

Lessons from the Field: An Autoethnographic Account of a Mental Health Peer Worker

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Abstract

Background: The aim of this research was to explore the lived experience of a mental health peer worker; the thought processes and actions, and the way relationships are built in order to support those with mental health concerns. This article reflects the research journey of a Master's student discovering the skills that underpin her practice as a Peer Support Worker within mental health services of a rural community in Queensland, Australia.

Methods: Reflexive writing, storytelling, a focus group with key informants

Results: Seven 'Letters to Peers' were written by the first author, reflexively analysed, and discussed during a focus group with key informants. It was discovered that the key themes from reflexive writing and focus groups are skills used by the peer workforce and their support of people on their mental health recovery journey.

Conclusions: Peer workers are skilled in many areas that are used to support others on their recovery journey. These skills are acquired from their own journey of recovery, through life, and on reflection on the support given to others. Underpinning the peer practice are skills such as relationship building, validation, self-care, trauma-informed practice, implementation of boundaries, and self-education.

Key words

Autoethnography, Mental Health Peer Worker, Recovery Journey

Introduction

New practice environments can benefit from reflexive analysis through a situated researcher. Peer work in mental health practice is an emerging field of employment for people who have a lived experience of mental ill-health and recovery. This situated field reflexivity can form lessons through which meaning can be transformed into improved practice and outcomes for clients and peer workers. This paper discusses the experiences of a mental health peer worker from an autoethnographic perspective; the first author undertook this research as a postgraduate student, supervised by the second author. Whilst this is primarily the story of the first author, the second author was present during the research process as both a witness to the experience and an advisor to the student journey. Therefore, this paper is written in the voice of the first author, silently supported by the second author; it is the embodiment of the student-supervisor relationship. The aim of this research was to explore the lived experience of a mental health peer worker; the thought processes and actions, and the way relationships are built in order to support those with mental health concerns.

Background

The peer worker model to support recovery forms only one currently practised model of care within the Australian mental health care setting, the second being the medical model which drives clinical recovery, reduction of symptoms and hospitalisation, placing the clinician as the expert (The NSW Consumer Advisory Group – Mental Health Inc. (NSW CAG) (2009)). The National Framework for Recovery-Orientated Mental Health Services Guide for Practitioners and Providers (p.2), defines recovery as ‘being able to create and live a meaningful and contributing life in a community of choice with or without the presence of mental health issues’ (Australian Government Department of Health (2013)). There is a general lack of understanding of these recovery principles (Gray et al., 2017) with limited support and guidance arising from the lack of clarification of the role of peer work (Ahmed et al., 2015; Asad and Chreim 2016; Cabral et al. 2014; Gray et al., 2017), subsequently increasing the challenges and difficulties faced by the Peer Support Worker (Gray et al., 2017).

The World Health Organisation (2022) report that one in eight people in the world lives with a mental disorder. The Australian Bureau of Statistics (2022) report that 43.7% of adult Australians during the period of 2020-21 experienced a mental disorder during their lifetime, at a cost of \$220 billion each year (Australian Government, 2022).

The recent introduction of the National Disability Insurance Scheme (NDIS), in Australia, is aimed at providing support to many Australian citizens suffering from a ‘permanent and lifelong’ mental health (psychosocial) disability. The Australian Institute of Health and Welfare (2022), recognise that peer or consumer workers, or those with a lived experience of mental health conditions, are a vital component of mental health care. Within the guidelines of NDIS, there is an allowance for psychosocial participants to employ a Peer Support Worker (PSW). This support is for guiding the person towards the improvement of their mental health symptoms, utilising the PSW’s own mental health practice, and tapping into their own recovery experiences to assist others on their journey to better mental health.

The Positioning in Context

During the research, the first author was employed by a large Non-Government Organisation (NGO), in a rural community as a Peer Support Worker, engaging with psychosocial participants of the NDIS. All peer workers arrive at the role having had their own personal experiences with mental illness and it is the experience of the first author that informs this research. The second author, MC, is a registered nurse with experience in forensic mental health care and acute clinical care.

