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ORIGINAL PAPER

"What We Have in Common": A Qualitative Analysis of Shared Experience in Peer-Delivered Services

Ana Stefancic[1] · Sophia House[2] · Lauren Bochicchio[3] · Brianna Harney-Delehanty[4] · Sharon Osterweil[5] · Leopoldo Cabassa[6]

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Abstract

"Shared experience" has been described as a key element of peer-delivered services, but it is not well-understood how it is used in practice, particularly among peer specialists working in more conventional mental health agencies. In-depth qualitative interviews were conducted with eight peer specialists and two supervisors working in a Peer Wellness Program within a Housing First agency to explore peer specialists' approach to service delivery, with a focus on the role of shared experience. Peer specialists rarely reported explicitly sharing experiences related to mental health with clients, but described how it was nevertheless ever-present through the unique ways it shaped features of their practice (e.g., empathy, patience, consistency, listening, unstructured time, and a client-centered approach). In contrast, explicit discussion of shared experiences related to other life domains, such as culture, physical health, and significant life events, were frequently relied upon to support and build rapport with clients.

Keywords Peer support · Mental health · Self-disclosure · Recovery · Qualitative

While peer positions exist in a variety of fields, within mental health services, peer specialists are typically defined as individuals who have personal experiences of successfully living with serious mental illness (SMI e.g. schizophrenia), and who can tap into these experiences, often in combination with specialized training, to provide services to others with SMI (Chinman et al. 2014; SAMHSA-HRSA 2011). Peer-delivered services may work, at minimum, as effectively as clinical or non-peer interventions and peer-delivered services may offer distinct advantages. Studies have found that peer-delivered services can improve outcomes among people with psychiatric disabilities, including quality of life and functioning, health-related behaviors, self-advocacy, hopefulness, and satisfaction, and reduce hospitalizations and emergency room visits (Bellamy et al. 2017; Chinman et al. 2014).

While peer-delivered services have garnered increasingly positive attention, questions remain as to exactly how they work. Current theories emphasize key mechanisms, such as trust, rapport, credibility, role modeling, and the importance of shared lived experience with regard to mental health and treatment that distinguishes peer from non-peer staff. Generally, relationships involving peer support promote a sense of belonging and worthiness among clients and are thought to be more reciprocal, flexible and empowering for clients (MacNeil and Mead 2005; Dennis 2003; Solomon 2004).

Much of the success of peer-delivered services has been attributed to "shared experience," which is typically assumed to refer to experiences of mental illness or interactions with mental health treatment that peers and clients may have in common (Mead et al. 2001). Peers are encouraged to share stories of their own experiences based on the belief that this sharing fosters hope on the part of clients, establishes the

✉ Ana Stefancic
as2463@columbia.edu

1 Columbia University, 1051 Riverside Dr., Rm 6203, New York, NY 10031, USA

2 Yale University, 600 N. 4th St., #555, 85004 Phoenix, AZ, USA

3 Columbia University, 1255 Amsterdam Avenue, New York, NY 10027, USA

4 Fairleigh Dickinson University, 1500 Hudson St., Apt. 12S, Hoboken, NJ 07030, USA

5 Lifelong Medical Care, 414 29th Ave, #13, Oakland, CA 94601, USA

6 Washington University in St. Louis, Campus Box 1196, One Brookings Drive, St. Louis, MO 63130, USA

peer as a role model who can inspire positive behavioral changes, and promotes trust and rapport (Solomon 2004).

Despite the abundance of theories regarding what peer specialists do and how peer-delivered services work, rigorous investigation into the mechanisms underpinning these services is sparse (Salzer and Shear 2002; Solomon 2004). This shortcoming results, in part, from several limitations in this field of research, including an emphasis on studying issues related to peer specialists' integration into the workforce, as well as how being a peer-specialist influences peers' own recovery versus empirically examining the quality of the peer-client relationship. For example, among two recent meta-syntheses of peer-delivered services, the peer providers' perspectives reported in one focused more on the structural and environmental aspects of peers' experiences as employees (e.g., pay and hours, relationships with non-peer coworkers) (Walker and Bryant 2013), while the other focused on how supporting clients impacted the peer specialists (MacLellan et al. 2015). Further, most studies that have explored how shared experience actually manifests in relationships have used mutual support groups as their unit of analysis. Key structural differences exist between mutual support groups and peer services that are embedded within more conventional mental health programs. Support in this latter context is less reciprocal as peers in this role use their own recovery to provide a service to clients, mirroring a more traditional structure of provider and recipient (Chinman et al. 2014; Davidson et al. 1999). Thus, the mechanisms underpinning mutual support may not necessarily generalize across different modalities. (Davidson et al. 2006) Adding further complexity is that specific training, job descriptions, and agency environments are likely to influence the particular ingredients of peer support that are activated in practice.

