Understanding Peerness in Recovery-Oriented Mental Health Care

Patrick W. Corrigan, Psy.D.

Emotional and interpersonal support systems are fundamental to recovery-oriented support programs. Peerness represents the quality of shared lived experience that enhances such support programs. Through peerness, providers of formal peer support (FPS) strategically disclose their lived experience to help service recipients reach their goals. FPS disclosure is limited compared with the kind of free sharing in mutual support programs, with FPS focusing on information that specifically helps service recipients on their recovery journey. Peerness has additional value for shared experiences relevant for diversity, equity, and inclusion efforts. This Open Forum also considers where peerness conceptually fits into research of recovery-based services.

Psychiatric Services in Advance (doi: 10.1176/appi.ps.20230392)

Recovery is a first principle that guides services for people with psychiatric disabilities, with peer support providers emerging as leading agents facilitating recovery in mental health care systems. Emotional support (i.e., elements of social support that include unconditional positive regard to connect with a person) and instrumental support (assisting persons in achieving discrete needs and accomplishing tasks for their recovery goals) are evidence-based tools fundamental to recovery.

UNDERSTANDING PEERNESS IN RECOVERY-ORIENTED MENTAL HEALTH CARE

Support, however, is not unique to peer support providers; almost every profession offering recovery services grounds their work in support. The question in this Open Forum is one of peerness: What are the unique ingredients of support provided by peers, that is, by people with lived experience, in contrast to the services provided by the broader mental health system? I first define lived experience and then unpack disclosure of such experience and other approaches for sharing personal experiences with service recipients. I begin by describing the evolution of peer support specialists and peerness in terms of two ways that peer support is offered in the United States: mutual support programs (MSPs) and formal peer support (FPS) services. I conclude with a discussion of the implications of peerness in ongoing research for recovery and support.

TYPES OF PEER SUPPORT PROGRAMS

Peer support is grounded in recovery, a dynamic construct with two common definitions in the literature: as outcome and as process. Recovery as outcome involves long-term follow-up to examine whether people with serious mental illness such as schizophrenia become symptom free, overcome disabilities, and achieve life goals. Framing recovery as process partly reacts to this approach by arguing that recovery is not defined by some kind of external diagnostic criterion; people with mental illness receiving treatment should be hopeful and can achieve their goals despite recurring symptoms (1). A research review examining peer-supported services and recovery (2) divided the services into MSPs and FPSs within different settings. MSPs reflect the grassroots history of peer support. Formerly more commonly known as self-help groups, MSPs are programs created by people with lived experience of mental illness for people with such experience. The programs are built around principles and practices meant to assist members of mutual support groups in understanding life challenges and improving well-being, framing personal goals in terms of well-being, and developing and implementing action plans to address these challenges or achieve specific goals. Participating peers benefit from MSPs in two ways: they receive support from other peers, and they offer help to their peers in return. Based on the helper principle, the social and empathic acts of addressing others' concerns are valuable to peers in their own right (3).

FPS involves peers working as paid professionals, frequently in existing recovery-based service programs (4, 5). Hence, peer support providers in FPS are guided by many of the same expectations as are other paraprofessional and professional members of the recovery team. FPS peers uniquely bring their shared lived experience to the team. In the United States, FPS has been recognized by the Centers for Medicare and Medicaid Services as a reimbursable service, and many states are now enacting legislation to make FPS available for their residents.

Support is essential to recovery and has been divided into emotional and instrumental support (6). Emotional support is "being there" when the person seeking help needs emotional assistance, and this support is offered unconditionally. Peer support providers use variations of basic listening skills to meet people's needs related to affection and affiliation, that is, a sense of belonging or connection to a group or community. Instrumental support is goal focused, providing people with information, hands-on help, and resources in the field, so that problems can be overcome and aspirations achieved. Instrumental support often includes the principles and practices of shared decision making (7) and interpersonal problem solving (8) in specifying goals and developing action plans. Emotional and instrumental supports are fundamental to recovery services offered by all providers: those with lived experience and those without. For example, such support is essential to assertive community treatment, individual placement and support services, and supported education (5). Peerness has additional strengths in providing support, and, hence, its components need to be defined to understand its utility.