Setting the scene, a Peer Worker's Journey

My life of traumatic experiences started by being placed in several orphanages, and then into the foster care system. This set up a life devoid of self-worth, which continued through to adulthood and consequently hospitalised in the Adult Mental Health Unit (AMHU) at the age of 46.

When I finally became a patient in the AMHU, I first learnt firsthand of the compassion that flowed through the volunteer peers (Consumer Companions) interacting with patients on the ward. From this hospital contact with peers to becoming a peer worker, was the next stage in my life. In order to fulfil the role, I needed to expose my own vulnerabilities and diagnosis. Increasing difficulties arose in those early working days, trying to 'fit in' with work colleagues, other mental health non-peer workers working in the community, whilst carrying the constant feelings of shame, and defensiveness, and the perceived feeling of judgement, having them know I was a mental health 'peer'. For me, as proud as I was to be a peer and to work in the field, the word itself was an admittance of an unstable state of mind.

The use of first-hand experience in research

Autoethnography (AE) is used to describe a first-hand account of a life, the personal experience of participating in cultural life, and it is through these personal experiences the person will make sense of the culture (Adams and Manning 2015). Autoethnography realises that culture cannot be separated from the self, so whilst I write this article, I am therefore writing about myself and simultaneously writing about the culture of mental health (Ellis et al., 2011). This is reflected by Adams and Manning (p. 362, 2015) who state 'autoethnography is a process that unfolds through the research and writing process'.

As with other autoethnographic research, I exposed personal thoughts and actions and encountered personal vulnerabilities whilst writing about my own perspectives and emotions (Farrell et al., 2015). Sociological imagination allows empathy to play a major factor (Bousalis 2016) and by incorporating stories from other individuals, similarities in societal dilemmas can be distinguished, and compassion created. Likewise using the technique of introspection and reflexivity allowed access to my chosen private experience and allowed the exploration of the complex nature of emotional experience (Ellis, 1991).

Ellis and Bochner (2006) argue that reflexive writing enables the researcher to not only write about personal experiences but show the passion and struggle as sense is being made of situations. In making sense of the situation, Spry (2001) asserts that the writer creates a cycle of talking, thinking, writing, looking inwards, looking outwards, recognising and interpreting the culture. These techniques were embraced in my research in order to create the raw data,

consequently allowing the themes of human relationships, emotional fatigue, validation, resilience, holding hope, and uncovering trauma to arise and be reflected upon in order to create the findings presented for the research.

Ethical Consideration and clearance

This research was informed by the eight principles of the Australian Code for Responsible Conduct of Research (2018); honesty, rigour, transparency, fairness, respect, recognition, accountability, and promotion of responsible research practices, and was given clearance by a university ethics committee as part of a Masters Project (H19REA132).

The Journey of my research

The raw data for this research was created from a collection of historical data in the way of reflexive journals, ‘Letter to Peers’, personal artefacts, and approximately 12 months of historical journals detailing memories and events from past experiences. These journals of work experiences detailed the journey of supporting clients and the thought process used to better understand the values of peer work encountered. The reflexive work undertaken, allowed the examination of relationships, culture and the principles that underpin practice.

Three data sets used for the research are described in Table 1.1. Data were interpreted and analysed thematically according to the type of data collected. By looking inwards at the data that was created (how does this affect me, what does this mean to me?), then looking outwards (what does this mean to others, how does this fit within society?), looking at how each piece informs and links together, themes were extracted and informed the meanings in order to create concepts, and the story of the lived experience.

Table 1. *Data set for research*

Data Set	Description
Private	Private journals and artefacts not shared with anyone.
Public	Data shared with others – Personal Reflections 2018 Community Speech ‘Letter to Peers’ Personal artwork Informants’ artwork Informants’ data Photographs, images Transcription of focus group recordings Interpretation of data
Social	Data given to me - gained through social interactions. Telephone conversations Emails

Informants

Convenience sampling was used to invite potential informants to the focus group, aged 18+ over, from Toowoomba and the South Burnett areas of Queensland, Australia, currently working as a PSW (paid or voluntary) via the Cert IV Mental Health Peer Work Facebook group. In keeping with the methodology, and the ability to ‘look outwards’ as part of the data gathering process, an audio-recorded focus group was formed to discuss the ‘Letter to Peers’.

