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and mutual aid among peer supporters: a qualitative analysis**

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Pepperdine University  
Graduate School of Education and Psychology

THE IMPACT OF GROUP FACILITATION ON EMPOWERMENT, SELF-CONCEPT, AND  
MUTUAL AID AMONG PEER SUPPORTERS: A QUALITATIVE ANALYSIS

A clinical dissertation submitted in partial satisfaction  
of the requirements for the degree of  
Doctor of Psychology

by

Jonathan Parker

March, 2021

Natasha Thapar-Olmos, Ph.D. – Dissertation Chairperson

This clinical dissertation, written by

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under the guidance of a Faculty Committee and approved by its members, has been submitted to and accepted by the Graduate Faculty in partial fulfillment of the requirements for the degree of

DOCTOR OF PSYCHOLOGY

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## ABSTRACT

The ramifications of mental illness within society have had significant impact economically and socially. The estimated annual cost of mental health services can be upwards of billions of dollars in the United States. The social impact of mental illness on the individual level can often lead to stigmatization and social isolation, which are known factors that contribute to and exacerbate mental illness. Those unable to secure treatment are more likely to experience substance abuse, psychiatric hospitalization, and homelessness. Although the need for mental health services is not new, its' impact on society continues to grow. Thus, the need for mental health services is greater than ever before. Research examining peer support programs designed to treat a variety of mental health issues have shown to help ease the impact of mental illness. Peer support programs work from a wellness model that focuses on strengths and recovery and their services are often offered by individuals who are viewed as equals in salient ways. Additionally, peer support research has identified the concepts of mutual aid, empowerment, and self-concept as beneficial aspects of peer support programs. Project Return Peer Support Network (PRPSN) is an organization that offers peer support groups throughout Southern California in a variety of community settings. Utilizing focus groups, this study sought to further understand the domains of mutual aid, empowerment, and self-concept within the context of facilitating PRPSN peer support groups. Of the three domains examined, mutual aid appeared most frequently followed by empowerment then self-concept. This appears to highlight the importance of reciprocally sharing resources within the peer support environment.

## **Chapter 1: Introduction**

Mental illness in its most serious form has had a significant and enduring social and economic impact upon the society within which we live. There has been an enormous financial cost resulting from mental illness. For example, the overall financial cost of mental illness in the United States alone was estimated to be approximately \$300 billion in 2013 (Taylor & Johnson, 2013). Furthermore, the cost of inpatient psychiatric hospitalizations alone was estimated to be roughly \$26.5 billion in the United States in 2006 (Stensland et al., 2012). The financial burden of mental illness is also a global concern, with the cost of mental illness in China during 2013 estimated at nearly \$88.8 billion (Xu et al., 2016).

Mental illness has also inflicted a tremendous social impact upon our society. Within the individual, mental illness can lead to increased social isolation as well as increased feelings of alienation from the community where they live (Helmchen, 2013). These feelings of social isolation are often exacerbated by a social stigma that is prevalent throughout society (Livingston & Boyd, 2010) and can in turn, contribute to an increase in homelessness, substance abuse and psychiatric hospitalization, which serve to further increase the experience of alienation and isolation in the individual (Boyd et al. 2016). Additionally, the social consequences resulting from severe mental illness often reach beyond the level of the individual, and impact the friends and families of those who are suffering from mental illness. Studies have shown that families coping with the mental illness of one of their family members experience a significant increase in stress and distress (Chen et al., 2016), which can often result in alienation between the individual and the larger family unit (van der Sanden et al., 2016).

The significant impact that mental illness has had on society is not something new that we have recently been forced to address. Concern about how to manage mental illness has been

present throughout recorded human history (Shorter, 2009). A wide range of interventions have been used through the centuries in order to manage and treat the mentally ill. In modern/industrialized Western societies, interventions such as professionally administered individual and group therapy, psychiatric medication and psychiatric hospitalization have been employed as the primary means of addressing mental illness (Porter, 2006). While these traditional methods of treatment have made a positive impact on the treatment of the mentally ill, significant financial costs (Shern et al., 2008) and lackluster treatment outcomes (Yanos et al., 2001) leave room for other, newer methods to be attempted in an effort to further improve the treatment outcomes and quality of life for this population. It is believed that the global cost of mental illness will continue to rise from an estimated \$2.5 trillion dollars in 2010 to over \$6 trillion dollars per year by 2030 (Insel, 2011). As the financial and social impact of mental illness on our society continues to grow, the need to find more effective and lasting methods to treat it continues to grow as well.

Peer support is one treatment modality that although not widely applied in treatment settings, has shown some efficacy for improving recovery from a range of mental illnesses. For example, there is evidence that peer support has led to decreased rates of inpatient psychiatric hospitalization for people with previous hospitalization history (Chinman et al., 2001), as well as decreased lengths of stay for those who are already hospitalized (Galanter et al., 1998). Peer support has also been shown to help decrease psychiatric symptoms, substance abuse and criminal activity in people diagnosed with serious mental illness (Rowe et al., 2009). Other studies have shown that peer support relationships can lead to an improvement in social functioning and general decrease in social isolation (Bouchard et al., 2010) and can also serve to repair damaged relationships between individuals suffering from mental illness and their families

(Baxter & Diehl, 1998). Finally, there is evidence that peer support serves to both minimize and prevent much of the stigma that is traditionally associated with mental illness (Whitley & Campbell, 2014), while still working well in conjunction with more traditional group interventions (Pallaveshi et al., 2014). In light of the evidence presented above, further study of the ways that consumers of peer support themselves understand and experience the benefits of peer support is warranted.

### **Peer Support Defined**

There is a range of definitions and conceptualizations of peer support in the literature, resulting in a term that captures an amorphous construct encompassing a variety of services (i.e., educational, occupational, social, and psychological) within the mental health field (Johnsen et al., 2005). In its simplest form, peer support can be viewed as the giving of assistance and encouragement by an individual considered to be an equal, and the promotion of a wellness model that focuses on strengths and recovery (Dennis, 2003; Repper & Carter, 2011). This system of giving and receiving help is founded on respect, shared responsibility, and a mutual agreement on what is helpful (Mead et al., 2001).

Simpson et al. (2014) and Solomon (2004) define peer support in a similar way, which is the provision of emotional, informational, and social support by people with a lived experience of mental illness to others who share a similar condition, with the broader goal of bringing about social or personal change. At its heart, peer support involves the advancement and promotion of mental health within its consumers, recognition and respect for human diversity, and the establishment of community in order to facilitate the integration of persons with mental illness into society. By addressing social and personal consequences of mental illness rather than primarily focusing symptomatology, some peer support organizations appear to have achieved

success in attracting consumers to their model of treatment. This is significant because these organizations who have implemented a similar peer support model have been found to foster early detection of mental illness, shown improvement in compliance with formal therapeutic intervention, increased knowledge of disease, and reduced feelings of isolation (Vaisman-Tzachor & Thames, 2010).

According to Pfeiffer et al. (2011) emotional support, within the context of peer support, concerns itself with expressions of caring, attentive listening, reflection, and a nonjudgmental environment that is free of criticism or unwanted advice giving. This dynamic promotes empathy, respect, admiration, and a sense of value despite personal issues (Johnsen et al., 2005; Pfeiffer et al., 2011). Informational support includes help with problem solving, the receipt of feedback concerning skills building and interpersonal issues, and solicitation of advice from peers. The exchange of informational support can have both an implicit and an explicit effect within the peer relationship. One individual would have explicitly received help with an issue and the other individual would have experienced an implicit benefit by having value placed on a lived experience (Johnsen et al., 2005). Moreover, there is a shared perception that people with similar experiences are better equipped to provide authentic empathy and validation and have the ability to better relate with one another (Repper & Carter, 2011). Therefore, they can create a more genuine connection. The connection is strengthened by empathically recognizing and understanding the position of another through shared experiences of emotional and psychological suffering (Mead et al., 2001). This information can be pertinent to self-evaluation and the appropriateness of emotions, cognitions, and behaviors. These include an individual's specific motivations, reassurances, frustration tolerance, and optimism (Johnsen et al., 2005). This can be

analogous to a social barometer regarding an individual's thoughts, emotions, and behaviors. The third component of peer support, social support, will be discussed in a later section.

Peer support environments tend to manifest as drop-in-centers, recreation centers, and educational programs (Johnsen et al., 2005). These environments include services such as peer mentoring and teaching, the sharing of lived experiences, and crisis prevention. The environment in which these interactions take place is an integral part to recovery, because the peer support environment must be a safe place where individuals can examine their assumptions about who they are while learning new ways of interpreting their experiences (Pfeiffer et al., 2011). As such, the environment must be a non-coercive environment in order to alleviate and possibly prevent any fears from being triggered as a result of any trauma that may have occurred during prior mental health treatment. The ideal environment would do its best to stay away from clinical diagnosis, allow the participants to create the rules/norms of the group, use an informal setting, minimize the distinction between staff and clients, and it should be easily accessible (i.e., meeting times, transportation, and accommodations; Clay, 2005).

In the subsequent sections of this review, we focus on a set of key constructs as they relate to peer support: self-concept, empowerment, and mutual aid. These constructs were identified in reviewing the literature and were selected for their particular relevance to the population and context that we examine.

### **Self-Concept**

Self-concept is a feature of the peer support process that is a known predictor of improved mental health. A person's self-concept is made up of self-efficacy and self-esteem and they are influenced by internal and external forces (i.e., self-perception and social interactions; Bracke et al., 2008; Vaisman-Tzachor & Thames, 2010). Due to their climate of empowerment

and encouragement, peer support groups are often considered fertile environments for the fostering of self-concept. There is evidence that the positive impact of self-concept is twofold and affects both the recipient and giver (Castelein et al., 2008; Weber et al., 2010). Within the peer support dynamic, an individual's self-concept relies on reciprocal interactions, and the impact of peer relationships is maximized when there is both giving and receiving of peer support within the dyad (Bracke et al., 2008; Verhaeghe et al., 2008). In regards to peer support organizations, this bidirectional positive impact on self-concept occurs within peer-to-peer interactions during peer support groups.

Self-efficacy refers to an individual's perception of their ability to influence events that effect their life and control over the way these events are experienced (Bandura, 1995). According to Bandura (1997), mastery experiences, vicarious experiences, acts of verbal persuasion from others, and internal or physiological states play a role in the development of an individual's perception of self-efficacy. Additionally, an individual's ability to set goals and the subsequent performance of those goals play a big role in that individual's perceptions of self-efficacy (Bracke et al., 2008; Chen Yi-Feng et al., 2008). Helping others by providing peer support can increase the helper's feelings of competence and social usefulness. In regards to peer supporters, self-efficacy is bolstered by increasing knowledge, creating value out of lived experiences, sharing common experiences with others, developing skills, increasing self-knowledge, experiencing initiative and perseverance, improving communication skills, increasing confidence, and fostering personal growth (Miyamoto & Sono, 2012). The peer supporters' experience of self-efficacy is also affected by the multiple roles that they play. For example, they are looked at as role models within the peer community and they often act as



liaisons between staff and peers within various organizations (Castelein et al., 2008; Miyamoto & Sono, 2012).

Self-efficacy seems to be more positively correlated with the giving of peer support while self-esteem is more positively correlated by the receiving of peer support, however both affect the individual's overall experience of self-concept (Castelein et al., 2008; Chen Yi-Feng et al., 2008; Weber et al., 2010). Some research suggests that men tend to report a higher self-concept when the balance of giving/receiving peer support is skewed towards the giving, while women show the opposite to be true and tend to report a higher self-concept when the balance is skewed towards receiving peer support (Verhaeghe et al., 2008).

The second component that makes up an individual's self-concept is self-esteem. Self-esteem is defined as a positive thoughts, attitudes, assumptions, or beliefs towards oneself and it has been linked to increased rates of recovery within consumer run services (Chen Yi-Feng et al., 2008; Vaisman-Tzachor & Thames, 2010; Weber et al., 2010). Like self-efficacy, self-esteem plays an integral part in subjective well-being and mental health recovery. As such, its enhancement is a major goal within the peer support community (Verhaeghe et al., 2008). It is positively correlated with optimism and negatively correlated with depression, loneliness, and social isolation (Weber et al., 2010). People with high self-esteem view themselves as more capable, competent, have a tendency to contribute more, and feel successful as a result of their contributions (Chen Yi-Feng et al., 2008).