A few studies, however, offer promising insights into the process of service delivery by peers in the context of conventional service delivery. Clients in a study by Beehler et al. (2014) described the importance of understanding, trust, and sharing in their relationship with peer staff. Clients in another study reported that shared experience with respect to psychiatric disability helped normalize their own experiences, allowed them to form a personal connection, and their peer specialists served as role models who inspired hope (Gidugu et al. 2015). In attempts to more comprehensively operationalize peer-delivered services, Chinman et al. (2016) developed a measure to assess fidelity to multiple dimensions of the peer role. The measure identifies critical ingredients such as instilling hope and empowerment, developing trust and rapport, and serving as a role model. Finally, one of the oldest but most illuminating studies (Paulson et al. 1999), compared the work of peer specialists to non-peer providers and found that while both groups conducted similar tasks, they differed in their overall approach to their work with clients. Peer providers were less authoritarian, more flexible, and demonstrated greater willingness to utilize self-disclosure to establish reciprocity (Paulson et al. 1999). This was one of the few studies that explored the content of self-disclosure utilized in peer-delivered services and found that peer providers' self-disclosure was related to both recovery and common interests.

Overall, few studies examine what constitutes shared experience and how peer specialists integrate it into their practice, particularly from the perspective of the peer specialists themselves. This study addresses this gap by parsing out the role of shared experience in the peer provider-client relationship. Based on in-depth interviews with peer specialists and their supervisors, we develop an analysis of the specific, under-researched mechanisms through which shared experience may enable peers to serve as effective service providers.

Methods

Setting

Data came from interviews with Peer Specialists and their supervisors working at an agency operating a Housing First program in an urban setting. The Housing First model provides individuals who have experienced homelessness and SMI with scatter-site housing, that is not contingent on achievement of clinical benchmarks, and comprehensive client-driven service supports (Stefancic et al. 2013). A peer wellness program was created to supplement the organization's standard support services (e.g., Assertive Community Treatment and Intensive Case Management), with a particular focus on assisting clients with their long-term goals. While the peers often collaborated with existing service teams, they were explicitly embedded within the peer wellness program and reported to two supervisors, one of whom was dedicated solely to coordinating the program. The goal was to maximize the peers' ability to maintain a perspective, approach, and function that was distinct from the agency's other providers, and to buffer them from routine aspects of service delivery in which other providers engaged (e.g., entitlements, housing support, medication management). The peer specialists offered an array of services including assistance with employment, education, social connections, family reunification, criminal justice issues, and healthier lifestyles in the office or community. In addition to working one-on-one with peer specialists, clients could also attend groups at a Peer Wellness Resource Center, on subjects such as nutrition, computer skills, art, photography, harm reduction, and current events.

Participants

All eight peer specialists and two non-peer supervisors working at the Peer Wellness Program participated. Five participants were female, 4 were African-American (4 White, 1 Hispanic, 1 other). Both supervisors held masters-level degrees, one in social work and the other in psychology, and had previous experience supervising peers. All except two were over the age of 40. All the peer specialists were diagnosed with a SMI. Two peer specialists were employed full-time and six worked part-time delivering services both one-on-one and in groups. All had served in the role of peer specialist within the program for approximately one year, at minimum (ranging from 11 to 18 months). All peer specialists had completed an intensive peer specialist training program with an external peer-run training agency. Through this training, peers completed 6 months of coursework (approximately 450 h) and a 3-month internship which allowed them to learn how to use their life experience to assist others, as well as about wellness, recovery, evidence-based practices, and administrative responsibilities. Additionally, The Housing First program's internal training covered topics such as Intentional Peer Support, wellness tools, Stages of Change, Motivational Interviewing, and minimizing burnout. While peer specialists provided a broad spectrum of support, four had subspecialties (employment, education, financial, and nutritional and parenting) that allowed them to work intensively with clients in these areas.