Seven informants accepted and were provided via email with an invitation, details, and objectives of the two-hour focus group. Informants were also advised by email of a) the conversations being audio recorded for use in this research; b) that names will not be used in transcribing of the data and c) at any stage they may withdraw, and have their data withdrawn from the group, without prejudice. The ethical protocol was followed for the focus group and informants were encouraged to make themselves comfortable before the reading and recording of the letters commenced. The venue was a conference room at the University of Southern Queensland where refreshments were provided, and informants were free to move around the room or even leave the room to take phone calls. All of this was observed by the second author as the Masters supervisor.

Adding to the Literature

During the reading of the letters, informants were encouraged to freely express their thoughts and ideas by drawing or writing anything that came to mind. For this to happen, I provided coloured marking pens, A3 size blank paper, or photocopies of photographs and drawings that I had created to capture my feelings about each story. Examples of these are shown below (Focus Group Data: Perspectives; Focus Group Data: Trees; Focus Group Data: The storm). After each of the letters was read, group discussion took place, and each of the informants was free to discuss what had been said, how they felt, or what they have previously experienced pertaining to the Letter. The recording was stopped after two hours, and all discussions had ceased. At a later date, the recording was transcribed and an interpretation from other artefactual data captured from the focus group was completed.

The data was used to answer three research questions that have not previously been found within the literature.

- 1) What is the process by which an MHPW builds working relationships with individuals seeking support with mental illness?
- 2) How does the MHPW’s working relationship differ from other non-peer mental health workers (e.g. support workers, service coordinators)?
- 3) What does the MHPW contribute to the recovery process for people with mental health issues?

After collating all the data, each of the themes were reflected upon as to which research question they would support. If the theme didn’t fit the research question, it was placed at the end of the research in Findings and Implications - What I have learned. The following sections will be brief descriptions of the letters, and how each of these underpins my practice.

Letter One: Triggers

The first letter recalled a time when I became triggered (Personal reflection: Triggers), feeling the lack of power, the lack of control and the helplessness felt by the client, as was previously experienced by myself. This all happened without any realisation of what was going on and it was only through external supervision that this understanding was revealed. The general consensus of the group (Focus Group: Supervision) was that self-care, supervision and debriefing are incredibly important to peer work, and although supervision is not readily available, it should be considered a part of personal development training.

As a peer worker, a high proportion of my work time is spent validating pain, validating the intense feelings that come with lifelong trauma. Those requiring such intense validation are emotionally unable to listen to anyone or anything but have a deep longing for the need to be listened to, with the expectation that if someone understands or validates, this will reduce the pain they are feeling. Such as the situation of being triggered that occurred, the sense of validation, and the sense of having feelings normalised, enabling the creation of an egalitarian relationship (MacLellan et al., 2015). The sense of validation is built within the relationship of a peer worker to the supported person, however, the relationship with ourselves is where self-care is of utmost importance.

Personal reflection: Triggers

The 'being triggered' and having my non peer manager not understand what was going on for me, was yet another learning curve. I questioned why didn't the manager understand, they were more 'qualified' than me, been 'in the game' much longer than me, being my manager, my upline, so why didn't they know? Why could they not see what I saw? In this particular situation the peer was never going to be easily understood by a non-peer. The use of reflection, and reframing through professional supervision allowed me to understand that the manager did not understand, in fact how could they as it was purely emotional based what I was 'feeling' and how could they possibly 'feel' the same? My empathy from the situational feelings created for the client arose from similar feelings that I too had encountered and I believe needed to heal from. By recognising and acknowledging this, I have created the ability to utilise my knowledge in the future to be able to pre-empt any situation like this and through selected strategies, change the direction of outcome or effect on myself again.