Peer support groups appear to foster three important factors that influence an individual's experience of self-esteem: interpersonal relationships, the perception of social support, and a decrease in an individual's experience of stigmatization (Chen Yi-Feng et al., 2008; Vaisman-Tzachor & Thames, 2010; Verhaeghe et al., 2008). A review of the literature suggests that self-

esteem is correlated with the quality of interpersonal relationships. One possible explanation is that people with increased levels of self-esteem tend to be more cooperative and popular amongst their peers and they tend to be more aware of social cues, which enables them to be more responsive to others, therefore their overall quality of relationships is better (Chen Yi-Feng et al., 2008). Perceived social support and peer support groups tend to affect self-esteem by providing emotional comfort and information to solve problems, helping in the decision-making process, and helping to combat stressful situations. An added benefit to these dynamics is that they can become protective factors against hospital recidivism (Vaisman-Tzachor & Thames, 2010). Finally, stigmatization negatively affects self-esteem both directly and indirectly. The direct effects occur when rejection by others leads to negative perceptions of evaluation and appraisals. Indirectly, self-esteem is affected by experiences of devaluation and discrimination. When this occurs, individuals often experience shame that can lead to a re-conceptualization and self-devaluation of the self (Verhaeghe et al., 2008). Fortunately, these dynamics are often counteracted within the peer support community and self-esteem, self-efficacy, and self-concept are bolstered through social and emotional support and empathetic understanding (Chen Yi-Feng et al., 2008; Vaisman-Tzachor & Thames, 2010; Verhaeghe et al., 2008).

### **Empowerment**

A person's sense of empowerment is conceptualized as a sense of internal strength that, generally, manifests in behaviors that assist the individual in gaining control over their life and influencing the organizational and societal structure in which they live (Clay, 2005; Segal et al., 1993). Some example of empowered behavior includes, but are not limited to advocating for self and others, using coping strategies, making decisions, being assertive, asking and accepting help, persuading others, setting and initiating new goals, understanding and exercising one's rights,

and effecting change in one's life and community (Segal et al., 1993). Peer support environments can foster empowerment by promoting tolerance of actions and beliefs that may be generally viewed as symptomatic or inappropriate in other settings (Clay, 2005). One explanation for this may be that the power dynamic between peers tends to be more evenly distributed than in the typical provider/client relationship. Additionally, the act of self-disclosure by the therapist is generally kept to a minimum, however within the peer support environment, mutual self-disclosure is considered beneficial because it allows other members to learn from shared experiences. In contrast to traditional settings where the facilitator is considered an expert, within the consumer-run community, the group facilitator is considered a peer with the task of leading the day's discussion. At its heart, the goal of empowerment within the peer support community is to work as a catalyst of change and assist the consumer in modifying their locus of control from external stimuli to internal functions and process (Schutt & Roger, 2009). An example of this process in action is when consumers make the transition from passively attending their peer support meetings to actively engaging in the therapeutic alliance with the peer community. As such, the road to recovery within the consumer movement is viewed as a shared journey between peers, and new community members are often supported by peers who have been on the road a little longer. Therefore, empowerment is fostered as the peer support process unfolds and new consumers are encouraged to no longer be carried by their peers, but rather, walk alongside them on the road to recovery.

A fundamental aspect of empowerment that occurs within the dynamic of peer support and the recovery model is the helper's principle (Solomon, 2004). First observed in the early 1970s while observing Alcoholics Anonymous meetings, Frank Reissman identified that the act of helping another person often heals the helper more than the recipient (Chinman et al., 2002).

In the recovery model, this phenomenon is generally experienced by the person in the role of the peer/advocate. By providing assistance and support to others with shared experience peer support has shown to decrease feelings of dependence and helplessness while increasing a sense of strength and empowerment in the helper (Solomon, 2004). Moreover, helpers tend to earn status in their community, which is associated with improvements in feelings of self-worth (Beehler et al., 2014). The helper's principle has been shown to increase an individual's sense of empowerment on four fronts. First, there is a positive correlation between helping behaviors and an individual's internal sense of competence. It appears that this dynamic can be attributed the person's ability to make a positive contribution to another's life. Second, the helper often feels a sense of satisfaction from the act. This suggests that act of helping is mutually beneficial to both parties. Third, because every situation and interaction is unique in its dynamic, the helper must constantly adapt their approach and teaching style in order to accurately provide optimal care for each individual. This results in a form of personalized learning for the helper. Finally, through the helping behaviors and social interactions, the helper begins to develop an enhanced sense of self. This is often recognized by a shift in identity from a person who suffers from mental illness to a person who is a productive member of society (Solomon, 2004).

Research suggests that peer support organizations have a positive impact on consumers' mental health recovery, and that peer support can also lead to an increase in feelings of personal empowerment with in consumers (Bologna & Pulice, 2011). Peer support communities offer peer support services that are provided by individuals with lived experiences of mental illness and programs such as these focus on empowering consumers to understand that their recovery is possible through self-determination, partnership, and hope. Many programs hope to foster consumer empowerment by encouraging self-determination, providing practical assistance, and

advocacy (Vayshenker et al., 2016). One way in which this is done is by placing the decision-making process back into the hands of the consumer. By giving the consumers the ability to manage their own affairs and encouraging them to take responsibility for treatment decisions focuses the attention on their need to improve community functioning while normalizing the treatment process (Schutt & Roger, 2009). Taking it one step further, some consumer run organizations have sowed the seeds of empowerment by including members in the higher order decision making process of the organization which has likely had a positive effect on their member's recovery (i.e., reduced hopelessness and symptom recovery, increased personal empowerment, self-efficacy, and social integration; Vayshenker et al., 2016).

Achieving empowerment within the peer support community can sometimes prove to be a difficult, but extremely valuable task. It requires the individual to overcome multiple hurdles including the effects of stigma and self-stigma, social isolation, emotional insecurities, and social difficulties. However, for those that can gain a sense of empowerment, research predicts overall positive outcomes for their long-term recovery (Schutt & Roger, 2009). There has also been evidence that empowering consumers and their peers aids in recovery and reduces psychiatric hospitalization readmission rates (Simpson et al., 2014). Furthermore, the positive effects of empowerment on an individual's recovery include new ways of thinking and behaving, an increased sense of independence, stability in work, education and training, and many consumers became actively involved in their recovery by researching their illness independently and this resulted in them feeling like they were gaining control over their symptoms (Repper & Carter, 2011).

## **Mutual Aid**

One final key concept within the overarching framework of peer support related recovery is mutual aid. Like empowerment, mutuality or mutual aid is a key value of many peer support organizations. The belief is that regardless of job title, all individuals are equal and should treat each other with dignity and respect regardless of differing thoughts, feelings, and opinions (Project Return Peer Support Network [PRPSN], n.d.a.). Mutual aid functions like a buttress that strengthens the interactions between peers (Miyamoto & Sono, 2012). The process of mutual aid relies on individuals being able to receive support while simultaneously giving support, combined with the ability and willingness to learn from each other (Bellamy et al., 2012). This concept is characterized by reciprocity in sharing personal experiences and role modeling to foster the learning of problem-solving skills while providing hope during the recovery process (Chinman et al., 2000). Moreover, it appears that the act of giving back provides people the opportunity to make something good out of difficult situations.

Mutual aid refers to people who have similar problems who aid one another in the context of a reciprocal relationship. Simply put, mutual aid is the sharing and receiving of resources between peers. In the context of peer support environments, resources shared between peers, generally, come in the form of instrumental support and social and emotional support. Moreover, mutual aid services can play a complementary role alongside professional treatment with little to no extra cost to the consumer. For example, integrating such practices has shown success with smoking cessation and staff in rehabilitation centers view psychiatric mutual support groups as more helpful than those in treatment or case management programs (Chinman et al., 2002).

The role that mutual aid can play in an individual's recovery is multifaceted. One notable aspect of mutual aid is that it focuses not only on an individual's symptoms, but also the social and personal consequences of mental illness. The reciprocal relationship between peers has been shown to foster early detection of mental illness, improve compliance with formal interventions, improve coping mechanisms, increase knowledge of mental illness through psychoeducation, and reduce feelings of isolation (Vaisman-Tzachor & Thames, 2010). Participation in peer support groups that foster mutual aid have shown to aid in mental health recovery and is associated with reduced hospitalization rates, fewer days spent in the hospital, and reduced symptomatology. Another positive effect of mutual aid on recovery appears to be new ways (offered by peers) to address problems in lieu of or supplemental to traditionally available means (Chinman et al., 2000).

A key ingredient to mutual aid is the peer supporter. The presence of a peer supporter offers unique opportunities for participation (Chinman et al., 2000), and they can provide services that a non-peer supporter cannot. For example, homeless people are traditionally reluctant to engage in mental health services. Having a peer supporter may be beneficial because it can provide an alternative route to mental health services for those who are wary of traditional services (Bologna & Pulice, 2011; Chinman et al., 2000; Miyamoto & Sono, 2012). Moreover, a peer supporter can improve the sensitivity of non-consumers by decreasing stigma and enhancing the team's capacity to reach out to difficult to engage clients (Bologna & Pulice, 2011; Miyamoto & Sono, 2012).

An example of this dynamic is best illustrated in the What's Up program that was developed within the walls of a maximum-security prison. This mutual aid program consists of incarcerated and formerly incarcerated prisoners who come together and share what is going on

in their lives while accepting and receiving feedback and suggestions from one another. Individuals begin by sharing and then receiving feedback. During feedback, the individual is encouraged not to respond and just listen. The act of giving feedback is based on inmates developing the ability to give back to other inmates by providing suggestions and other ways to address challenges. Equally important as giving back, is the ability to get back. During that time, the inmate is able to gain suggestions, strategies, and encouragement on how to manage situations when things are going well or not so well. This program has resulted in decreased recidivism rates and early releases for participants. Additionally, researchers found that inmates who were able to identify with formerly incarcerated individuals showed stronger social bonds within the group and was positively correlated with psychological well-being (Bellamy et al., 2012).

### **Research Questions**

The research questions for this project are informed by the literature reviewed above, as well as the goals of the larger program evaluation project from which data will be obtained. This project is a subset of a multi-year program evaluation effort in collaboration with Project Return Peer Support Network, which is described in more detail in the Proposed Method section. Our research questions and hypotheses are described below, according to our individual project goals:

1. Based on the review of the literature concerning self-concept, I hypothesize that participation in PRPSN groups can positively foster an individual's experience of self-efficacy and self-esteem resulting in an overall positive self-concept.
2. The literature also suggests that peer support groups foster a sense of empowerment in its consumers, thus I hypothesize that participation (i.e., facilitating, providing supporting,



and receiving support) in PRPSN peer support groups will increase an individual's sense of empowerment.

3. Finally, mutual aid appears to be unique within the peer support movement due to diminished power roles between peers (i.e., group facilitators and group members) which allows for a reciprocal affect that is generally absent in traditional mental health milieus. Therefore, I hypothesize that mutual aid acts as a catalyst to promote self-concept and empowerment.

## **Chapter II: Methodology**

### **Description of Project Return Peer Support Network**

PRPSN is a community-based, client-run peer support organization that was established in 1992 in order to provide support for individuals living with mental illness. PRPSN was developed using the Mental Health Recovery Model, which is a treatment model that empowers mental health consumers to make decisions about their own care (Vaisman-Tzachor & Thames, 2010). Serving Los Angeles County, PRPSN provides over 150 self-help groups throughout all eight mental health services areas and while serving over 2,000 mentally-ill peers. The peer-run support groups provided by PRPSN are often conducted in community-based outpatient settings that are accessible to the general public such as local parks, community resource centers, community mental health facilities or private homes. Support groups can also be held in locked facilities such as Institutions for Mental Disease and Los Angeles County Jail or in an online setting. In addition to peer support groups, PRPSN also provides numerous other services including a Spanish speaking, client-run service center where Spanish speaking peers are able to connect with one another and work toward meeting their goals, a drop in center where peers are able to relax, socialize and engage in fun activities, peer advocate and training programs, assistance finding employment both within and outside of PRPSN, as well as a toll-free “warm-line” where peers are able to call for support from a trained peer advocate during a 20-hour window each week (PRPSN, n.b.b.). For the purposes of this project, we propose to evaluate participant experiences in on the ground peer support groups that are conducted in English (as opposed to online support groups or groups conducted in Spanish). Furthermore, the Pepperdine University lab responsible for conducting this project and PRPSN have worked closely together in order to explain their respective understanding of what peer support is and how it works in the

community. Both groups co-presented at the Pepperdine Graduate School of Education and Psychology's Research and Project Symposium on June 2, 2017 and were able to provide specific information about the peer support process and answer any questions that arose from the audience.