Procedures

Participants were interviewed individually by a trained research assistant using a semi-structured qualitative interview guide that elicited their thoughts and experiences related to the Peer Wellness Program, the role of peer specialists, and the unique contributions of peers in service provision. Interview guides included the same questions for all staff with slight variations in wording given the type of staff being interviewed. Sample questions for the peers included: What would you say might be unique about the way you work with clients as a peer specialist? Clients and peer specialists may have similar experiences—is this something that you talk about with clients? How do you identify goals to work on with clients? Each interview lasted approximately 1 h. Research assistants were embedded within the peer wellness program in several ways including having their offices co-located within the program and conducting a longitudinal quantitative evaluation of the program. Research protocols were approved by the Institutional Review Board of the Housing First agency and by the Committee on Activities Involving Human Subjects at [name removed for masked review] University.

Analysis

Interviews were audio recorded, transcribed verbatim, and analyzed using a thematic analysis approach (Boyatzis 1998). After reading the first three transcripts, two coders developed an initial code list. While some codes reflected *a priori* topics from the interview guide (e.g., role descriptions, challenges), other codes emerged directly from interviews, (e.g., consistency, change in attitude/outlook). The initial code list was revised and finalized after each researcher independently coded three interviews, with coding discrepancies resolved through in-person discussion. After the remaining transcripts were similarly coded, the associated excerpts were clustered into themes based on similarities in the narratives emerging within codes and across participants. Several aspects of the analytical strategy sought to maximize rigor, credibility, and trustworthiness. Using multiple coders minimized the potential for individual bias. Utilizing in vivo codes, as well as frequent meetings between coders, maximized the consistency with which codes were applied. Memos documenting discussions and emerging themes, along with relevant interview excerpts, formed an audit trail.

Results

Shared Experience

Peer specialists and supervisors indicated that "peer" status contributed to greater levels of trust, empathy, and open communication in relationships with clients. In the words of one peer having shared experience creates "rapport and trust," and makes it "easier to empathize." Another explained,

> I think it helps them in that…it takes off the cap, of the professional, you know…it's wearing a cap of, 'I'm like you.' And I think that that may be helpful to them in being open and accepting of the situation.

As a result, another peer explained, "it's easier to make that contact stick," and "there's a closer dynamic" between peers and clients.

While peers possess qualifications through training, many reported that the ability to tell clients that they have "been there" is their main source of credibility used to establish trust. Here, a peer contrasts the trust they can build as a result of their status, with that of clinicians whose title connotes a more hierarchical and directive approach with clients:

> ...the clients trust us. More than they trust the staff. Cause it's that clinician thing…people with mental illness, all their lives, clinicians have been in their face. Psychiatrists and therapists. "You do this, you do this, you take that, you take that, time to go to the hospital," and this has- been a circle, round and round in their lives.

Similarly, a supervisor stated that "once the peers share their story, usually the skepticism falls away." One peer described sharing their personal history of treatment with clients to demonstrate credibility, build trust, and make participants feel less isolated:

> Some of them'll come in just like "Who the hell are you?" I say "Listen, buddy, I been there, done that." I have been to gigantic hospitals… "You are not alone..." They must know that they're not alone…And um, that also helps with the trust factor.

Another peer shared, "I tell them- "I been to the hospital, twice, I been through a program, I've used drugs…I did all that stuff. So, I know where you comin' from."

Despite consensus that shared experience serves an important function in the peer/client relationship, these examples of peers' explicitly referencing mental health were exceptions. Interviews revealed that peers rarely disclosed specific experiences related to their own mental illness, substance use, or treatment typically presumed to define peers' use of self-disclosure with clients. While participants identified how these personal experiences infuse all aspects of their practice, only three peers described any instances of explicitly discussing these traditional categories of shared experiences with clients. As one peer explained, in most cases…it's in the background so I don't, I don't disclose that much, but the individual…said he would feel better if I did, so in his case I make exceptions.

Similarly, a supervisor described that peer might say,

> there was a time in my life when I was- I was really troubled by voices- that I heard all the time. To the point that it really interfered with my life," it was just kind of a general statement…that's usually how people use it. And it has a kind of power.

