		
P		Well (psw)'s very much into his cycling, so I invested in a mountain bike and we went on some nice cycle rides, he introduced me to some new places to go, he also looked up information on his computer about activities, er, you know, things like walking, model railway because I've got a big model railway and er and other things, and he did a Wellness plan with me.	<p>PSW interest in cycling</p> <p>Went cycling</p> <p>Psw found information on client's interests</p> <p>Completed wellness plan together</p>	<p>Developed interest from psw</p> <p>Activities as bonding</p> <p>Activities of interest and value</p> <p>Managing MH</p>
I		Oh okay.		
P		We spent a few weeks on that, where it was questions and you filled the answers in and it's about maintaining your mental	Useful to plan how to maintain MH	Managing MH

		<i>health and your wellbeing and what to put in place to maintain that, and that was very useful.</i>		
I		Okay. So it sounds like there's the kind of activities and things like that, and then there's the Wellness Plan and well. It sounds like you've done quite a lot of different things.		
P		<i>Yeah, yeah, and I mean (psw) had got a spiritual side to him as well, he did meditation and I think he was sort of a spiritual sort of a person and we were able to talk about those things. Er, so you know, I mean it was quite a dark time for me when I came out of Hospital, because you know even though it was an awful experience in Hospital, you've got people around you and you get a bit institutionalized and I was just on my own at home and er I used to really look forward to our visits and that, you know.</i>	<p>Able to talk about spirituality</p> <p>Dark time coming out of hospital</p> <p>Institutionalized</p> <p>Isolated</p> <p>Looked forward to visits</p>	<p>Shared value of spirituality</p> <p>Difficult transition</p> <p>PSW addressing Social inclusion</p>
I		Er, and um, when you were kind of working out what you wanted to do together, how did you decide you'd be going cycling, or you'd be going to, er, do other activities?		
P		<i>Well (psw) would let me take the lead, you know, he wouldn't say</i>	Led by client	Collaboration valued

		<i>"Oh we're doing this, we're doing that" you know. And I remember then I wasn't very motivated with my cleaning and maintaining my house and myself, you know, so he'd give me little challenges to, you know, do a little bit at a time and build on it.</i>	No imposition of goals from psw Giving challenges to improve cleanliness incremental	Empowering through choice Gradual process to meet abilities of client
I		And how did you find that?		
P		<i>Yeah I felt it was very helpful because you know if my environment's not very nice then I'll feel worse, you know.</i>	<i>Environmental impact on MH</i>	<i>Identifying holistic influences on recovery</i>
I		Yes. And how do you think it compares to other Professionals?		
P		<i>Well in a way I think it ... in a lot of ways it's more valuable, because you know a CPN is important, but they're more the medical side and co-ordinating things, and the Psychiatrist is responsible for the medication and analysis, but it just seems ... it gives a nice human touch to the care, having a Peer Worker.</i>	<i>more valuable than MH pro</i> <i>CPN medical and coordinating</i> <i>Human touch</i>	<i>Valued psw over others</i> <i>Interpersonal qualities important</i>
I		Okay.		
P		<i>And, you know, I know they've got to keep a professional distance, but it's sort of a lot more friendly, and lot more helpful in a lot of ways, you know.</i>	<i>Professional but friendly</i> <i>More helpful</i>	<i>Bridge professional/non-professional barrier</i>

I		So what sort of things, kind of, make him more human, I suppose.		
P		<i>Well he's had life experience, you know, with him having had Mental Health problems himself, so he could relate to me and he had had some difficulties ... he didn't go into detail ... but he'd had some difficult times in his life, and in telling me that, that encouraged me because it gave me hope for the future, because if he can do it then I can, you know.</i>	<i>Able to relate through life experiences</i> <i>Having difficulties makes more human</i> <i>No specifics around disclosure</i> <i>Giving hope through precedent</i>	<i>Ability to relate through diffs</i> <i>Limited disclosure</i> <i>Setting positive example</i> <i>Hope through experience</i>
I		Yeah. And did he talk specifically about the experiences that he'd had, or ...		
P		<i>I don't think he went into detail but he just said he's been in a similar dark place to me, it was a long time ago, but it's a bit difficult to remember.</i>	<i>No specifics around disclosure</i> <i>Similarities in experiences</i>	<i>Limited disclosure</i> <i>Disclosure as shared experience</i>
I		No, that's okay. I was just wondering if, kind of, that was enough for you, or if you'd wanted to know a bit more about him, or ...		
P		<i>Er, well I didn't want to pry (laugh) but yeah I'm always</i>	<i>Didn't ask more</i>	<i>Hard to ask about</i>