Focus Group: Supervision

Help to recognise and reframe is sooo important for us....supervision and debriefing is very important but has not been available to all PS's in mental health. Participant One

Letter Two: Perspectives

Although not everyone with mental unwellness experiences psychosis, from what I have experienced myself, and have witnessed it is debilitating, to say the least. A friend of mine rang me one day, we had a long chat, obvious to me that they were experiencing psychosis,

however, it was the conversation with NP (Conversation: Reality or not reality?) that ensued which reminded me that reality for one, is not always the reality of another. The second letter was surrounding the differing realities that arise from a contradicting perspective; a situation in which I argued the case of a person in psychosis. Whatever was going on for them at that time was their reality. It's not mine, but theirs, and it is just as real for them, and my own reality that I experience.

Conversation: Reality or not reality?

Liz: "This person and the relative have different realities"
 NP: "If it is not real, it is not the truth. It's not reality, it's not real, it's a dream it is their imagination. What's real is what's happened. There can only be one reality, not two. It's not reality it is their imagination. How can there be two realities. If it is not the truth it is not real."
 Liz: "So what is real?"
 NP: "It's what happened"
 Liz: "To you or the other person?"
 NP: "Otherwise history would just be a dream. What's happened was real. WWII was real"
 Liz: "It's their perspective"
 NP: "Their perspective is not reality. It is like a big bloody fog"
 Liz: "Their perspective is their perspective, it is how they see things"
 NP: "That does not make it reality. Reality is what happened, and in their mind they changed everything. It's like a false reality"
 Liz: "This is your perspective"
 NP: "No, no no. If you think like that everyone will have their own reality and there will be no truth at all, and that's bloody wrong. Everything is based on the truth. So anybody that does the wrong thing can lie and say that is their reality. That is wrong. Can't understand why you think like that. There is something wrong in their head. I think you are way too involved with that person, that is why you don't realise they are nuts. The other day on the phone I reckon they should have gone to hospital that day. That is not the language of someone who is sharp in the head. What they are going to have to learn is to talk to people differently."
 Liz: "I think what they have is just anger. Just angry to everybody."
 NP: "I used to talk like that"
 Liz: "So you understand how they feel?"
 NP: "I understand how they feel, but that is not going to resolve anything. Are they Sagittarian?
 When they talk like that normal people will think they are crazy"
 Liz: (Thinking in my head) – 'Sagittarian, yes that is the answer!'

Further discussion ensued with regard to the stigma that arises from identifying as a person with mental illness (Focus Group: Is it contagious?). My recent experience with stigma was something that I was unprepared for. I was having a chat with a person that worked in Disability, and when they enquired, I mentioned that I worked in Mental Health. The immediate response was to ask if I was scared. I was really confused and asked, why would I be scared? And they replied 'It must be so dangerous'. Of course, my response was to say that the people I support are just like you and me, they are not dangerous at all. But my curiosity peaked, with so much focus on mental health these days, why are we all still considered

‘dangerous’? The response from the focus group participants (Focus Group: Psycho or something), gave me my answer.

Focus Group: Is it contagious?

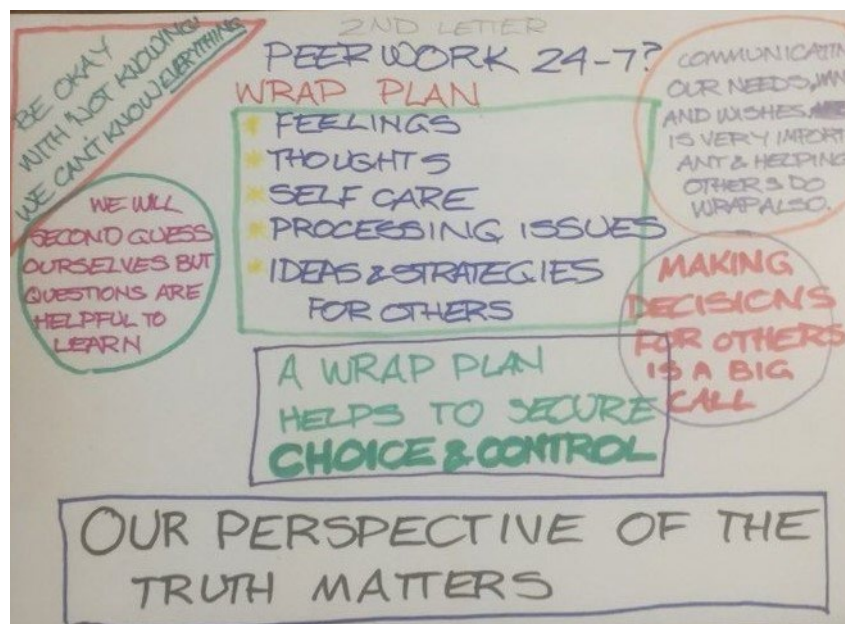
I have cousins that have no experience of depression or anxiety or at least they never talk about it and they get like the dad at one stage was quite like fearful of me coz I had come out of hospital, a couple months before and he was waiting and he was cooking a barbeques and I was like hey uncle Michael and he’s like ‘ooh, don’t come over here, and I didn’t go over there, like, I had actually someone when I moved into a house, he’s a Pentecostal, I said I’ve got bipolar, oh yeah just thought I would let you know and he said oh is it contagious? (Informant Four)