Rather than explicitly sharing their personal experiences, the peers more so described how the moniker of "peer" acted as a signal, relaying to clients that they share a common background, even without knowing peers' individual histories.

> I don't talk about- my personal journey, because- I don't…But I do say to them, you know, "I've walked right side of you, even though you didn't know who I was." And they understand what I'm sayin' there, you know?

When asked about the role that shared experiences play in his work, one peer summarized the distinction between explicit sharing and allowing experiences to inform one's perspective: "I talk about being a peer- every day. I mean, I put my personal experience into almost everything that I do…Except for, you know, engaging with the, clients? Um, I use that sparingly, you know, my personal stuff." The paradox of this peer's claim that shared experience is at once integral to and absent from his interactions with clients was reconciled through the idea of a shared perspective that influences all aspects of their work in unique ways.

How Shared Perspective Influences Practice

Peer specialists explained that their shared experience of mental illness served a more implicit function in their work, shaping their approach to service delivery rather than serving as a mechanism to build rapport with clients. Unlike many service providers, peers understand through direct personal experience what it feels like to stand on the receiving end of mental health services. One peer explained, "Well, when I go to a psychiatrist and they'll say 'I know what you mean'- no, you don't." Other peer specialists also expressed the sentiment that shared experience is often prerequisite to understanding client experiences, with supervisors also stating, "[peers'] ability to understand where the clients are really coming from is not something I can ever match." In the words of another peer specialist,

> one of my favorite sayings is, a woman that's never been pregnant can't tell me what it feels like. Or a man can't tell me…. "I understand." Or maybe understand's not the right word, but "I know what you're talkin' bout." Nuh-uh. (*laughs*) Maybe you gonna sympathize but you can't really empathize …same way with the peers.

However, peers went beyond acknowledging the positive impact of empathy in and of itself on clients and described how they use this empathy to motivate their own behavior as service providers. As one peer stated, "most of us came from some serious- trials and tribulations. So we know, how serious it is, and the effect of doing the right thing, and what it can bring to an individual."

Peers can empathize with the potential emotional impact, both positive and negative, of treatment and institutionalization on clients. This understanding shapes how they support and interact with clients, making their approach distinct from non-peer providers:

> I just try to give 'em- what I would want, you know? I been in a lotta lotta institutions, and I know what it's like to be uh, mistreated, or misled, or just misinformed, or just neglected, over and over and over, by

> people who are supposed to, they get paid to provide you a service, so I work real hard at not being that individual.

With a unique understanding of the challenges that clients face, for example, they expressed greater tolerance for clients' expressions of extreme frustration.

> The relationship I have with all of the [participants], even when they're cursing me out- and I get that a lot- I kinda understand…where it's coming from. Not that I like it, but I understand where it's coming from, so that helps me to identify it and be able to deal with it…

Another peer specialist noted how experiencing treatment fostered an approach that emphasized listening and being present with clients rather than assuming a more active therapeutic role. She noted, "sometime people just- they don't want you to psychoanalyze them. They just want you to be quiet and listen to what they're saying." Other times, as another peer described, peers may ask unique questions that emerge directly from this shared perspective: "you as a peer will ask 'em something that a clinician wouldn't ask 'em."

Peers also emphasized the importance of being there for clients "consistently" and how their prior experiences had led them to appreciate the need to follow-through as providers:

> You learn not to make empty promises, um…little things, like calling if you have to cancel your appointment. Or, or if they miss your appointment, call them... That's it... give them courtesy, respect- same stuff that any- anybody else would want. The little things.

Related, peer specialists explained how, compared to the clinical staff, they devoted more time with individual clients per session, and even if they were scheduled to complete a specific task, they built in unstructured time to interact with the client:

> Because the team…they got like, fifteen minutes, you know, and they're doing it really fast and really hard, and it's technical, and they get to the time, and then they move on. Whereas, you know, I'm like, more laid-back, and, I'll talk or I'll ask basic questions and then we'll go on in the [wellness manual].

A supervisor also commented that, in contrast to the agency's other providers, the peers "come and visit on a regular basis, or interact with [clients] on a regular basis, and spend quality time, and really get to *know* them."