### **Participants**

Seven focus groups of peer support group facilitators were conducted across various locations and areas within Los Angeles County (see Table B1, Appendix B). Of the 52 individuals who participated in these seven focus groups, 48 provided information regarding age, which ranged from 20 to 75 years ( $M = 49.7$ ,  $SD = 12.34$ ). Of the 46 participants who provided information about ethnicity, 14 identified as Caucasian, 11 as African-American, 10 as Hispanic, five as Asian, two as multicultural and four as Other. Forty-eight of the 52 participants provided data pertaining to gender and there were 23 males, 24 females, and one individual who identified as transgender female. Table B1 presents participant demographic data according to focus group participation.

Participants were included in the study if they were 18 years or older, English speaking, and were currently or previously involved in PRPSN. Participants were excluded from the study if they did not meet one or more of the inclusion criteria. Minors were excluded because they are not included in the population served by PRPSN.

### **Procedure**

Research team members and/or PRPSN administrators contacted potential participants initially. The methods of this initial contact included email, word-of-mouth, and flyers. Because PRPSN depends on a network of individuals to both facilitate and participate in their groups (Vaisman-Tzachor & Thames, 2010), snowball sampling was utilized in order to reach a broad

range of individuals who may have been eligible to take part in this study. Individuals who were interested in participation were referred to the Project Coordinator and the Principal Investigator. Individuals who elected to sign up for a focus group were informed of the date, time, and location of the focus group. In some cases, individuals were invited to participate in focus groups in person by a member of the research team, as research team members attended various PRPSN groups in the community as observers. Regardless of the method of initial contact, all potential participants were informed that before the focus group they would be provided with the opportunity to give written informed consent for the focus group. Participants were also offered the opportunity to receive the informed consent form in advance of their appointment via mail if they wished to review it before the appointment.

Upon arrival for a focus group, individuals were greeted by a member of the research team and provided with an informed consent form if they had not yet received one. Individuals were given the opportunity to review the informed consent form and were asked by a research team member if they had any questions before they decided whether to provide written informed consent or not. Written informed consent was obtained before the focus group commenced. After consenting to the research, individuals were then given a Background Questionnaire to complete prior to the focus group. The focus groups lasted approximately 45-60 minutes and were audio-recorded. Upon conclusion of the focus group, individuals were thanked for their participation.

All data collected from the focus groups was transcribed into Dedoose, which is a qualitative data analysis software. In the transcription process, research personnel de-identified the data by inputting initials in place of any full names.

All data provided on demographic questionnaires was entered by research team personnel into SPSS on an encrypted university-issued password protected laptop located in the PI's university campus office. Codes were assigned to questionnaire packets upon data entry so that the SPSS data file does not contain any identifying information.

## **Materials**

### ***Background Questionnaire***

Participants were asked to write their names on the demographic questionnaire sheet, in addition to their email, telephone number, age, city/zip code of residence, and race/ethnicity (see Appendix C).

### ***Focus Group Questions***

During the focus groups, participants were asked various questions about their experiences with PRPSN and the peer support process in general. Questions focused on a range of specific topics including participant's general experiences as facilitators of peer support groups, how running and participating in these groups has impacted their lives, how the peer support groups are structured, how the groups work etc. (see Appendix D). It is important to note that the focus groups may have been quite different from one another as each group had different participants and different facilitators. This may have lead to the focus group questions being asked in a different order than another group and the possible omission of certain questions, ultimately determined by the specific content of each focus group discussion.

### ***Other Materials***

Appendix E is a recruitment flyer that was created in conjunction with PRPSN and was used to recruit participants for the focus groups. Appendices F and G present the IRB-approved HIPAA form and consent form respectively.

## **Chapter III: Results**

### **Coding of Transcripts**

All recorded focus groups were transcribed and uploaded to Dedoose for analysis. All seven of the transcripts that were originally included in this proposal were coded and analyzed. A consensual qualitative research framework was adopted to inform the qualitative coding approach (Hill, 2012), with the intention to inductively analyze emerging themes in the focus groups within the main constructs under study.

The initial phase in creating the coding tree was to define the three key domains of Mutual Aid, Self-Concept, and Empowerment. A research assistant then reviewed each transcript to identify potential category codes located within each domain and potential sub-category codes located within each category code. Then, this writer and the dissertation chair finalized the code tree by eliminating redundant codes. Subsequently, the research assistant separated each transcript into relevant sections of data called *excerpts*, followed by the research assistant reading and coding the seven transcripts. The final coding tree is represented in Table B2 (Appendix B).

There are three domains that highlight broad themes across every transcript. Within each domain are between 0 to 2 category codes and between 0 to 4 sub-category codes that capture key aspects of each domain. In coding the transcripts, multiple domains could be applied to the same excerpt (i.e., double coding) and in many cases, one or more category codes and sub-category codes within the applied domain code was also assigned to an excerpt (i.e., up coding).

### **Quantitative Analysis: Code Frequency and Co-occurrence**

Table B3 (Appendix B) presents the frequencies of all domain codes, category codes, and sub-category codes. A total of  $n = 617$  codes were applied across all categories and sub-categories. Mutual aid was the most frequently coded domain code ( $n = 316$ , 51.2% of all

domain codes). The second most frequently coded domain code was empowerment ( $n = 166$ , 26.9%) followed by self-concept ( $n = 135$ , 21.9%). Analysis of domain code co-occurrences in Table B4 (Appendix B) indicates that the majority of time the domain codes of empowerment and self-concept were coded, mutual aid was also coded. Of the 166 total times empowerment was coded, mutual aid was coded  $n = 51$  of those times (31%) and of the  $n = 135$  times self-concept was coded, mutual aid was coded  $n = 41$  times (30%).

Within the domain code of mutual aid, the category code social and emotional support was coded more frequently than other category codes ( $n = 174$  times; 55%). The next most frequently coded category code within mutual aid was instrumental support ( $n = 112$  times; 35.4%). Of note, there were no category codes within the domain of empowerment. Within the domain of self-concept, the category code of self-efficacy was coded ( $n = 95$  times; 70%). Self-efficacy is the only category code that contains sub-category codes. The most frequently coded sub-category code within the category code of self-efficacy was physiological states which was coded ( $n = 29$  out of  $n = 95$  times; 31%), closely followed by mastery experiences ( $n = 28$  out of  $n = 95$  times; 29%). The final two sub-category codes within self-efficacy were vicarious experiences, coded ( $n = 18$  out of  $n = 95$  times; 19%) and verbal persuasion coded ( $n = 15$  out of  $n = 95$ ; 16%). Lastly, within the domain of self-concept, self-esteem was coded  $n = 55$  times (41%).

### **Qualitative Analysis**

Analysis of the data produced from these focus groups highlighted multiple examples of what peer support group facilitators believed to be beneficial about their role within Project Return Peer Support Network. An analysis of the qualitative findings is presented here and organized according to domains: mutual aid, empowerment, and self-concept.

### ***Mutual Aid***

The majority of the codes applied were located in the domain of mutual aid. Across all focus groups, social and emotional support emerged as the most frequently discussed category code followed by instrumental support. These codes reflect the breadth of mutual aid and inform how mutual aid has become a meaningful byproduct of the peer support process.

Mutual aid can be conceptualized as the offering and receiving of resources between peers. One group facilitator identified a mutually beneficial aspect of working with peers in PRPSN and how it has aided in their own mental health recovery and coping with symptom relapse.

...you'll be on a path to recovery and you'll always maybe remain on the path to recovery but at times, like with the pit, you might slip and fall but because you've been in that pit before you're like, "I know where the ladder is to get myself out of here. Oh, look there's a friend, let me not only help the friend to get out of here. Maybe we can help each other get to the ladder and climb up it. Like you're tired? Let me help you get up this ladder. And now I'm tired. You know, let's help each other as we get tired of climbing up the ladder and moving forward instead of backward sort of thing."

In the next examples, group facilitators allude to how helping one another and interacting with peers who have traversed similar experiences can be encouraging and aid in their recovery.

And it's kinda like you relate to people on an equal level because everybody at Project Return has a diagnosis. Including myself. I have a diagnosis too. It's when people that have been through it, they have a diagnosis, they've been through the stuff, they come out and are able to encourage, help the other people who have been through the diagnosis and help them go through it.

Additionally, this group member expresses an increased perception of credibility towards other peers within the support group.

Just um kinda helping each other heal that way and discussing like "I know cause I've been there." As opposed to the therapist who's like "You know, I would like to do my best to understand. I can't say I understand completely but I empathize with you."



**Social and Emotional Support.** Peer support group facilitators frequently reported the benefits that directly resulted helping someone feel valued, loved, and/or cared for. Some examples of social and emotional support might include providing empathy, attunement, and emotional responsiveness. One group facilitator highlighted the importance of social support from peers and how it has reduced their experience of isolation and offered some relief by normalizing shared experiences.

One of the most prominent things um people with mental illness experience is isolation. It's devastating. Uh, and it's confining and it's a downward spiral. When in a group, you hear others talking about an experience that you can identify similar to your own it's liberating. You're not alone. You have something in common. Um, that was very important is in my experience and how it helped.

Another group facilitator mentioned how an individual's willingness to open up about their issues helps the person cope by allowing other group members to provide support, encouragement, and teach coping skills.

But, it is good when a member, like, shares their feelings and puts their cards on the table and [mumbling] they see, yeah, to learn to cope with that pain easier. I can tell before it is a really big problem for them, and they cannot cope and deal with that, but since they put it out into the open it's easier for them to recognize oh, where they're struggling and so they're willing to practice [the coping skills] in their lives.

This group facilitator emphasized how social and emotional support can nurture bonds between group members and cultivate positive emotions by valuing each other, stating, "And this group is like family, we learn from each other and it is always a good feeling to feel wanted and appreciated."

**Instrumental Support.** Within the domain of mutual aid, instrumental support was the second most frequently coded category code. As such, PRPSN group facilitators frequently reported benefits that directly resulted from the exchange of information or resources. Instrumental support can include learning new coping skills, receiving material resources or new

information (Hill, 2016). In the first excerpt one group facilitator discussed how they utilize their group to share knowledge and help members navigate traditionally difficult systems in order to gain access to resources.

...persons that come to my group, persons... attendees... uh, we talk about principles about home, housing... uh how they could benefit from, uh... looking into what might be what section 8, [inaudible] various conditions that they're living in. And other things, uh... wellbeing for medical services, and, uh... benefits, uh... with peer support other than just psychological peer support.

Another group facilitator how they created a group in order to help members rejoin the workforce and gain employment.

I can share something with you like I have a group called Work Readiness and this group I go, I just bring literature and stuff on the work source place tool and then we talk about resumes and how to dress at an interview and all that. And I'm telling you, I've been doing this group since January of this year and every month, every month somebody gets a job.

This group facilitator highlighted the flexible nature of groups within PRPSN and how facilitators have leveraged this fluidity to mutually support each other by sharing tangible resources that aid in activities of daily living.

My group is here at this apartment building, and uh, since it's an apartment building we all live here. uh, prizes I have at bingo are like toilet paper, paper towels, dish soap, bar soap, disinfectant, stuff like that. And the people really like those because, "Hey, I get to save a dollar and I get what I need."

### ***Empowerment***

Empowerment was the next most frequently coded domain and it was the only domain that did not have any category codes. Empowerment can largely be seen in the description of a person's actions and behaviors. In this study, empowerment was defined as gaining control over one's life and influencing the organizational and societal structure in which one lives (Segal et al., 1993). Examples of empowerment can include but are not limited to advocacy for self and others, coping strategies, decision making, assertiveness, asking/accepting help, persuading

others, activities of self-growth, initiating new tasks/setting goals, having access to information and resources, learning about and expressing anger in a healthy manner, understanding your rights and exercising them, and effecting change in one's life and community.

While sharing the impact involvement in PRPSN has had on their recovery, one group facilitator expressed a willingness and desire to advocate for others, effect change in their life, and set goals for themselves.

And I still would like to go to work. I'm even trying to become a peer advocate. I would also like to be a social work and work with people who have mental illnesses. I'm willing to do that. I have a desire to go back to school.

This group facilitator identified the positive effect on mood that occurs when they are able to use their past experience to help others make changes in their lives.

What I feel about that is the empowerment that I feel when helping someone else and the joy of how someone talks about something and I can relate. You know, and that's the main thing. That's what I enjoy is just the empowerment of helping others.

After discussing the stigma experienced from others and low self-concept that developed over a lifetime of mental health difficulties, this group facilitator expressed how involvement in PRPSN has empowered them to effect change in their life and advocate for themselves.