Focus Group: Psycho or something

We need to make mental health mainstream. So I go out now and people go what are you doing, ‘Oh my God how do you do it?’.....they think, they honestly think people are running around with knives...I am quite serious, they do not know what it is....like the film psycho or something” (Informant Five)

It is my opinion that regardless if we want to be or not, we are peers 24/7, so we have a strong need to set boundaries accordingly. We have a responsibility to ourselves and those we support to be continuously updating information and continuously learning. I know that I never stop learning, or fighting for the supported person’s choice and control, and once again the need for all persons experiencing mental unwellness to be stringent with self-care.

Focus Group Data: Perspectives



Letter Three: Holding Hope - Hope of Recovery

Letter three bought about the journal entry questioning what it is to ‘hold the hope’ and the difficulties that arise, the questioning of your own value as a peer worker and wondering if you are actually making a difference. Holding the hope, hope for recovery for another, whilst building a relationship (Asad and Chreim 2016; Cabral et al., 2014 Davidson et al., 2012), is a central task of a PSW. This job of holding the hope whilst the client is unable was reflected by an informant (Focus Group: Getting through).

Focus Group: Getting through

We all have obstacles we have to get through and um if we can deal through our issues and our problems then somebody, then we know that that person that we are trying to support should be able to hopefully get through their problems eventually but it takes time and might only take a few minutes or it might take years but we know that they can, that they should hopefully get through their problems. (Informant Seven)

My own understanding of what holding the hope was all about was finally made clear in a journal entry (below), now having experienced what this ‘holding the hope’ is all about.

Letter to Peers: Holding the hope

This morning I had a revelation. I realised that as peers we truly do carry the hope for those that are unable to carry their hope at this point in time. For the whole time however I have felt that my efforts have not been of any worth. I have felt that the words I have spoken have not been heard. This client has been a real challenge for me..... How is it that I can get this client over the line? How can I get this client to start to realise their true value and self-worth? How can I assist this client in starting to believe in themselves?..... I could certainly see what the other person was saying and I felt most of it to be true however there was an element that left doubt in my mind. It is this doubt I have felt to be my driving force. It is this doubt that I have held onto. I knew that if I don't have the answers that does not mean that I can give up on them. This is why I have not exited this client. Is this resilience or tenacity? I believe that this doubt I felt was actually hope. I have been holding the hope for this client until they were able to hold their own hope. This client is now starting to move forward, don't know why, don't care, just thankful that they are now holding onto their own hope now. Perhaps that is the goal, that is the outcome, for the client to hold their own hope!

Holding the hope can be the hardest part, and yet at the same time, the easiest and most rewarding part of peer work, instilling in the person that they are valuable enough for me to want to spend time with. Being socially isolated, the people being supported have little social support or connection, and sometimes it is their peer worker that provides the social balance to life. This can also bring forward complications as the person may feel that they are becoming ‘friends’ as this relationship grows, adding another layer that the peer worker must also navigate. For myself, holding the hope is intertwined with skill building, teaching resilience, the building of community, understanding trauma, and other necessary tools in order to move forward on their recovery journey.