		<i>interested in people's experiences, and how they've come through them, you know.</i>	<i>details</i> <i>Acknowledge privacy of psw</i>	<i>experiences of PSW</i> <i>Barriers to disclosure</i>
I		Yes. So it wasn't the case of him saying "I've been through this and you should do this as that's what I did"?		
P		<i>No, but what he did say inspired me, you know, he didn't say you've got to do this, this and this to get where I am, he didn't put it that way you know.</i>	<i>Inspiring</i> <i>Not dictating strategies that helped them</i>	<i>Valued disclosure</i> <i>Not prescriptive strategies</i>
I		And was that a good thing?		
P		<i>Yeah I think so, yeah.</i>		
I		It makes it a bit more about you, rather than just copying him?		
P		<i>Yeah, yeah.</i>		
I		Um, and what did you ... when you started Peer Support work, what did you want to get out of it? Did you have like an aim?		
P		<i>Well he wanted to, if it's the wrong word, liberate and enable me.</i>	<i>Psw's aims for him</i> <i>Enable and liberate</i>	<i>Goal of empowering</i>

Appendix K

Charmaz (2014) tool for evaluating qualitative analysis

Credibility

- Has your research achieved intimate familiarity with the setting or topic?
- Are the data sufficient to merit your claims? Consider the range, number and depth of observations contained within the data.
- Have you made systematic comparisons between observations and between themes?
- Do the themes cover a wide range of empirical observations?
- Are there strong logical links between the gathered data and your argument and analysis?
- Has your research provided enough evidence for your claims to allow the reader to form an independent assessment and agree with your claims?

Originality

- Are your themes fresh? Do they offer new insights?
- Does your analysis provide a new conceptual rendering of the data?
- What is the social and theoretical significance of this work?
- How does your grounded theory challenge, extend, or refine current ideas, concepts and practices?

Resonance

- Do the themes portray the fullness of the studied experience?
- Have you revealed both luminal and unstable taken-for-granted meanings?
- Have you drawn links between larger collectivises or institutions and individual lives, when the data so indicates?

- Does your grounded theory make sense to your participants or people who share their circumstances? Does your analysis offer them deeper insights about their lives and worlds?

Usefulness

- Does your analysis offer interpretations that people can use in their everyday worlds?
- Do your analytic themes suggest any generic processes?
- If so, have you examined these generic processes for tacit implications?
- Can the analysis spark further research in other substantive areas?
- How does your work contribute to knowledge? How does it contribute to making a better world?

07 May 2014

Mr Bailie
University of Nottingham
YANG Fujia Building
Jubilee Campus
Wollaton Road
Nottingham
NG8 1BB

Dear Mr Bailie

Study title:	A grounded theory study of service users' perceptions of professional peer support work
REC reference:	14/EM/0042
Protocol number:	13145
Amendment number:	Substantial Amendment 1
Amendment date:	26 March 2014
IRAS project ID:	139218

The above amendment was reviewed at the meeting of the Sub-Committee held on 02 May 2014.

Ethical opinion

The members of the Committee taking part in the review gave a favourable ethical opinion of the amendment on the basis described in the notice of amendment form and supporting documentation.

Approved documents

The documents reviewed and approved at the meeting were:

Document	Version	Date
Advertisement	2	05 March 2014
Protocol	2.0	26 March 2014
Notice of Substantial Amendment (non-CTIMPs)		26 March 2014

Membership of the Committee

The members of the Committee who took part in the review are listed on the attached sheet.

NRES Committee East Midlands - Leicester

Attendance at Sub-Committee of the REC meeting on 02 May 2014

Name	Profession	Capacity
Mr John Baker	Radiation Protection Advisor and Senior Lecturer (retired)	Lay
Professor Geoff Dickens	Research Manager & Head of Nursing Research	Expert - Chair

Also in attendance:

Name	Position (or reason for attending)
Wendy Rees	REC Manager

Appendix M

Example Memo

Spectrum of disclosure

It would appear that there are varying degrees of disclosure. For Faye, this was limited to the peer support worker acknowledging their identity as being a service-user through their job role. No further disclosure took place but would appear to be sufficient to feel understood by the peer support worker.