And that was the first time in my life that I really wanted to fight for myself. And that people know that I am not incompetent and that I am very competent and they will not [defame] my character.

### ***Self-concept***

The domain that was coded with the next most frequency was self-concept. This domain includes the category codes of self-efficacy and self-esteem. Self-efficacy is the only category code that contains sub-category codes (physiological states, mastery experiences, vicarious experiences, and verbal persuasion).

**Self-efficacy.** Self-efficacy was the category code that appeared the most frequently within the domain of self-concept. Drawing from Bandura's (1997) concept of agency, self-efficacy is a belief in one's ability to influence events that affect their life and control over the way these events are experienced. Bandura suggests an individual's experience of self-efficacy can be influenced by physiological states, mastery experiences, vicarious experiences, and verbal persuasion, thus researchers measured these concepts as sub-category codes within self-efficacy. In the following excerpt one group facilitator described how their connection to peer support groups assisted in increasing awareness and belief they were on path to recovery.

Once I found out about the cycle of change, that I saw in the cycle of change, the steps that I had made, and then where I had to go to recovery, that's a part, but you keep ascending, you keep coming up, and eventually I won't have those problems

Another participant shared how facilitating peer support groups can promote self-efficacy through connection with others and having a sense of purpose, stating, "Coming to these groups and having this little job helps me get out of self and be productive, you know. Be productive and feel part of society."

**Physiological States.** Physiological states refer to a person's mood, emotions, and any other physical states that may influence our interpretation of self-efficacy. This group facilitator expanded on positive internal states that occur as a product of their involvement in peer support groups.

It's just like being yourself because... it's like when you're doing groups, it's like being yourself and when you're being yourself, there's something that... happens to you miraculously. Uh, it's like the spirit is flowing through you and the blood starts getting excited or hot and what happens out from the inside here, pours through wisdom beyond comparison. And it opens up a well of wisdom inside of you.

**Mastery Experiences.** Mastery experiences refer to the learning that occurs by taking on challenges and succeeding in them. Some examples might include learning new skills and setting

and accomplishing goals. This member shared how facilitating peer support groups over multiple years has provided a medium where they can create and develop an environment that fosters self-efficacy in themselves and others.

I've been leading an art and craft group for seven years with Project Return and [lists names of groups]. And I have enjoyed all the group members and the fun projects each group day. And it's positive to the group members, positive to self-confidence... attitude, and to myself. And I also have self-confidence

**Vicarious Experiences.** By observing the endurance and success of other people similar to themselves, vicarious experiences appear to have a positive impact on an individual's belief in their ability to influence events in their life. One group facilitator expressed how attending and facilitating peer support groups within PRPSN has aided them.

I really like group because I can carry mental health hope. I see it help other members... and I'm like, "Oh I can identify with that person. They go too dark and I can go dark too." Actually, doctor or whoever says a lot of things I cannot understand so I go there to group and see how members say they can do it and, yeah, I can do it too. That is good, hope. So, now I like to facilitate group because I want to give them the hope too. Yes, they can do it too.

**Verbal Persuasion.** According to Bandura (1997) positive encouragement from others, especially role models or mentors that are similar in salient features or characteristics can have a positive effect on an individual's experience of self-efficacy. When describing their experience of self-efficacy one group member shared how others within PRPSN encouraged them to take on a new role as group facilitator.

I was supposed to be experimenting, my case worker and counselors were like, "Oh just try it out, you'll like it," cause I'm one of the functional people and it basically just kind of, year after year, just grew into it.

**Self-esteem.** Another important aspect of self-concept is a person's thoughts, attitudes, or beliefs about themselves. A person's self-esteem can be affected by both positive and negative cognitions. Numerous group facilitators identified self-esteem as a benefit of the peer support

process and one facilitator alludes to how their connection to PRPSN has created positive beliefs about themselves and those beliefs appear to have generalized to other parts of their life.

There's more a part of me than just the 2 hours I spend on Friday night or the 2 hours I spend on Tuesday night. It carries through your personal life and it just becomes, um.. it became a focal point for me, really. Here is something I really do well, I'm gonna improve here and spread it out to other areas of life.

In the next excerpt a long-time group member and facilitator sums up how their involvement in PRPSN has empowered them to advocate for themselves and the subsequent impact those changes have had on their view of themselves. They stated, "It gives you hope in being able to advocate for yourself. You grow. You get self-esteem. You can move forward at a more consistent pace."

### ***Domain Overlap***

Although these data reflect how individual domains served the benefit of peer support group facilitators, there was significant overlap between domains. This was especially illustrated in the relationship between the domain of mutual aid and the domains of empowerment and self-concept. Many excerpts contained codes that reflect multiple domains simultaneously. In the following excerpt a group facilitator illuminated the intersection between mutual aid and self-concept by stating how their experience of sharing and receiving peer support has positively impacted their self-esteem.

And it's about giving back. Giving out of self. It's like, people took time out of their life to give me what I needed in order to succeed in recovery, you know, to give me self-esteem, and so forth. It's about giving back.

Another group facilitator reported how the skills he has used and taught (instrumental support, a category code of mutual aid) has provided them with healthy coping skills (empowerment) to avoid negative consequences.

So you can't relapse so you gotta go out there and really use your tools and techniques that you learned as a facilitator and as a client. That way you won't end up in jail because somebody said something wrong on the bus or bumped into you. You know what I'm saying? So I think it helped me with my social skills, amazing...

In the following excerpts, focus group participants express various ways in which Project Return has influenced their self-concept by empowering them to use their lived experiences and knowledge to create customized peer support environments that allow for the process of mutual aid to occur.

My group is for healthy foods because when I was homeless I was concerned people with diabetes and myself... eating healthy, getting our vegetables in because we get a lot of starchy foods. So if we can get some fruits and vegetables in, then that makes my day.

Heart Smart Art. That's something I can do. I can do art and Project Return is like parallel with my recovery. So all the things that I developed. like coping skills for myself, I bring them into the group. Such as color, just how it affects my mood, aromatherapy, music, and I introduce it to my group and we create. I've been doing it for four and a half years.

I'm telling you that it makes me... it's so... its priceless. I feel so good about leading groups. I don't mind coming to work on Friday because I know I'm finna have a good group and that somebody finna get something outta this group. You know what I mean? If it's nothing but learning how to write a resume or learning how to dress for an interview or you know, learning how to talk in an interview, or how to sit in an interview, you know.

## **Chapter IV: Discussion**

This pilot study examined the experiences of group facilitators of Project Return Peer Support Network. Utilizing qualitative data in the form of focus groups, researchers in this study explored group facilitators' understanding of how and why peer support groups are effective for treating consumers of mental health services, with a specific focus on the constructs of mutual aid, empowerment, and self-concept. Of the three domains, mutual aid was discussed most frequently, followed by empowerment, and self-concept. Based on the coding scheme used in this study, the themes of mutual aid and self-concept contained sub-themes (i.e., category codes) that serve to add additional depth to our understanding of them.

Within the domain of mutual aid, the category codes of social and emotional support and instrumental support underscore mechanisms that make mutual aid a vital part of the peer support process. Within this domain, social and emotional support was the category code that appeared the most frequently. This suggests that social and emotional connection with others are some of the most prevalent aspects of the mutual aid that occur as part of the peer support process. One explanation for this may be that individuals involved in the peer support process lack this type of support in other areas of their lives. In addition to receiving social and emotional support, peers within this environment have the opportunity to reciprocate. Bouchard et al. (2010) suggest that the mutual giving and receiving of social and emotional support amongst peers can help to improve social functioning, decrease general social isolation, and positively impact a person's sense of self-worth. Moreover, the peer support literature suggests that the social support that occurs within peer support groups can reduce symptomatic distress associated with mental health issues (Castelein et al., 2008; Sargent et al., 2002; Weber et al., 2010).



Though social and emotional support emerged as the most frequently discussed aspect of mutual aid, instrumental support was also present in approximately one third of the instances in which mutual aid was mentioned. Some participants identified that reciprocating instrumental support has aided some peers in navigating disability applications, homelessness, substance abuse, and psychiatric hospitalizations. Therefore, it is likely that the exchange of these resources is a highly valuable piece in the peer support community. It could be hypothesized this type of support is difficult to obtain outside of the peer support process for mental health consumers. Isaacs et al. (2019) reported that access to mental health resources contributes to increased wellbeing among individuals with severe and persistent mental illness. In addition to the positive impact that access to mental health resources has on the individual who receives it, the helper's principle purports that the offering of support through tangible resources adds value to the givers experience which increases the giver's overall sense of worth. Thus, a shift in identity occurs and the helper begins to identify as a productive member of society (Solomon, 2004).

The second most frequently coded domain was empowerment. We defined empowerment as gaining control over one's life and influencing the organizational and societal structure in which one lives (Segal et al., 1993). A person's sense of empowerment generally manifests in their actions and behaviors, and examples of empowered behavior include advocacy for self and others, coping strategies, decision making, assertiveness, asking/accepting help, persuading others, activities of self-growth, initiating new tasks/setting goals, having access to information and resources, learning about and expressing anger in a healthy manner, understanding your rights and exercising them, and effecting change in one's life and community. The data gathered and the literature reviewed for this project suggest peer support environments can foster empowerment by promoting a power dynamic among peers that tends to be more evenly

distributed and conducive to self-disclosure which can be beneficial as it allows for members to develop their ability to speak within group settings and learn from one another (Clay, 2005). Additionally, empowered behaviors are reinforced within the peer support environment when consumers are encouraged to participate in decision making processes. By being involved in decision making processes, peers are given the opportunity to become assertive, advocate for their needs, and set and achieve new goals, all of which can have a direct impact on developing a person's overall sense of empowerment.

Self-concept, the third most frequently coded domain in this study, includes an individual's belief in their ability to influence events that affect their life and control over the way those events are experienced (i.e., self-efficacy). A second and equally important aspect of a person's self-concept consists of positive or negative thoughts, attitudes, assumptions, and beliefs about the self (i.e., self-esteem). Of these two category codes within the domain of self-concept, self-efficacy was the most frequently coded category code. Influenced by Bandura's (1995) work on agency and self-efficacy, we utilized the sub-category codes of physiological states, mastery experiences, vicarious experiences or observational learning, and verbal persuasion to identify mechanisms of self-efficacy reported by facilitators of peer support groups. Physiological states such as emotions, moods, etc. were the most frequently coded sub-category code that appeared when measuring self-efficacy followed by mastery experiences, then vicarious experiences, and verbal persuasion. Interestingly, physiological states and mastery experiences were coded with nearly identical frequency (29 and 28 respectively). These findings allude to cognitive research connecting emotions (i.e., physiological states) and behaviors (i.e., mastery experiences) to an individual's thoughts (i.e., self-concept; Beck, 1995). One possible implication of this finding is that peer support group facilitators could design group activities to

promote physiological states and mastery experiences that positively impact their members' self-concept. According to Bandura (1997), vicarious experiences and verbal persuasion are most impactful when an individual is able to learn from a model who is similar to themselves in salient features. This seems to highlight the importance of peer facilitators within the recovery environment. Specific to PRPSN, facilitators begin their affiliation with the organization as group members and over time work their way into leadership roles. This process materializes as a fertile environment to create opportunities for peers to experience positive encouragement and vicarious learning, supporting our hypothesis that participation in PRPSN groups can have a positive impact on a person's self-concept.

Self-esteem was the second most frequently coded category code within the domain of self-concept suggesting it is a relevant part of mental health recovery in the peer support process. Because self-esteem plays an essential role in a person's subjective well-being and recovery, it is likely that the peer support environment contains the ingredients to foster this experience among its members. Our data suggests that participation in peer support groups promotes self-esteem which can be an important factor in mental health recovery as an individual's self-esteem can work as a protective factor against depression, loneliness, and social isolation (Weber et al., 2010). Chen Yi-Feng et al. (2008) found that people tend to contribute more to their surroundings and view themselves as more competent when experiencing increased levels of self-esteem. Additionally, the extent to which codes for mutual aid and self-esteem co-occurred seems to support our hypothesis that the sharing and receiving of resources between peers can work as a bridge that connects participation in peer support groups and an individual's self-esteem.