Letter Four: Uncovering the Trauma Within

One of the last frontiers of our society is the lack of realisation about the extent of trauma

Professor Warrick Middleton

(Cited in Kezelman & Stavropoulos (2012), ‘The Last Frontier’ – Practice guidelines for treatment of complex trauma and trauma informed care and service delivery (n.p.)

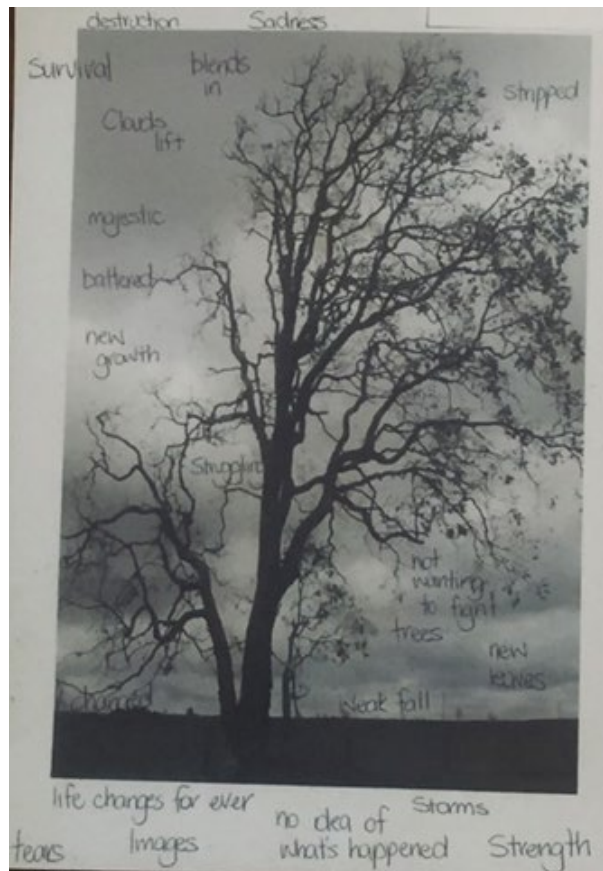
For most people, their understanding of trauma is directly related to a fatality, like a plane crash, or some other momentous disaster, not their painful life experiences. Even though I readily embrace that people are not capable of seeing the extent of the carnage that has been created within, I also understand that in order to perhaps protect themselves from the truth, they deliberately downplay the dreadfulness of their own life experiences. The line of questioning now used forms a more subtle approach with regards to their ‘distressing events’, which is easier for people to accept, enabling the person to share their negative life experiences, without realising that most of these events were in actual fact trauma, and traumatic to the younger self. This approach and the knowledge I have gained on trauma is a direct result of working in the industry and building relationships with supported persons.

Trauma and mental illness go hand in hand, and as I journeyed down the road after a massive storm, the beginnings of letter five were produced. The analogy compared the cycle of mental illness, and the storm that had just ripped through the area, destructing everything in its path, leaving only the strongest to survive another day.