INGREDIENTS OF PEERNESS: DISCLOSING LIVED EXPERIENCE

One of the first studies (9) to describe peerness in terms of recovery and mental illness has grounded the essential quality of peerness in the sharing of similar experiences with people receiving services. Shared lived experience is not defined by diagnosis—that is, by a diagnostic label that qualifies a person as having lived experience—but rather by identity. People with conditions meeting *DSM* criteria for schizophrenia are not automatically included in the lived experience category, and people who have relatively benign adjustment disorders are not routinely left out. Rather, the impacts of symptoms and related disabilities, as well as corresponding interventions, are considered in how they specifically affect—or imprint—a person's well-being and daily functioning. Identity with such an imprint is lived experience, which is further influenced by experiences of resilience and goal attainment. This kind of identity is mostly a private experience. Peer support providers must deliberately disclose their experiences to serve recipients so that the recipients can benefit from the shared lived experience.

A summary of consensus guidelines for peer support providers highlights which disclosures may benefit clients' recovery (10). Recommendations include crafting one's story in one's own words with concrete experiences, avoiding exaggeration, and ending with prospects of hope and empowerment. Stories include on-the-way-down anecdotes (e.g., the challenges of symptoms and disabilities) and, more importantly, on-the-way-up statements such as "I am hopeful because I have accomplished many of my aspirations." Aspirations are not defined by some objective societal bar—for example, graduating from college—but rather by personally meaningful actions that reflect a person's values, such as working at Walmart, joining a faith-based community, or volunteering at a homeless shelter. These stories embody a central theme of recovery: *despite* mental health challenges, people do achieve their personally defined goals. Peer support also has nonspecific and universal benefits. The presence of peer support providers in the services space is an unspoken symbol of recovery. Interactions with peer support providers, even in the absence of shared stories, are the embodiment of hope and recovery.

Peerness and peer support are important because they enhance the quality of relationships between providers and service recipients (11). Hearing stories about challenges of symptoms breeds familiarity—for example, "You've been there too!"—which enhances the therapeutic alliance, a necessary first step to effective service provision (11). Stories that include on-the-way-up messages about achieving one's goals frame this alliance in a positive and hopeful light, which further supports the recovery journey.

The practice of disclosing shared experiences differs between MSPs and FPSs, with mutuality being a key component. Peers in MSPs fully share their stories, both to give help to and to receive it from others. This practice may include mutually sharing personal challenges that currently block one's goals. FPS relationships are defined by professional responsibility where peer support providers are charged to unidirectionally meet the needs of service recipients and help them achieve their goals. Hence, FPSs limit shared experiences to those that directly help the service recipient. This sharing might include relating on-the-way-down experiences to illustrate hurdles the peer support provider has overcome as well as on-the-way-up anecdotes modeling ideas that service recipients might adopt for their own recovery journey. FPS sharing does not include experiences for which the peer support provider seeks feedback from a service recipient. FPS providers are vigilant about the impact of specific stories on the service recipient and may back away from shared experiences that are not well received by the recipient. For instance, a peer support recipient may say, "I don't want to hear about your experiences in college because it is not relevant to me." Peer support providers' disclosures have exceptional promise to aid recipients' recovery, but disclosure has its limitations. However, service systems that do not embrace peer support services at all or fail to provide sufficient resources to sustain them may deprive service recipients of the value of sharing lived experience for recovery (12).

SHARED EXPERIENCE OF DIVERSITY, EQUITY, AND INCLUSION (DEI)

Peerness extends shared experiences beyond recovery into the area of DEI. The therapeutic alliance is enhanced not only through the shared experience of mental health challenges and victories but also by shared identities related to ethnicity, gender, sexual orientation, and other DEI domains (13, 14). Service recipients who identify as African American, for example, may benefit from support provided by a Black peer. DEI is also influenced by shared experiences of social disadvantage among members of disenfranchised groups, such as poverty and its adverse effects on housing, education, employment, and health care; challenges wrought by the two poles of criminal legal involvement—being a victim or a perpetrator; and the challenges many immigrants face. Shared experience of social disadvantage is another facet of peerness that enhances emotional and instrumental supports.