To gain a more comprehensive understanding of the peer support process it is important to examine the frequency with which more than one domain was coded for a single excerpt (i.e., domain overlap). Mutual aid co-occurred approximately 30% of the time empowerment was coded. Mutual aid also co-occurred approximately 30% of the time self-concept was coded. This implies that the reciprocation of resources is an equally relevant aspect of empowerment and self-concept within the peer support process. Our data appears to support this and adds to the research that highlights how reciprocity amongst peers can function as a buttress to strengthen peer interactions. For example, the peer support literature suggests that the sharing of social and emotional support from peers who share similar experiences can be both comforting and empowering (Chan & Mak, 2016). Thus, if organizations such as PRPSN can reinforce interactions between peers emphasizing the sharing of resources which could increase an individuals' access to mental health resources and the positive impact of those interactions. According to Miyamoto and Sono (2012), mutual aid seems to have a bidirectional effect as the act of giving back appears to provide the sharer with an opportunity to make sense of their experiences which can then facilitate an increased sense of empowerment and a higher likelihood of repeating the behavior. Additionally, there appear to be multiple benefits to the receiver of the resources and their perception of self-concept. For example, if the receiver is gaining instrumental support like problem solving skills, then the opportunities for vicarious learning and mastery experiences are likely to occur. When the receiver is feeling loved, valued, and cared for in the form of social and emotional support, domain overlap shows that self-concept is, also, often coded which suggests a possible connection between a person's self-esteem and mutual aid. These findings are consistent with our hypothesis that suggest mutual aid serves to promote empowerment and self-concept among individuals recovering from mental illness. As such, it

appears that mutual aid is an integral aspect of the peer support process and must be considered in order to understand the mechanisms that make peer support groups beneficial to mental health recovery.

### **Study Limitations**

One limitation of this study is the use of one coder to code the data. In order to have more verifiable results, it is recommended that at least two coders are used to counterbalance any bias that may occur during the coding process. However, this was not possible due to limited resources available for the project. A convergent process was used while generating the code tree in which the writer and dissertation chair examined code applications to ensure adherence to the code tree.

A second limitation of the study is that the data are cross-sectional in nature and therefore it is unclear how perceptions of the participants of the study may fluctuate over time. Study participants represented facilitators of PRPSN support groups and it is likely that this population has had more positive experiences within the peer support environment than those who have had limited participation in peer support groups, individuals who have had negative peer support experiences, or individuals who do not engage in peer support services.

Another set of limitations is related to the way in which data were collected. Data for this study was collected through multiple focus groups conducted by a group of researchers and research assistants in a variety of settings. For example, the majority of the data was collected through focus groups conducted during PRPSN's quarterly facilitators meeting which was held in a large multipurpose auditorium in Los Angeles. Other focus groups were held at PRPSN's main headquarters and public mental health facilities. Therefore, environmental factors specific to each focus group were not controlled for in the collection of the data in this study.

Additionally, the researchers and research assistants who facilitated the focus groups were given a standardized list of questions to guide data collection, however, variables such as facilitator style, adherence to question list, ability to create rapport, and the degree of participation by individuals within the focus groups were factors that were not controlled for and may have impacted the consistency of the data collected.

The lack of quantitative data presents another limitation in this study. Quantitative data could have benefited this study by providing researchers with various patterns, insights, and trends related to facilitating PRPSN peer support groups. Some examples of measures that correspond to the constructs coded in this study include the Rosenberg Self-Esteem Scale (Alessandri et al., 2015), the Self-Efficacy Survey (Anastasi & Urbina, 1997), and the Patient Empowerment Scale (Cerezo et al., 2016). Comparing an individual's length of time facilitating PRPSN support groups to data collected by the aforementioned measures is one way in which researchers would have gained additional insight into study participant's experiences.

The degree to which our results would generalize to other peer support environments is unclear as the data of this study specifically examined PRPSN peer support group facilitators. Additionally, it is unclear how the data would generalize to PRPSN group members. Moreover, it is unclear how the findings of this study would generalize to facilitators and group members of other peer support groups outside of PRPSN and, more broadly, peer support groups outside of Los Angeles. Finally, thorough mental health histories of study participants were not collected and it is unclear how the results of this study would generalize to specific diagnostic categories.

Although these limitations occurred within the study, our findings contribute to the body of literature that helps to identify factors that make peer support a valuable part of the recovery

processes. Additionally, the sample of peer supporters who participated in this study represent a broad range of cultural intersections and mental health diagnoses.

### **Clinical Implications**

In addition to reinforcing the understanding that peer support groups can be an effective intervention for people recovering from mental illness, our data expands the collective understanding of what mechanisms may serve to promote recovery within peer support groups. When considering future peer support groups, a useful finding within our study is the interwoven nature of reciprocal relationships between peers, specifically, when sharing instrumental, social, and emotional support. It seems as though the sharing of resources between peers like social and emotional support are highly valued, thus empathy, attunement, and emotional responsiveness provided in the peer support environment highlights the importance of connection to others and reminds us that human beings are social animals (Aronson, 1992). Social isolation is a known exacerbating factor of mental illness (Castelein et al., 2008) and it is likely that the giving and receiving of social and emotional support in peer support groups can directly impact the negative effects that social isolation has on mental illness (Schwartz & Sendor, 1999; Williams, 1995) making it a significant contributor to mental health recovery. Therefore, it will be important for group facilitators to understand this and promote it within their groups, not only for the benefit of group member's recovery but also for their own.

Another important finding when considering the reciprocity of resources within peer support groups is the offering of instrumental support. This process of peer support allows members to provide each other with a wide range of tangible resources which can include but are not limited to the sharing of knowledge, helping to fix a problem, providing a ride to various appointments, or helping someone complete a task. One practical way in which instrumental

support could possibly directly benefit group members is by the sharing of knowledge of how to navigate historically difficult to navigate systems within mental health such as psychiatric hospitalizations, disability applications, homeless shelters, and substance abuse facilities. A review of the coded excerpts within this study found an example of instrumental support where a group member described how they learned how to do laundry and other activities of daily living as a result of participating in peer support groups. The prior examples emphasize the importance of instrumental support and imply it can possibly assist in alleviating the impact of environmental stressors. From a clinical standpoint, instrumental support provided within the peer support environment could positively affect an individual's mental health recovery by lessening the impact of environmental stressors of group members.

Within conventional mental health services, the provision of resources is traditionally shared unidirectionally from provider to consumer. Due to the bidirectional nature of resource sharing, connection to peer support groups could increase an individual's opportunities and access to means conducive to mental health recovery. In addition to the direct benefits that occur as a result of access to resources, domain overlap appears to imply there is something valuable in the bidirectional relationships that are created in peer support systems. This could likely be the utilization of peers within the recovery model. Peers could potentially be taught to use their lived experiences to provide mentorship, teach skills, provide crisis prevention, etc. at significantly lower costs creating model scalability and more access to resources to individuals who need them. With this type of grassroots style of mental health services, peer support groups like PRPSN could begin to manifest in recreation centers, public facilities, parks, educational programs, and more.



## **Recommendations for Future Research**

Continued research is warranted to further examine the role mutual aid, empowerment, and self-concept hold within peer support programs. It may be helpful for future researchers to integrate quantitative measures to examine correlational relationships between domains. Additionally, it may be useful to integrate quantitative measures to examine relationships between domains and category codes, for example, exploring the relationship between the domain of empowerment in relation to the category codes of self-esteem or self-efficacy. There is also a need to utilize longitudinal methods to further understand the development and changes of the specific domains in this study over time within PRPSN and the peer support environment as a whole. Finally, based on the findings of this study, it would be important for future research to examine if an individual's involvement in peer support programs would serve as a suitable stand-alone treatment for mental health issues or be combined as an adjunct to traditional mental health services.

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## APPENDIX A

## Literature Review Table

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
1 Alessandri et al. (2015). On the factor structure of the Rosenberg (1965)	Investigating goodness of fit to measure general self-esteem	$n = 11,028$	Rosenberg self-esteem scale	Bifactor model	Rosenberg self-esteem scale is a commonly used and reliable measure of a person's subjective experience of self-esteem.
2 Anastasi, & Urbina (1997). Psychological Testing. (7th ed.)	n/a	n/a	n/a	Textbook	This textbook focuses on psychological testing and the administration of those test. Specifically, how tests are selected, interpreted, and results are communicated. This was used when considering test that measure themes highlighted in our research.
3 Aronson (1992). The social animal (6th ed.).	n/a	n/a	n/a	Textbook	This textbook was used to discuss the social nature of human beings and various theories that are used to conceptualize behavior
4 Bandura (1995). Self-efficacy in changing societies	n/a	n/a	n/a	Textbook	This textbook examines various ways beliefs of personal self-efficacy work within a complex web of sociocultural influences and how they impact a person's life trajectory. Researchers used this to discuss agency and cross-cultural factors.
5 Bandura (1997). Self-efficacy: The exercise of control	n/a	n/a	n/a	Textbook	This Textbook was used to introduce and consider Albert Bandura's Social-Cognitive Theory and expand on the concept of self-efficacy, its' development, and its' impact on a person's self-concept and mental health.
6 Baxter & Diehl (1998). Emotional stages: Consumers and family members recovering from the trauma of mental illness	Exploring how people with mental illness grieve repercussions of their illness	Members of the Bridges program	Interviews	Qualitative	This article was used to review conceptual models specific to the experience of individuals with SMI and their family members. Additionally, this article examined the Bridges and Journey of Hope program that offer peer support and psychoeducation classes ran by individuals with lived experiences of SMI.
7 Beck (1995). Cognitive therapy: Basics and beyond	n/a	n/a	n/a	Textbook	This textbook was used to discuss and introduce theory and concepts of Cognitive Behavior Therapy.

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
8 Beehler et al. (2014). Participant experiences in peer- and clinician-facilitated mental health recovery groups for veterans	Identify and compare experiences of peer facilitated vs. clinician facilitated recovery groups for veterans	n/a	Interviews	Qualitative	There were little differences between group structure, participation, and utility regarding who facilitated the groups and participants felt as though either group was helpful in supporting their recovery.
9 Bellamy et al. (2012). Giving back and getting something back: The role of mutual-aid groups for individuals in recovery from incarceration, addiction, and mental illness.	Discussing mutual aid within peer support	n/a	n/a	Literature Review	This article reviews and defines the concept of mutual aid within the context of peer support groups and mental health recovery. Additionally, it examines a peer support program utilized within prisons where ex-cons use their lived experiences to assist inmates navigate incarceration and reintegration into society upon release.
10 Bologna & Pulice (2011). Evaluation of a peer-run hospital diversion program: A descriptive study.	Program evaluation to compare mental health clients' experiences with environments, services, and staff in a peer-run hospital diversion program	39 respondents returned surveys.	Surveys five-part, 70-item measure	An uncontrolled, single-group, retrospective study design	Respondents were found prefer peer support services more than clinician run services as they perceived there to be more components like being greeted warmly, explanation of services and treatment, and encouragement in the recovery process. They also felt staff behavior across programs, specifically staff availability, respect for clients, active listening, and encouragement of interaction by the client with others was more preferable.
11 Bouchard et al. (2010). Peer support among inpatients in an adult mental health setting	To explore naturally occurring peer support in inpatient hospitals	60 individuals within inpatient hospitals	Interviews	Qualitative	When describing experiences of peer support, three themes emerged. They included the nature of peer support, outcomes of peer support, and the context of peer support. Within these themes there were thinking about peers, helping peers through actions, providing emotional support, receiving peer support, sharing advice, and personal and structural factors

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
12 Boyd et al. (2016). Internalized stigma of mental illness and depressive and psychotic symptoms in homeless veterans over 6 months	Exploring the impact of internalized stigma on the chronically mentally ill	<i>n</i> = 777 homeless veterans	Internalized Stigma of Mental Illness Scale The Stereotype Endorsement Scale The Discrimination Experience Scale	Quantitative	Peer support assisted with lower a person's experience of internalized stigma, which also had a positive impact on symptoms of depression and psychosis.
13 Bracke et al. (2008). Self-esteem, self-efficacy, and the balance of peer support among persons with chronic mental health problems.	Studying subjective well-being and the balance of giving and receiving peer support	628 users of vocational and psychiatric rehabilitation centers	Data collected via survey  Cross sectional design	Rosenberg Self Esteem Scale  Quantitative	Providing peer support is more beneficial than receiving it. Helping others increases the helper's feelings of competence, social usefulness, makes them feel important, & self-esteem. Self-esteem can be threatened by the peer support group when it elicits feelings of distress, inferiority, failure, and powerlessness. Providing support can mitigate negative effects of peer support received.
14 Castelein et al. (2008). The effectiveness of peer support groups in psychosis: A randomized controlled trial	To investigate the effect of a (minimally) guided peer support group (GPSG) for people with psychosis	56 patients in the peer support group and 50 patients in the control condition	16, 90min peer support sessions  10 people per group	Randomized controlled study	Peer support groups are a useful intervention for psychosis and they can improve their social networks which leads to increased social support and decreased isolation and resulted in overall better quality of life.
15 Cerezo et al. (2016). Concepts and measures of patient empowerment: a comprehensive review	Analyze definitions and dimensions of empowerment	29 articles reviewed	n/a	Literature Review	The review covered 17 definitions of empowerment and 10 separate dimension and then the authors offered their own definition of empowerment. Overall, it is a process of collaboration that aids patients in gathering information and resources and fostering within them the autonomy to use those resources and information.