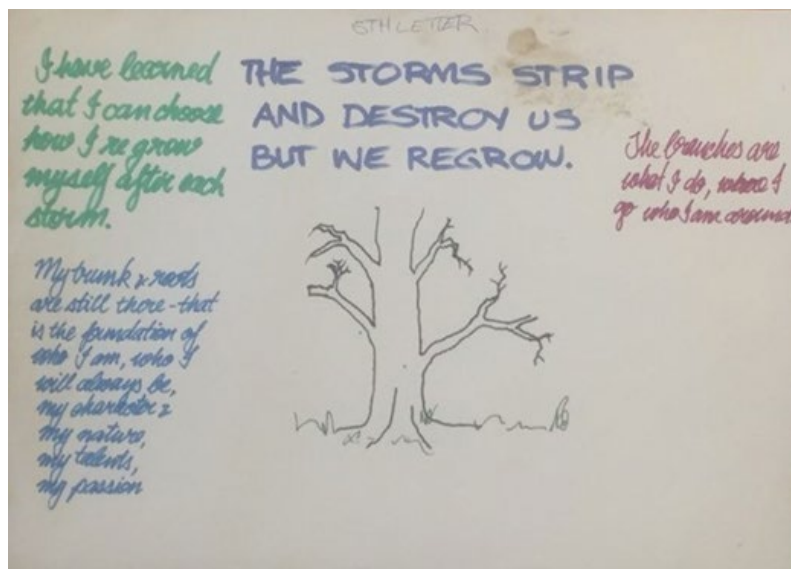
Focus Group Data: Braving the storm

The huge storm left a trail of mass destruction to the trees. Trees were stripped bare by the storm, just like living with a life of mental unwellness. During times of mental unwellness, vulnerabilities are exposed, just like the bare branches of the trees. It is the bravest of the brave, and only the strongest of the strong that will continue to survive. Some people will drive by and appreciate what they see, knowing the extent of the damage of the trees, others will zoom by, and just comment that it must have been a bad storm. However, as a peer worker I focused on the small amount of new growth on the trees, beckoning ‘hey don’t give up on me, I am still alive’: just like the storm leaving only the resilient trees, as is the same with mental illness. Similar thoughts were captured by the focus group

Focus Group Data: Trees



Focus Group Data: The storm



Letter Five: Who are our Peers?

After reading the ‘Letter to Peers’ in the focus group, I was questioned by a member of the group about how I felt about the counsellor stating ‘clients are not your peers’, and did I think they (clients) were my peers? Varying statements from members of the focus group show that even among a group of peers, there is still confusion as to whether we are even peers to the people we are supporting.

My experience has taught me that I am a peer 100% of the time, I cannot just move between roles, like an ‘on-off’ switch. It is my life experiences that have made me who I am, and what I stand for. My life experience determines what I value, and drives my morals, ethics, and integrity. It also drives how I treat people and what I say to them, how I motivate them, and how I inspire them. I am a 100% mental health peer.

Focus Group: Peer or not peer?

“It’s not either or”

“It’s not always black and white”

“I am here to help them, help them find and reach goals, I am being paid to support, then I am not their peer”.

“I have a lived experience of mental health challenges, working with people, I have the Cert IV (Mental Health Peer Work), so have more knowledge and experience, more than the people I am working with, but when supporting someone, I do not consider myself their peer”.

Letter Six: Resilience

The word resilience unfortunately reflects the immense pain that was suffered throughout my life, however, it could be said that from the survival of these events, incredible resilience has been built. Consequently, this resilience is a skill utilised by peer workers created from the scars of healed wounds. Their lived experience.

Letter six incorporated an excerpt from a journal entry describing an understanding of how the peer workers use their scars of lived experience to benefit others. It is the PSW’s job to find and encourage strengths, to help build resilience, and to allow the person to utilise the peers’ spikey ball ‘scars’ of life experiences. But it is also this resilience that allows PSWs to sit with those that do not appear to be moving forward, to look for the tiniest little crack, the slightest ray of hope and sometimes hanging on for dear life, with constant encouragement. PSWs hold their hope, all the while using immense resilience in order to do so.

In searching through the literature, a study by Goldstein, Faulkner, and Wekerle (2013, Abstract; Results) stated “In addition, there was a significant Sexual Abuse × Resilience interaction, wherein high resilience was associated with a reduction in depression scores at higher levels of sexual abuse.” This report states that the high levels of sexual abuse that I experienced as a child gave me the resilience to combat depression. The simple word resilience brings an emotion for me that reflects all of the pain and suffering experienced during childhood, and whilst it may have been beneficial to ‘combat depression’, it is felt for me, that

benefit came at quite a cost. The benefit to the peer worker whatever the cost, is that the resilience required for holding hope, and for connection, is a tool that they have already acquired.

Personal reflection: Spikey balls

So I was thinking about Peer Work and a picture of this ball came into my head. That is it! Peer workers are like this! Yes! Each one of the spikes is a scar, our past hurts, wounds, and traumas that have now healed. And it is our past scars that connect with the hand that holds it. The spikes massage and soften the hand, they massage the soreness of the person, bringing relief. The more 'spikes' the more connection to the person that holds it, the more relief is bought. The depth of the spikes going into the person depends on how hard the person squeezes, it is in their control, not the balls control, they control how 'deep' or how 'hard' the spikes are pushed to bring relief. And over time the spikes can go deeper as the areas become less 'sore'.