These remarks illustrate how peers' experiences as recipients of mental health services shape their perspectives, allowing them to develop a distinct approach when working with clients. In addition to influencing how they deliver services and interact with clients, peers also described how shared experience framed their overall perspective on client goals and progress. They emphasized the importance of empowering clients to develop their own highly individualized goals and defined progress as relative and incremental: "It's not about me and what I think. It's about what they want cause that's the whole goal of this program. To help the individual to get where they feel they need to go or want to go…"

Peers operationalized progress more often as a client's change in attitude or perspective, rather than as a concrete, objective accomplishment. In the words of one peer, "If I can get someone to - maybe see a different side of things- I consider that an accomplishment." While supervisors also described client progress as individualized with many small steps, they were more likely to name more tangible achievements such as reuniting with family, keeping appointments, or reducing smoking than changes in a client's outlook. Peers focused on the more intangible markers of progress and emphasized the importance of clients engaging in the process of change, versus achieving their ultimate outcome.

> see, for me, success doesn't necessarily mean the end goal. But if you take one step- like she never talked to nobody. So to me, that was a success…that she spoke…at least I was able to get her to talk about something that she liked to talk about.

While working on goals might entail submitting a job application or returning to school, peers also described cases in which a desirable option might be helping a client who is afraid of leaving his/her home just to walk down the stairs: "if they haven't done that in thirty years, then that's an accomplishment!" Peers understand progress can mean different things to different clients, saying that "little things can go a long way. And it might motivate people to uh- to where it's not just something that they're *doing*, they're working towards something." When clients struggled with achieving a goal, the peers were explicit that their role was to encourage the clients not to abandon it, even if the clients themselves had lost hope, and to help them continually devise other ways of achieving or adjusting the goal itself while keeping its overarching spirit/theme.

> …if along the way, they get to the point where they say, "You know - this? I don't think so." So then I would say to them, "Well, you know, you've gone X-amount of the way. So let's see if there's something- within this particular field- that you can do that doesn't take as much schooling, that doesn't take as much money, that doesn't take as much whatever."

Peers' perspectives not only influenced their direct work with clients, it also defined their role as members of a support team. They identified sources of disconnect between clients and clinical teams and understood clients' hesitation

to bring up certain issues, while also understanding how best to explain client adversities to other providers. In one instance, a peer broke the news to the team when a client was afraid to let the team know directly that they began using again. In another case, a client felt apprehensive about an impending visit with an abusive family member and the peer specialist acted as an "intermediary" to restore the client's relationship with the team:

> So now she's afraid…She said, "Yeah, I talked it over with the team, but- I don't think they hearin' what I'm sayin' to them." So I in turn went and talked to the team, and gave them some details. And they were like "…Oh! We didn't understand that." And I was like, "Well, that's what's goin' on. And you guys need to- rally around her. And help her."

Peers attributed their effectiveness as mediators in part to the fact that they share perspectives with both providers and clients, which allowed them to effectively understand and translate information for both sides. Ultimately, however, they identified that their role was to be an advocate for the clients.

> My job is to advocate for the client. That's- my job first and foremost…to make sure these guys are afforded their rights. And if [agency] is supposed to be doing something for them? It's my job to make enough noise so that it's done.

Explicitly Shared Experience: Other Commonalities

While shared experience related to mental illness and treatment was rarely discussed explicitly, instances of shared experiences related to other domains and life experiences, were much more common. For example, one peer recounted how she re-engaged a reticent client by tapping into their shared cultural knowledge:

> these teams that had been trying to engage [this client] for the longest- I went to visit [the client] in their house, and they- just wouldn't open up at all…I was really grasping at straws…and I'm looking around their house, and... I saw [a mask] on the walls that my mother had and passed down to me, so- not the exact one, but, you could tell, the art- and I said, "Is that from the [African] tribe?" So that was a way for me to engage them…she started to talk about the history of the piece, and everything.

Another peer similarly cited her Puerto Rican heritage as a source of cultural awareness about clients' attitudes and behavior that allowed her to make personal connections:

> Shared experience…uh, culture…I'm originally from Puerto Rico...so I do know the dynamics of- how to find myself out of place, and- a lot of the participants here, we discuss a lot of things from our backgrounds? Wh-what we have in common…like things we like to eat, or, um- why sometimes we're afraid to even- talk about certain things, you know? Because you don't want to be- looked at like- funny. You know, why it took us so long to share, that we had this problem.