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
16 Chan, & Mak (2016). Common sense model of mental illness: Understanding the impact of cognitive and emotional representations of mental illness on recovery through the mediation of self-stigma	Understand mechanism of cognitive and emotional representations of mental illness	<i>n</i> = 376 people in recovery	Surveys	Cross sectional	Low perception of control over mental illness lead to poor recovery outcomes and can have severe consequences. Negative emotional response to mental illness correlated with poor recovery outcomes. Self-stigma of mental illness effected representation and recovery. Adaptive beliefs about recovery fostered recovery
17 Chen et al. (2016). Resilience moderates the association between stigma and psychological distress among family caregivers of patients with schizophrenia	To describe the prevalence of psychological distress in caregivers of people with schizophrenia.	<i>n</i> = 126 family caregivers	Kessler Psychological Distress Scale, Perceived Devaluation and Discrimination Scale, and Connor-Davidson Resilience Scale	Self-report measures	Caregivers of people with schizophrenia in China reported high psychological distress. Caregiver resilience and stigma directly affect their psychological distress. Individual resilience can moderate the effects of stigma on psychological distress.
18 Chen Yi-Feng et al. (2008). Similarity in gender and self-esteem for supportive peer relationships: The mediating role of cooperative goals	Do cooperative goals mediate the relationship between similarity in gender and self-esteem and social support and relationship quality?	<i>n</i> = 209 student dyads	Social Support Scale and Leader and Member Relationship Scale	Self-report measures	Low SE people are more suspicious but more passive in managing their relationships. High SE people are more cooperative and more popular amongst their peers. People with high self-esteem contribute a great deal and feel successful through their contributions, whereas persons with low self-esteem appreciate and value the assistance. High self-esteem is more capable, competent, and aware of the cues of others, which enables them to be more responsive to others.
19 Chinman et al. (2001). Chronicity reconsidered Improving person-environment fit through a consumer-run service	To evaluate the effectiveness of peer support programs.	n/a	n/a	Literature review and program evaluation.	The Welcome Basket Program appears to be effective as it helps people broaden their social network, assist others, and participate in community activities. This is helpful because it addresses isolation, demoralization, and recidivism.

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
20 Chinman et al. (2002). Service providers' views of psychiatric mutual support groups	Assessing attitudes towards mutuality.	<i>n</i> = 400 peer support providers	Researchers created their own survey	Self-report surveys	Five Beneficial Criteria of Mutual Support Groups: (1) Purpose of the group (2) Origin (was it created by members) (3) Source of Help (do they use each other) (4) Composition (is the group made up of people with similar issues) (5) Control
21 Chinman et al. (2014). Peer support services for individuals with serious mental illnesses: Assessing the evidence.	To assess the evidence and effectiveness of peer services by people in recovery.	20 studies	n/a	Literature Review	Effectiveness varied by service. Two types of services emerged which include peer aided and peer delivered. Consumers preferred peers compared to MH staff. Peers helped to improve recovery rates.
22 Chinman et al. (2000). Comparing consumer and non-consumer provided case management services for homeless persons with serious mental illness.	To examine the effect of case management relationship and clinical outcomes in homeless with SMI.	<i>n</i> = 2,798	n/a	Two cohorts receiving 12 months of services in the ACCESS program.	When there was a high alliance and relationship between client and case manager there was significantly less days of homelessness over a 12-month period and a, reported, moderate overall life satisfaction.
23 Clay (2005). With us: Where are going	n/a	n/a	n/a	Textbook	Helper's Principle: "acting for the benefit of both oneself and others" by helping others recovery, it inherently aids in your own recovery. Help/advice is viewed as friendly rather than professional that may implicitly demand compliance Peer Relationship: equality, mutual acceptance, and unconditional respect.
24 Dennis (2003). Peer support within a health care context: A concept analysis	The goal of the analysis is to provide conceptual refinement	Lit from the past 10-15 years from social psych, health care, & med domains	n/a	Literature Review	Recognizing that health professionals alone are unable to address evolving health needs, consumers (peer lay individuals with experiential knowledge) Peer support significant part in the delivery of quality health care Peer Support Defined: "giving assistance and encouragement by an individual considered an equal



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25 Galanter et al. (1998). Homelessness and mental illness in a professional- and peer-led cocaine treatment clinic	Evaluate peer services as an adjunct to SUD treatment for cocaine use.	<i>n</i> = 340 patients attending cocaine day treatment	Five day a week outpatient treatment.	CBT for SUD combined with peer support services	Combining professional services with peer leadership is a viable treatment model for cocaine use disorder.
26 Helmchen (2013). 'Early Psychosis' as a mirror of biologist controversies in post-war German, Anglo-Saxon, and Soviet Psychiatry	Critical review of a journal article.	n/a	n/a	Response to a journal article.	Terms like schizophrenia should not be used because they create negative stigma for sufferers. The term phase should be replaced with episode as schizophrenia may not fully remit over the course of a person's life time
27 Hill (2012). Consensual qualitative research: A practical resource for investigating social science phenomena	n/a	n/a	n/a	Textbook	This book was used to inform and guide the qualitative research approach used for this dissertation project.
28 Hill (2016). Quality of life and mental health among women with ovarian cancer: Examining the role of emotional and instrumental social support seeking.	To study the role of emotional and instrumental social support.	Women with ovarian cancer.	Quality of Life Questionnaire	Self-report measures	As a coping mechanism, social support seeking behavior is an important factor in overall quality of life and can positively impact mental health in individuals suffering from cancer.
29 Hruschka et al. (2004). Reliability in Coding Open-Ended Data: Lessons Learned from HIV Behavioral	n/a	n/a	n/a	Team of coders creating a code book based on common themes found in the collected data.	This article was used to inform and guide the qualitative research method of this dissertation process. It was specifically used to model the approach used to code the focus group transcripts.
30 Isaacs et al. (2019). Unmet needs of persons with a severe and persistent mental illness and their relationship to unmet accommodation needs	To explore the unmet needs reported by people with SMI.	Individuals with SMI, receiving assistance from public services, and be supported by friends or family.	Data analysis of demographic and public health status reports.	Cross-sectional	People with SMI have difficulty accessing food, self-care, childcare, physical health needs, housing, and transportation. People with SMI are 3.5 times more likely to not have financial needs met. Current support provided by government is inadequate to meet the basic needs of people with SMI.

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31 Johnsen et al. (2005). Common ingredients as fidelity measure for peer-run programs.	Comparison of 2 sets of interventions: 1) Consumer operated service as adjunct to traditional MH services 2) traditional MH services alone.	8 Districts 1998-2002 across US	n/a	Textbook	Three different types of peer support: Drop in centers, peer support services, & educational programs. Social support, recovery, individual autonomy, and empowerment are some common aspects Peer Support formal/informal, Expression, Lived Experiences, Peer mentoring/teaching, Crisis Prevention formal/informal
32 Livingston & Boyd (2010). Correlates and consequences of internalized stigma for people living with mental illness: A systematic review and meta-analysis	Exploring internalized stigma and a variety of sociodemographic variables	127 articles	n/a	Meta-analysis	There is a significant negative correlation between internalized stigma and hope, self-esteem, and empowerment. Internalized stigma was positively correlated with psychiatric symptom severity and lack of treatment adherence.
33 Mead et al. (2001). Peer support: A theoretical perspective	Examine theories of peer support	n/a	n/a	Literature Review	Based on empathetically understanding another's position through shared experiences of emotional and psychological pain. This can create a feeling of connection that someone with a mental health issue may not have ever felt. Diminishes power dynamic. The connection is based on mutual experience.
34 Miyamoto & Sono (2012). Lessons from peer support among individuals with mental health difficulties: A review of the literature	The purpose of this review is to describe the principles, effects and benefits of peer support, as documented in the published literature. Moreover, we discuss the challenging aspects of peer support and their lessons.	51 articles	n/a	Literature Review	Self-efficacy from helping others, increased knowledge due to the sharing of common experiences with others, the development of skills through service work towards others. Peer supporters are seen as role models and their focus is on optimism and action-oriented recovery Having a mixed role peer supporter/staff means supporters act as liaisons between the staff and patients, helping each to better understand the other.
35 Pallaveshi et al. (2014). Peer-led and professional-led group	Evaluating the experience of people with co-occurring disorders	6 individuals engaged in peer support services	Semi-structured interviews	Qualitative pilot study.	Peer led and professionally led groups contribute to mental health recovery. Both interventions provide benefits when offered

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
interventions for people with co-occurring disorders: A qualitative study	in relation to peer support groups.				together. Peer led groups can be offered at relatively low costs and made more available than professionally led groups. Professionally led groups can be limited due to difficulty starting and finding participants. They are delivered in groups or pairs and by phone, in person, or over the internet. Generally, at low cost and more readily available. Peer support interventions may decrease isolation (direct effect), reduce the impact of stressors (buffering effect), increase sharing of health and self-management information (direct effect), and provide positive role modeling (mediating effect).
36 Pfeiffer et al. (2011). Efficacy of peer support interventions for depression: A meta-analysis	Meta-analysis of published randomized trials to determine the evidence base for peer support services for depression	10 studies	n/a	Meta-analysis	Peer support interventions may decrease isolation (direct effect), reduce the impact of stressors (buffering effect), increase sharing of health and self-management information (direct effect), and provide positive role modeling (mediating effect).
37 Porter (2006). Madmen: A Social History of Madhouses, Mad-Doctors & Lunatics.	Provide a history of mental health services.	n/a	n/a	Book	This book was used to discuss the history of mental health treatment within America and the development and introduction of the Recovery Movement within Southern California.
38 Repper & Carter (2011). A review of the literature on peer support in mental health services	Peer support workers employed in mental health services describe their experiences	n/a	Reviewed and summarized peer support articles.	Literature Review	Peer support workers can lead to a reduction in people who use those services. Careful training, supervision, and management of peer support workers is necessary, but if done properly they can have a positive impact on chronic consumers of mental health services.
39 Rowe et al. (2009). Citizenship, community, and recovery: A group- and peer-based intervention for persons with co-occurring disorders and criminal justice histories	Examine peer support groups for co-occurring SUD and mental health disorders	n/a	n/a	Meta-analysis	Peer led group therapy for people with co-occurring disorders can positively impact their experience of withdrawal, criminal recidivism, interactions with the criminal justice system, and aids with connection to community supports and housing.
40 Sargent et al. (2002). Sense of belonging as a buffer against	To determine a buffering effect provided by a sense of belonging	443 navy recruits.	Comparative design	Self-report surveys	Personal sense of belonging provided a symptom buffer for those with a family history of

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
depressive symptoms. 41 Schutt & Rogers (2009). Empowerment and peer support: Structure and a process of self-help in a consumer-run center for individuals with mental illness	Examine social processes and consumer run programs that help develop empowerment.	$n = 26$	Interviews and focus groups	Qualitative	alcohol abuse and the development of depression. Consumer ran services can promote empowerment and self-esteem. Consumers feel more comfortable with the informal nature of drop-in centers. Drop-in centers can provider instrumental and social support. The helper/therapy principle can help to develop empowerment in drop-in centers.
42 Schwartz & Sendor (1999). Helping others helps oneself: Response shift effects in peer support	Explores the positive impact of helping others on the provider.	132 people with multiple sclerosis	Quality of life questionnaire	Secondary analysis of a randomized trial exploring the impact of being a peer supporter	Peer supporters showed improvement in confidence, self-awareness, self-esteem, depression, and role functioning. Participants also reported improvements in how they viewed themselves and their relation to others.
43 Segal et al. (1993). Helping others helps oneself: Response shift effects in peer support.	To explore the impact of peer support on empowerment.	n/a	n/a	Literature review.	Peer support groups are structured to give patients roles that allow them to take responsibility and exercise discretion over things that affect them. Peers are allowed to seek changes in the larger society that better the conditions of people with disabilities and empower them to participate in decision making processes.
44 Shern et al. (2008). Medicaid managed care and the distribution of societal costs for persons with severe mental illness.	Examine access to resources for people with SMI.	$n = 628$ adults with SMI	Interviews	Qualitative	Adults with mental illness may need to rely on Medicaid services to gain necessary financial support and gain access to treatment based on the rising costs of mental health treatment.
45 Shorter (2009). Review of Changing American psychiatry: A personal perspective	n/a	n/a	n/a	Response to article	This article was used to provide context for historical changes within the APA and the integration of peer support services for people with chronic SMI.