Letter Seven: The power of connection and human relationship

Letter seven created a discussion around connection. Jacobson et al. (2012), reported that building a sense of community was important for peer workers, and their life experiences encouraged meaningful connections to be built (MacLellan, Surey et al. 2015). Peer work encourages the building of therapeutic relationships with other humans that are not centred on the medical model of diagnosis and treatment. The careful navigation of these relationships requires complex skills and a dedication to those (clients) requiring support.

In this study, the role of authentic human connection as a healing tool for peer workers emerged as a theme, raising the question of; how much of the human mental health condition is improved by genuine human connection? Existing research shows how beneficial human connection is (Soler-Gonzalez et al., 2017), reporting that genuine social connection is beneficial and social isolation is detrimental (Stallard 2015, Hojat 2016). People requiring support from a PSW have been socially isolated, the anxiety, the shame, the feelings of inadequacies, all of those things that I have experienced, are hidden within them too. Connections formed through peer work give supported people the sense of being valued, being cared for, and increased self-worth, whilst the peer worker acknowledges feelings of being appreciated, along with increased self-esteem and self-confidence through their giving of support (Bracke et al., 2008).

One member of the focus group who has been carrying ten years of relationship pain and hurt, reports that they are now finally starting to heal since undertaking the Certificate IV Mental Health Peer Work and being supported by the other group members. Not only is this person learning how to be a Peer Worker, but they are also building connections, building community, being validated, sharing stories and experiences, and having their feelings normalised. “Thank God for this course.....When I have got friends like these (Cert IV participants), anything is possible” (Informant One).

Discussion

The skills a peer worker carries are unique to each individual, but they are skilled in relationship building (Jacobson et al., 2012, Scott 2015), and creating a ‘friendship’ through disclosure of intimate details (Repper and Carter 2011). Peers educate themselves on their recovery and job position (Asad and Chreim 2016) and are also called upon to educate clinical staff and non-peers on recovery (Cabral et al., 2014).

Throughout this journey of peer work, I have learnt that many things are required and not easily understood by the general population or those in the health sector. This is in contradiction to Ahmed et al. (2015), who found no differences between the peer worker and other professionals in endorsing empowerment, however, the peer workers were able to implement strategies to manage their own relapse.

The people being supported understand that I do have a lived experience, and it is my experience that I use to guide their understanding of recovery through their own lived experiences. Some people listen, and some are not yet ready to listen. It is like perhaps, the parent trying to give their child the benefit of their lived experience, some listen, some don't,

and perhaps acceptance of recovery experience as being beneficial may come as peer work becomes more understood.

Conclusion

No child ever has their dream of growing up to be a peer worker. It is thrust upon them in adulthood as a deliberate choice of turning around a bad situation in order to make it work for themselves. As with most professions, education from formal education is required of all peer workers, however, this is not the be-all and end-all. Most of the skills gained come from life experiences, which are utilised on a daily basis.

The attributes of a peer worker include but are not limited to, relationship building, validation, self-care, resilience, the ability to hold hope, incorporating a trauma-informed practice, implementing boundaries, and self-education. As the skill level increases, the peer worker will become more skilled in their ability to support others. For myself, one painful attribute, in particular, resilience, steered my recovery process. This recovery process allowed knowledge to be gathered about myself, and my diagnosis, and is now being used to benefit those supported. It is suggested also that resilience is an understated factor in recovery, and it is certainly an area for more research. In conclusion, a quote from my research with a reflection on my contribution to peer work

‘As a mental health peer worker, I know that I am a person who can change someone else’s world. I have learned that my life is not yet over, and I have more to achieve, and that is why I am still here’.

This passion and perseverance, the ability to ‘give back’ is in itself a major contributing factor to peer work that has become my life, and the determination of resilience that I have yet to accept.

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