Other peers explicitly shared experiences of common life challenges such as the loss of a relative or caring for an aging parent. One peer described meeting with a client who had distanced herself from the program after the recent loss of her mother.

> I told her, "I understand how you feel." "Oh, no you d- nobody understands." I said, "Yes I do. And you feel like an emptiness, and you feel lost…" And she looked up at me…And I said "I do know. Cause I lost my mother…The pain is still there. The loss is still there. It just gets- a little better…" So- um, we made that connection.

Another peer described helping a client with an abusive boyfriend by explicitly discussing her own experiences of domestic abuse, which allowed her to provide emotional support and strategies for surviving:

> That I share. You know, especially if they're havin' a problem, I can say, "I've been there before." Like- [Client] and her- abusive boyfriend. I've been abused, so- I can relate to what she's going through. I know what it's like to have a man stalk you. So I'm able to talk to her about that.

Other peer specialists reported sharing about general physical health issues. One peer, cited an instance of "sharing" by saying, "I can share - diabetes. What do I do to keep it under control. We talk about that- alternative eating I'm not ashamed to say, 'I'm diabetic,' and we discuss things like that…" Supervisors similarly discussed instances of peers sharing other commonalities such as having been homeless or living in extreme poverty. One supervisor recalled how she had been unable to engage a client who had her children taken away, but that one of the peer specialists was "actually able to have a conversation…she's able to say, 'I know what that's like – my own children were in the system, and so I've been through that.' I don't even *have* kids."

Altogether, peers *did* use shared experience in the workplace—in fact, they used it all the time—but more commonly peers' explicit use of self-disclosure pertained to commonalities in other aspects of life experiences. The primary function of traditional shared experiences was to inform their approach to practice.

Conclusion and Implications for Practice

While there is much discussion of the unique qualities that peer specialists bring to the clients, few studies have sought to empirically identify the "active ingredients" (Davidson et al. 2006) and actual mechanisms underlying peer-delivered interventions. The goal of this paper was to move past assumptions about the role of shared experience in the peer-client relationship to a more grounded understanding of the ways in which it informs peers' work.

Interviews revealed that shared experience in the domain of mental health, rather than being an explicit subject of discussion in peer-client interactions, was more implicitly present. Few peer specialists reported explicitly discussing the experiences that technically form the basis of the "peer" relationship (e.g., mental health treatment). Rather, they often relied on their title as a "peer" to signal the presence of shared experience in order to develop initial trust and credibility in their encounters with clients. Nevertheless, peers and supervisors described how shared experience of mental health and recovery was ever-present through the unique ways in which it influenced peers' approach to service delivery. Shared experience of mental health and treatment was credited for peers' ability to demonstrate greater empathy, tolerance, and patience in client interactions, as well as for their taking an approach that emphasized listening versus active intervention. Also highlighted was the importance of peers spending more time with clients (partially attributed to the peer specialist's role description at the agency, caseload size, and fewer contractual mandates), as well as their inclusion of more unstructured time. Reflecting on their own experiences also allowed them to tap into a pool of potentially unique questions to pose to clients. Consistency, follow-through, and a highly client-centered approach were further identified as important features of peers' practice. Peers' views of client progress were described as individualized and relative, prioritizing clients' recovery process rather than recovery goals. They emphasized the importance of less tangible markers of progress, such as changes in a client's outlook versus objective outcomes (e.g. obtaining a job). In addition to influencing the peers' approach to clients, shared experience of mental health and treatment also impacted their role among other providers, allowing them to serve as clients' advocates, while interceding to restore strained relationships with other providers or facilitating communication.

The types of personal experiences peer specialists did discuss with clients to engage them and build rapport most often reflected commonalities with clients in life domains other than mental health. Commonalities relating to culture, physical health, loss of family, and victimization constituted the majority of these explicitly shared experiences. This finding corroborates at least one other study which found that mental health issues did not constitute the body of experiences that peers and clients explicitly wished to discuss (Armstrong et al. 1995). Beyond a diagnosis of mental illness, the peer specialists often had backgrounds that were similar, on average, to clients (e.g. race, ethnicity, educational opportunity, socioeconomic class) than non-peer staff, potentially providing them with a wider range of commonalities from which to draw and explicitly relate to others. However, these findings also do not seek to imply a reductionist view that equates potential shared labels between peer providers and clients to complex processes of relationship-building through a variety of shared experience.