Author/Year/ Title	Research Questions/ Objectives	Sample	Variables/ Instruments/ Focus	Methodology/ Research Approach/ Design	Major Findings
46 Simpson et al. (2014).	Investigate the effect of peer support on feelings of hope and loneliness, quality of life and service use in mental health patients following discharge from hospital.	<i>n</i> = 46	Beck Hopelessness Scale (BHS) UCLA Loneliness Scale EuroQol Quality of Life Questionnaire Client Service Receipt Inventory Peer Support Activity Diaries	Self-report surveys	No significant difference between groups at baseline. At follow up, no statistical difference between Peer Support and Care as Usual. At follow up Peer Support showed some improvement in loneliness, but was not statistically significant. No statistical difference between groups at baseline. No statistical difference between groups at 1 month or 3 month follow up.
47 Solomon (2004). Peer Support/Peer Provided Services Underlying Processes, Benefits, and Critical Ingredients	Purpose of this article is to lay out the principles of peer support/peer delivered services that emerge from the literature.	n/a	n/a	Literature review.	Helper Principle: 1) the helper feels an enhanced sense of interpersonal competence from making an impact on another's life; 2) the helper feels that she/he has gained as much as she/he has given to others; 3) the helper receives "personalized learning" from working with others, and 4) the helper acquires an enhanced sense of self from the social approval received for those helped. With this positive feedback and affirmation of themselves, they are in a better position to help others.
48 Stensland et al. (2012). An examination of costs, charges, and payments for inpatient psychiatric treatment in community hospitals	Provide cost estimates for inpatient care.	<i>n</i> = 261,996 inpatient hospitalizations	n/a	Review of average charges using Premier's Perspective Comparative Database	Due to attempts to control pricing have created unintentional consequences that have raised the price of inpatient care resulting in gaps between charges and reimbursements, longer stays, and cost shifts onto the consumer.
49 Taylor & Johnson (2013). The cost of mental illness.	Examine the cost of mental illness within society at large.	n/a	n/a	Literature review	25% of adults experience mental illness annually. Annual estimated cost of mental illness \$300 billion. Projected \$193 billion lost in earnings

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50 Vaisman-Tzachor & Thames (2010). Project Return Peer Support Network: First survey of efficacy	Illuminate the relative impact of the peer-run clubs upon the quality of life of the members who participate in them.	$n = 257$	Self-report surveys	Pilot study	Can help with improve health conditions and prevent problems associated with chronic mental illness, maintaining tx effects for substance abuse & preventing relapse, reducing the need for medical services & lowering med use, and reducing the cost associated with providing services for people with mental illness. Does not focus solely on symptomatology. It Addresses the social and personal consequences of mental illness via mutual support and peer-helping models.
51 Vayshenker et al. (2016). Participation in peer support services and outcomes related to recovery	Explore the impact of peer support participation on recovery.	$n = 64$	Interviews at 3- and 6-month time interval	Naturalistic study	4 key aspect that promote change within peer support: 1) Exchange of Resources ex. work opportunities, access to information, and mutual support 2) Self-Appraisal i.e. feeling optimistic towards oneself, 3) Building Life Role Skills i.e. work, social, and coping skills, 4) Identity Transformation i.e. from dependent to independent and a sense of belonging. (the model remains unexamined)
52 Verhaeghe et al. (2008). Stigmatization and self-esteem of persons in recovery from mental illness: The role of peer support	Peer support provides a buffer from stress and stigmatization	$n = 595$	Squares regression analysis using data from structured questionnaires.	Quantitative	Stigmatization is negatively correlated with self-esteem. Peer support is positively correlated with self-esteem. Peer support can moderate the negative correlations between stigma and self-esteem. Stigmatization can block the formation of peer relationships.
53 Weber et al. (2010). Relationships between depressive symptoms and perceived social support, self-esteem, & optimism in a sample of rural adolescents	Examining the inter-relationships between depressive symptoms and perceived social support.	$n = 179$ high school students	The Reynolds Adolescent Depression Scale The Perceived Social Support Scale	Cross sectional self-report surveys.	Girls in this study reported more perceived social support from families and friends. Boys reported higher levels of self-esteem and optimism. Depressive symptoms were negatively correlated with perceived social support from friends, perceived social support from family, self-esteem, and optimism. Perceived social support from the family showed the highest negative correlation with depression.

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54 Whitley & Campbell (2014). Stigma, agency and recovery amongst people with severe mental illness	To analyze behavioral and psychological strategies to manage stigma within the SMI population.	$n = 28$	Focus groups	Qualitative longitudinal study from 2008-2012	Stigma and discrimination were not perceived as common experiences, but viewed as an always present potential problem, which leads to preemptive behaviors to appear normal. Having access to peer support and housing diminished that experience and gave the person a sense of normality.
55 Williams (1995). There are no free gifts: Social support and the need for reciprocity	Examines the need to reciprocate by the support recipient of peer support.	$n = 202$	Presentation of findings from a larger study	Sahlin's model of reciprocity	Stepwise reciprocity is when a support recipient then moves on and provides support to a new person if and when needed. This need to reciprocate is a generalized feeling that cuts across multiple cultural intersections.
56 Xu et al. (2016). The economic burden of mental disorders in China, 2005–2013: Implications for health policy	To quantify the national economic burden of mental health in China.	$n = 25,289$	Review of national surveys	Prevalence based, bottom up approach to estimate economic cost.	Total annual cost of mental health in China increased from \$1,094 in 2005 to 3,665 in 2013 per individual person. From \$21 billion to \$88 billion nationwide.
57 Yanos et al. (2001). Consumer-run service participation, recovery of social functioning, and the mediating role of psychological factors	Examines the relationship between participation in peer run services and recovery of social functions in people with SMI.	$n = 60$ participants with a diagnosis of schizophrenia	Self-report surveys	Data examined hopefulness, self-efficacy, coping strategies, social functioning, and premorbid functioning.	Participants in peer ran services had better social functioning than those who participated in traditional mental health. Problem centered coping strategies developed in peer ran services improved self-efficacy and hopefulness. Premorbid factors did not account for degree of social functioning except for education level.

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## APPENDIX B

### Tables



**Table B1***Participant Demographic Characteristics According to Focus Group*

Participant	Focus Group & Setting	Age	Gender	Ethnicity
1	Quarterly facilitator's meeting	49	Male	Latino American
2	Quarterly facilitator's meeting	55	Male	Missing
3	Quarterly facilitator's meeting	43	Male	White
4	Quarterly facilitator's meeting	63	Male	Caucasian (Irish/German/American)
5	Quarterly facilitator's meeting	61	Male	Black
6	Quarterly facilitator's meeting	69	Male	Jewish
7	Quarterly facilitator's meeting	59	Missing	Mexican
8	Quarterly facilitator's meeting	20	Female	African American/Italian
9	Quarterly facilitator's meeting	46	Female	African American
10	Quarterly facilitator's meeting	50	Female	Black
11	Quarterly facilitator's meeting	35	Female	White/Caucasian
12	Quarterly facilitator's meeting	Missing	Missing	Missing
13	Quarterly facilitator's meeting	62	Female	Black
14	Quarterly facilitator's meeting	51	Male	Black
15	Quarterly facilitator's meeting	Missing	Missing	Missing
16	Quarterly facilitator's meeting	50	Male	Native Morrish
17	Quarterly facilitator's meeting	31	Female	Hispanic
18	Quarterly facilitator's meeting	51	Female	Missing
19	Quarterly facilitator's meeting	26	Female	African American
20	Quarterly facilitator's meeting	47	Female	Black
21	Quarterly facilitator's meeting	58	Female	Black
22	Quarterly facilitator's meeting	46	Female	Caucasian
23	PRPSN headquarters	34	Male	Hispanic
24	PRPSN headquarters	46	Male	Hispanic
25	PRPSN headquarters	41	Female	Hispanic Mexican American
26	PRPSN headquarters	34	Male	Unknown
27	PRPSN headquarters	53	Male	White
28	PRPSN headquarters	Missing	Female	Caucasian
29	PRPSN headquarters	25	Female	Latino/Hispanic
30	Public recreational facility	42	Female	African American
31	Public recreational facility	63	Male	African American
32	Public recreational facility	59	Male	Asian
33	Public recreational facility	34	Female	White
34	Public recreational facility	68	Female	Colored
35	Public recreational facility	47	Male	African American
36	Public recreational facility	45	Female	Black
37	Public recreational facility	41	Female	Other
38	Public recreational facility	75	Male	White
39	Public recreational facility	62	Female	Hispanic
40	Public recreational facility	61	Male	White
41	Public recreational facility	32	Male	Korean
42	Apartment complex	60	Male	Caucasian
43	Apartment complex	53	Male	Asian American
44	Apartment complex	56	Transgender woman	Mexican
45	Apartment complex	56	Female	Black
46	PRPSN conference room	63	Female	Ispano
47	PRPSN conference room	45	Female	Hispanic
48	PRPSN conference room	Missing	Missing	Missing

Participant	Focus Group & Setting	Age	Gender	Ethnicity
49	PRPSN conference room	53	Female	White
50	PRPSN conference room	62	Male	White Caucasian
51	PRPSN conference room	54	Male	White
52	PRPSN conference room	49	Male	White

**Table B2***Code Descriptions*

Domain Code	Category Code	Sub-category Code	Description
Mutual Aid			The offering and receiving of resources between peers.
Self-Concept	Instrumental Support		Assistance received by others that is tangible. Ex. sharing of knowledge or advise, providing care, helping fix a problem, lending money, helping with school work, helping someone complete a task or errand.
	Socio/Emotional Support		Making someone feel valued, loved, and cared for. Ex. providing empathy, attunement, and emotional responsiveness. (Generally, cognitions) A combination of both self-esteem & self-efficacy
	Self-esteem		Positive or negative thoughts, attitudes, assumptions, or beliefs about the self.
	Self-efficacy		The belief in one's ability to influence events that effect their life and control over the way these events are experienced. These can include mastery experiences, vicarious experiences, verbal persuasion, and psychological states (Bandura, 1997).
Empowerment		Mastery Experiences	The learning that occurs by taking on challenges and succeeding in them. Ex. Learning new skills; accomplishing new goals.
		Vicarious Experiences	Observing the endurance and success of other people similar to themselves in salient features.
		Verbal Persuasion	Positive encouragement from others, especially role models or mentors.
		Physiological States	Emotions, moods, and physical states that influence our interpretation of self-efficacy. (Generally, behaviors/actions): Gaining control over one's life and influencing the organizational and societal structure in which one lives (Segal, Silverman, & Temkin, 1993). Examples of empowerment include advocacy for self and others, coping strategies, decision making, assertiveness, asking/accepting help, persuading others, activities of self-growth, initiating new tasks/setting goals, having access to information and resources, learning about and expressing anger in a healthy manor, understanding your rights and exercising them, and effecting change in one's life and community.

**Table B3***Code Frequencies*

Domain Code	Frequency (% of total domain codes)
<i>Category Code</i>	
<i>Sub-category Code</i>	
Total Number of Parent Codes	617 (100%)
Mutual Aid	316 (51.2%)
<i>Instrumental Support</i>	112
<i>Socio/Emotional Support</i>	174
Empowerment	166 (26.9%)
Self-Concept	135 (21.9%)
<i>Self-Esteem</i>	55
<i>Self-Efficacy</i>	95
<i>Mastery Experiences</i>	28
<i>Vicarious Experiences</i>	18
<i>Verbal Persuasion</i>	15
<i>Physiological States</i>	29

**Table B4***Code Co-occurrence*

	1	2	3
Mutual Aid	X	41	51
Self-Concept	41	X	31
Empowerment	51	31	X

## APPENDIX C

### Background Questionnaire

PRPSN/Pepperdine Study  
Background Questionnaire

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_

Email: \_\_\_\_\_

Age: \_\_\_\_\_

Race/Ethnicity: \_\_\_\_\_

City/Zip Code: \_\_\_\_\_

How long have you been involved in PRPSN (in any capacity)? \_\_\_\_\_

What capacity are in involved in PRPSN now? Please select the role(s) in which you have been involved:

- ☐ Been a few times as a member
- ☐ Regular member
  - How often do you attend PRPSN groups?
  - For how long have you attended PRPSN groups?
- ☐ Group Facilitator
  - How often do you facilitate PRPSN groups?
  - For how long have you facilitated PRPSN groups?
- ☐ Group supporter
- ☐ Administrator
- ☐ Other (please describe)

Are you employed? If no, would you like to be?