Disclosure from other peer support workers seems to have been more detailed but clearly begins with the acknowledgement of their role. This explicit acknowledgement of service-user identity may allow an immediate connection with the service-user.

Disclosure seems to be something distinct and nuanced for each peer support worker and indeed what is needed by each service-user. Some peer support workers offer more and some less. This seems to focus on similarity and the peer support worker finding ways in which they can show their common experience. The difficulty appears to come when service-users want more than the peer support worker is offering. Perhaps because of their friendship they feel unable to ask for more for feeling like they are prying. There is respect for the peer support workers privacy but this appears frustrating that they aren't able to get what they would like. This blurring of professional status is a difficult position to negotiate for all.

Background

- Peer support is “a process by which persons voluntarily come together to help each other address common problems or shared concerns” (Davidson et al., 1999, p.168)
- Professional peer support is an evolution of the naturally occurring peer support, where individuals with a lived experience of mental health difficulties are employed by statutory services in order to use their experience to help others in similar circumstances overcome the difficulties they are facing (Repper & Carter, 2011).
- Peer support workers are increasingly becoming employed with health services within the UK as a means of meeting the government’s policies on Recovery, personalisation, and self-care.
- The theoretical grounding for peer support is scarce but based on the theorising by Salzer and colleagues (2002).
- They propose five theories that account for peer support work:
 - Social learning theory
 - Social comparison theory
 - Experiential knowledge
 - Social Support
 - The helper-therapy principle
- There is no empirical grounding for this work and it aggregates the different types of peer support under one title.
- There is also a lack of service-users’ perspective within the literature that runs contrary to the principles of recovery oriented practice.

Aims

The aims of this research project were to explore service-users’ accounts of professional peer support work; to relate findings from these accounts to extant theory; and based on these findings the ultimate objective was to develop a theory that contributes to explaining the relationship developed within peer support work.

“From the same mad planet”. A grounded theory study of service-users’ accounts of the relationship that develops within professional peer support

Method

- A constructivist grounded grounded theory approach was utilised throughout the project.
- Ten participants were interviewed regarding their experience of peer support.
- All participants had engaged with a peer support worker for more than two weeks within the last 12 months. All participants were English speaking and were over the age of 18.
- Participants were recruited through current peer support workers employed within an NHS Trust.
- The project was also advertised within involvement centres and outpatient departments.
- Audio-recordings were transcribed verbatim and analysed using the guidelines set out by Charmaz (2014).

Results

Three overarching themes were developed from the constructed data

- The process of disclosure – this theme described the process through which disclosure was offered and received peer support workers and service-users.
- The product of disclosure – highlighted within this theme was the sense of perceived understanding that developed as a product of the disclosure and could be perceived to be the development of an in-group status based on mutual experience.
- Dual roles – this theme discussed the tenuous position that peer support workers hold being viewed as both friends and professionals to the service-users with which they work.

Discussion

The novel findings of this research are reported in relation to extant theory.

- Using social identity theory as a means to explain the constructed themes, mutual disclosure based on commonality developed an in-group status that allowed the service-user to understand their position within the social world (Tajfel & Turner, 1979).
- There was significant overlap in the data constructed within this study and that relating to therapist self-disclosure within the literature. This highlights that disclosure is used to establish similarities, credibility and empathic understanding (Henretty & Levitt, 2010).
- The data and accounts were consistent with that found within the therapeutic relationship literature. The relationship that develops has considerable overlap with the triad of therapist offered conditions of empathy, genuineness and unconditional positive regard (Josefowitz & Myran, 2005).
- The clinical implications are dependent on further support from future studies confirming the findings of the study. They include further training for peer support workers around how to ensure the disclosure offered meets the needs of their clients. There is also considerable potential for clinicians to utilise disclosure in order to develop their relationship with their clients.
- The limitations of this study include the recruitment strategy being at risk of cherry-picking by peer support workers, and limited diversity within the sample. Further research is necessary to distinguish between the types of peer support and on differences and similarities between therapist self-disclosure and peer support worker disclosure.
- Conclusion: This research has highlighted that appropriate self-disclosure can develop a sense of being understood within the social world, and an in-group status that may serve to address social isolation. The dual roles held by peer support workers may position them in a way that makes them accessible yet still within the safe boundaries of a professional relationship. Further support and supervision should be offered to ensure peers in order to help maintain this position.

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