IMPLICATIONS FOR RESEARCH

Peerness may be a useful construct in key elements of services research, including fidelity, feasibility, and impact. Fidelity is addressed through the following question: Is a peer support provider demonstrating the fundamental ingredients of disclosure and shared experience that yield the positive effects of peerness? Feasibility may be assessed by asking, Is disclosure actually manifested in a peer provider's work? and impact may be investigated as the central role of peerness in models examining the effects of peer support on outcomes that include service recipients' recovery and quality of life. Recipients' perceptions of the peerness of providers affect outcomes such as symptom change, recovery, and quality of life.

Ongoing studies need to be driven by community-based participatory research (CBPR) (15). Namely, people from marginalized communities with lived experience of recovery—i.e., peers—need to be full and active partners in the design and implementation of studies examining the effect of peer support on recovery. Peer support providers on the CBPR team also have a central role in making sense of findings and translating study results into plans and policies for moving recovery efforts and peer support forward. The peerness of these team members provides an essential lens through which recommendations for improving peer-provided services are made. As CBPR continues to mature in mental health services, leadership roles of people with lived experiences need to be recognized and nurtured through research and training in order to build a peer workforce that can assume leadership roles in mental health services (16).

AUTHOR AND ARTICLE INFORMATION

Department of Psychology, Illinois Institute of Technology, Chicago. Send correspondence to Dr. Corrigan (corrigan@iit.edu).

The author reports no financial relationships with commercial interests.

Received August 4, 2023; revisions received September 25 and November 3, 2023; accepted November 8, 2023; published online December 5, 2023.

REFERENCES

1. Deegan PE: Recovery: the lived experience of rehabilitation. Psychosoc Rehabil J 1988; 11:11–19
2. Davidson L, Chinman M, Kloos B, et al: Peer support among individuals with severe mental illness: a review of the evidence. Clin Psychol Sci Pract 1999; 6:165–187
3. Riessman F: The "helper" therapy principle. Soc Work 1965; 10: 27–32
4. Corrigan PW, Talluri SS, Shah B: Formal peer-support services that address priorities of people with psychiatric disabilities: a systematic review. Am Psychol 2022; 77:1104–1116
5. Watson E: The mechanisms underpinning peer support: a literature review. J Ment Health 2019; 28:677–688
6. Corrigan PW, Rüsch N, Watson AC, et al: Principles and Practice of Psychiatric Rehabilitation: Promoting Recovery and Self-Determination, 3rd ed. New York, Guilford Press, 2024
7. Drake RE, Deegan PE, Rapp C: The promise of shared decision making in mental health. Psychiatr Rehabil J 2010; 34:7–13
8. Thomas JM: A problem-solving approach to symptom management. Psychiatr Rehabil J 2000; 23:289–291
9. Silver J, Nemec PB: The role of the peer specialists: unanswered questions. Psychiatr Rehabil J 2016; 39:289–291
10. Corrigan PW: The Power of Peer Providers in Mental Health Services. New York, Nova Science Publishers, 2021
11. Wrobleski T, Walker G, Jarus-Hakak A, et al: Peer support as a catalyst for recovery: a mixed-methods study. Can J Occup Ther 2015; 82:64–73
12. Cubellis L: Care wounds: precarious vulnerability and the potential of exposure. Cult Med Psychiatry 2018; 42:628–646
13. Jonikas JA, Kiosk S, Grey DD, et al: Cultural competency in peer-run programs: results of a Web survey and implications for future practice. Psychiatr Rehabil J 2010; 34:121–129
14. Ong QS, Yang HZ, Kuek JHL, et al: Implementation of peer-support services in Asia: a scoping review. J Psychiatr Ment Health Nurs 2023; 30:309–325
15. Hutchinson A, Lovell A: Participatory action research: moving beyond the mental health "service user" identity. J Psychiatr Ment Health Nurs 2013; 20:641–649
16. Jones N, Atterbury K, Byrne L, et al: Lived experience, research leadership, and the transformation of mental health services: building a researcher pipeline. Psychiatr Serv 2021; 72:591–593