Overall, results confirm that shared experience is a key element of peer-delivered services, but challenge previous expectations that shared experience of mental illness specifically plays a primary explicit role in the peer/client dynamic. The seemingly paradoxical claim that shared experience of mental health is at once crucial to peers' ability to engage clients and yet rarely the subject of direct discussion is reconciled through the idea that shared experience instead functions as a source of shared perspective, influencing how peer specialists deliver services.

The infrequent disclosure of peers' personal mental health experiences may present both challenges and opportunities. Peers may be overstating the degree to which their "peer" title and role is sufficient for clients to recognize that they have a shared experience of SMI, thus creating a working relationship that lacks this critical foundation. Non-disclosure may also have occurred for problematic reasons including peers' potential ambivalence to share in this domain or peers adjusting to the norms of non-disclosure modeled by the agency's non-peer staff. However, it may also reflect a purposeful strategy that seeks to activate and build connections around other client identities (e.g., culture) outside of mental illness. It may also reflect the need for peer specialists to acknowledge and encourage client sharing of other challenges that participants faced related to poverty, physical health, and trauma/victimization. Given that clients were all part of a program that delivered services to persons with SMI, discussions regarding mental health may have been more ubiquitous, both among clients and with non-peer staff. In contrast, peers sharing about other life domains may have facilitated conversations around other topics that clients may have been more reluctant to disclose, such as intimate partner violence. The peers' more limited sharing of personal mental health experiences may, therefore, help keep them aligned with their overall approach of emphasizing listening over active therapeutic intervention, maintaining a more holistic perspective on clients, and keeping

interactions focused on the client and responsive to their needs and concerns.

A limitation of this study is that the peers' approach to practice here may reflect the specific combination of training, job description, and agency environment (including agency mission) that defined the context in this study. While any training may run the risk of emphasizing technical proficiency and constraining a peer role (Walker and Bryant 2013), the fact that the training in this study was peer-run may have minimized drift from preserving the unique aspects of peer-delivered services. Future research should explore whether our conclusions hold for other types of peer roles, agencies, and trainings. While staff's comfort level with openly discussing their work is unclear, the researchers attempted to maximize trust and minimize bias by embedding themselves within the peer wellness program and potentially benefitted from prolonged engagement (Padgett 2012). A related question is the degree to which the peer specialists (and providers generally) are able to faithfully describe their work, though supervisors' perspectives supported key findings. While the sample size was small, it is consistent with prior literature, which can be used as one indicator of whether the volume of data collected could be adequate for addressing particular questions in context (Marshall et al. 2013). For example, in MacLellan and at al. (2015) metasynthesis of the peer literature, studies using qualitative approaches with peers in mental health generally had sample sizes of 10 or fewer, but yielded important insights of peers' experiences. While this study did not include client participants, peer specialists' understanding of service provision has been particularly under-studied and helps lay groundwork for broader exploration among additional stakeholders, such as clients and other agency staff.

While the primary functions and responsibilities of peer specialists within the mental health workforce vary significantly across contexts, the aim of peer delivered services is consistent: to provide recovery-oriented services, rooted in personal experience, that are responsive to individual client needs and preferences. While personal experience constitutes the central core, training, job descriptions, and agency contexts will further shape how peer providers function. The findings from this study clarify the unique ways in which peer specialists use shared experience of mental health to inform their practice, particularly in the context of a non-peer-run agency. This should help facilitate wider implementation of peer-delivered services, which is often hampered by mainstream providers' lack of understanding of peer roles, functions, and contributions (Rebeiro Gruhl et al. 2016). However, because these shared mental health experiences were rarely discussed with clients, peer specialists may also need more training and on-going support to more explicitly clarify their role and experiences to clients, given that many clients will not necessarily be familiar with this role (Citation removed for masked review). Additionally, training and on-going support of peer specialists can be expanded to include the importance of how commonalities with clients in other life domains can be shared to build close connections and rapport.

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Compliance with Ethical Standards

Conflict of interest The authors declare that they have no conflict of interest.

Ethical Approval All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards.

Informed Consent Informed consent was obtained from all individual participants included in the study.

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