Are you on disability?

What is your source of income if not from employment or disability?

What is your education level?

Are you in school now? If no, would you like to attend school in the future?

What is your usual method of transportation for PRPSN meetings?

Do you have a car? If not, how do you get to PRPSN meetings?

Are you originally from CA? If not, how long have you lived here?

Do you have family in the area?

Do you have contact with your family?

Do you utilize other mental health services? If so, which ones?

Have you struggled with alcohol or drugs in your life?

Do you currently struggle with alcohol or drugs?

Are you in recovery from alcohol or drugs? If so, how long?

Do you attend any support groups for substance abuse specifically?

## APPENDIX D

### Focus Group Questions

PRPSN/Pepperdine Study  
Focus Group Questions

1. Describe your experiences with PRPSN groups.
2. How did you find out about or get involved in PRPSN?
3. What do you think is most effective about PRPSN groups?
4. How has PRPSN impacted your life?
5. Are there ways that PRPSN groups could be improved upon?
6. Is there anything that differentiates a PRPSN group from other peer support groups, or counseling groups?
7. How do PRPSN groups work?
8. How do you define recovery?
9. How has PRPSN aided in your recovery?
10. What are the benefits of PRPSN?
11. How can PRPSN groups improve?
12. What are your goals and how has PRPSN helped you work towards them?
13. Has your view of mental illness changed while at PRPSN?
14. What is your view of mental illness?
15. How has stigma of mental illness affected your recovery?
16. Has your friends/family views of mental illness you and your recovery?
17. What was your social support network like before PRPSN?
18. What is your social support network like now as part of PRPSN?
19. How has PRPSN affected your social life?
20. Do you participate in any other treatment outside of PRPSN? If so, what?
21. How have the tenants of PRPSN played a role in your recovery?
22. Where would you be without Project Return?
23. What types of things do you disclose and what types of things do you choose not to disclose?
24. What do you get out of facilitating groups?
25. How has facilitating groups aided in your recovery?
26. What motivated you to become a facilitator?

## APPENDIX E

### Recruitment Flyer



### Meet the Pepperdine Team:

**Andrew Miller:** I am a student at Pepperdine and proud father of a one year old daughter. I love cheering for the Lakers and the Dodgers and am an avid fan of hard rock and heavy metal music!

**Michael Morar:** I am the Project Coordinator on the team. I am back in school at 46. Ironically since I was lucky to graduate from high school. When nobody is looking, I like to Binge-Watch-Netflix to let my brain rest.

**Jon Parker:** I am a student-researcher at Pepperdine University. Before becoming a student there, I worked 2 years in a residential treatment facility where I found my love for recovery/peer focused treatment. My favorite TV show is Game of Thrones.

**Natasha Thapar-Olmos (Dr. T.O):** I'm a professor at Pepperdine University and I oversee this project and the research team. If I wasn't a professor, I'd probably be a fashion designer or a journalist- One thing you might not guess about me is that I'm obsessed with traveling to space.

**Tiffany White:** I am a research assistant on the team. I am graduating next year with my Masters in Psychology. I am the mother of twin boys and much of my free time is spent with them and catching up on various shows I like to watch with my husband.

**To sign up, contact:** Michael Morar (Project coordinator) at michael.morar@pepperdine.edu or (949) 355-5679

**For questions or feedback contact:** Natasha (Dr. T-O) at nthapar@pepperdine.edu or (562) 688-4924

**PEPPERDINE UNIVERSITY**  
Graduate School of Education and Psychology



Who? How? What?  
When? Why? Where?

Pepperdine /  
Project Return  
Peer Support  
Network  
(PRPSN)

# Focus Groups

---

Pepperdine  
/ Project  
Return Peer  
Support  
Network  
(PRPSN)

## What is a Focus Group?

A group of people that meets one time in order to share their ideas about a specific topic and learn from each other.

## With who?

Supporters, Managers, Facilitators and Members

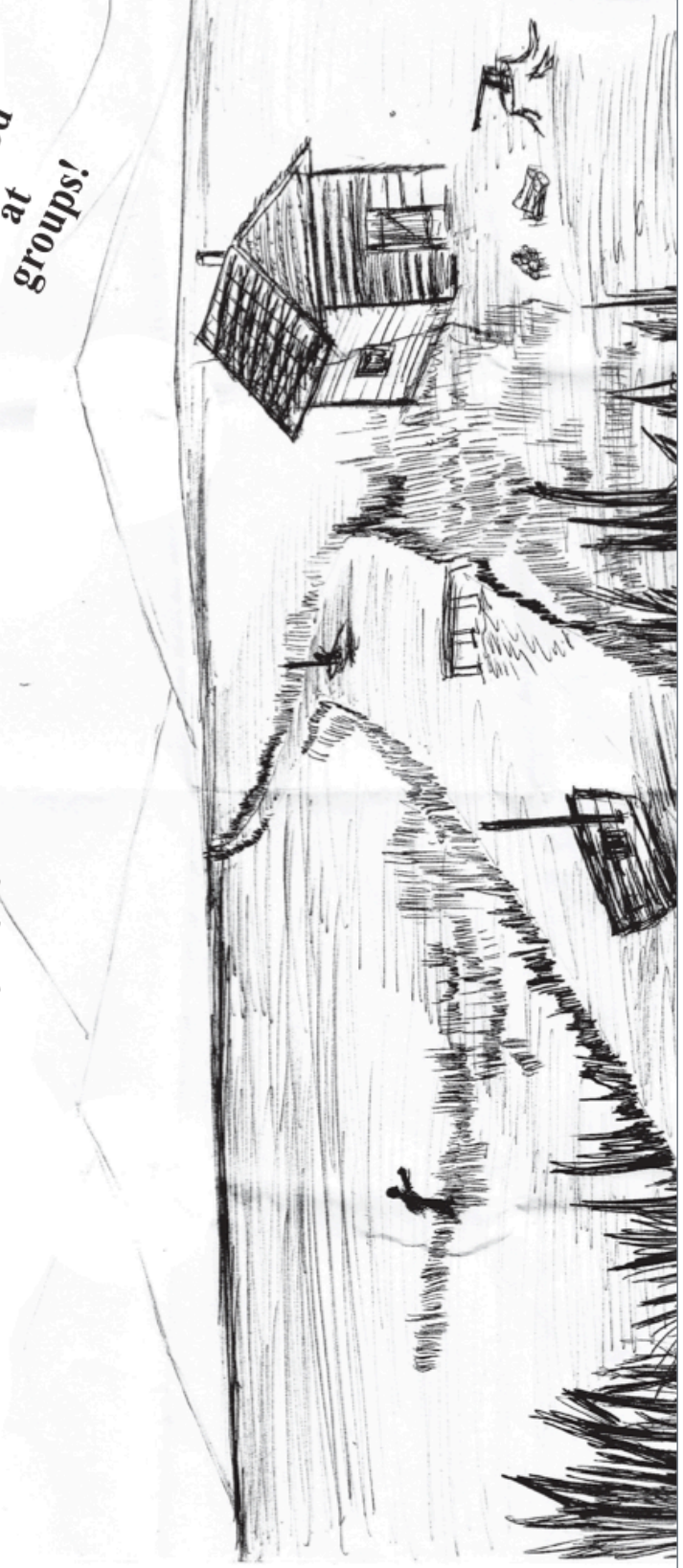
## We invite you to sign up for a Focus Group to:

- Help us demonstrate that PRPSN groups work
- Help us identify Best Practices: What about PRPSN works?
- Help us learn who most benefits from PRPSN group
- Help us learn how being in a PRPSN group impacts people's lives

## Anything else I should know?

- Information shared in the Focus Groups will be confidential
- Each Focus Group will last 60-90 minutes

**BY THE WAY:**  
Free food at groups!



## APPENDIX F

## HIPAA Form

This Notice is effective on August 1, 2014

## **NOTICE OF PRIVACY PRACTICES**

THIS NOTICE OF PRIVACY PRACTICE (“NPP”) DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NPP PROVIDES YOU WITH INFORMATION TO PROTECT THE PRIVACY OF YOUR CONFIDENTIAL HEALTH CARE INFORMATION, HEREAFTER, REFERRED TO AS PROTECTED HEALTH INFORMATION (“PHI”). THE NPP ALSO DESCRIBES THE PRIVACY RIGHTS YOU HAVE AND HOW YOU CAN EXERCISE THOSE RIGHTS. PLEASE REVIEW IT CAREFULLY.

If you have any question about this NPP, please contact Kim Miller, HIPAA Compliance Officer, 24255 Pacific Coast Highway, Malibu, CA 90263, 310.506.4208.

## **OUR COMMITMENT REGARDING YOUR PHI:**

Pepperdine University is committed to maintaining and protecting the confidentiality of your PHI. This NPP applies to Pepperdine University (Athletics, Boone Center for the Family, Counseling Center, Disability Services Office, Graduate School of Education and Psychology (PRYDE, Union Rescue Mission, Clinics), Human Resources, and Student Health Center; “Departments”). Pepperdine University is required by federal and state law, including the Health Insurance Portability and Accountability Act (“HIPAA”), to protect your PHI and other personal information. We are required to provide you with this NPP about our policies, safeguards, and practices. When Pepperdine University uses or discloses your PHI, Pepperdine University is bound by the terms of this NPP, or the revised NPP, if applicable.

## **OUR OBLIGATIONS:**

We are required by law to:

- Maintain the privacy of PHI (with certain exceptions)
  - Give you this notice of our legal duties and privacy practices regarding health information about you
  - Follow the terms of our NPP that is currently in effect
- HOW WE MAY USE AND DISCLOSE PHI:** The following describes the ways we may use and disclose PHI. Except for the purposes described below, we will use and disclose PHI only with your written permission. You may revoke such permission at any time by writing to Pepperdine University’s Compliance Officer.
- For Treatment.** We may use and disclose PHI for your treatment and to provide you with treatment- related health care services. For example, we may disclose PHI to doctors, nurses, technicians, or other personnel, including people outside our office, who are involved in your medical care and need the information to provide you with medical care.
- For Payment.** We may use and disclose

PHI so that we or others may bill and receive payment from you, an insurance company or a third party for the treatment and services you received. For example, we may tell your insurance company about a treatment you are going to receive to determine whether your insurance company will cover the treatment. **For Health Care Operations.** We may use and disclose PHI for health care operations purposes. These uses and disclosures are necessary to make sure that all of our patients receive quality care and to operate and manage our office. For example, we may share information with doctors, residents, nurses, technicians, clerks, and other personnel for quality assurance and educational purposes. We also may share information with other entities that have a relationship with you (for example, your insurance

company and anyone other than yourself who pays for your services) for their health care operation activities.

**Appointment Reminders, Treatment Alternatives, and Health Related Benefits and Services.** We may use and disclose PHI to contact you to remind you that you have an appointment with us. We also may use and disclose PHI to tell you about treatment alternatives or health-related benefits and services that may be of interest to you.

**Individuals Involved in Your Care or Payment for Your Care.** When appropriate, we may share PHI with a person who is involved in your medical care or payment for your care, such as your family or a close friend. We also may notify your family about your location or general condition or disclose such information to an entity (such as the Red Cross) assisting in a disaster relief effort.

**Research.** Under certain circumstances, we may use and disclose PHI for research. For example, a research project may involve comparing the health of patients who received one treatment to those who received another, for the same condition. We will generally ask for your written authorization before using your PHI or sharing it with others to conduct research. Under limited circumstances, we may use and disclose PHI for research purposes without your permission. Before we use or disclose PHI for research without your permission, the project will go through a special approval process to ensure that research conducted poses minimal risk to your privacy. Your information will be de-identified. Researchers may contact you to see if you are interested in or eligible to participate in a study.

**SPECIAL SITUATIONS: As Required by Law.** We will disclose PHI when required to do so by international, federal, state or local law.

**To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health and safety or the health and safety of others. Disclosures, however, will be made only to someone who may be able to help prevent or respond to the threat, such as law enforcement or a potential victim. For example, we may need to disclose information to law enforcement when a patient reveals participation in a violent crime.

**Business Associates.** We may disclose PHI to our business associates that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. For example, we may use another company to perform billing services on our behalf.

All of our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

**Organ and Tissue Donation.** If you are an organ donor, we may use or release PHI to organizations that handle organ procurement or other entities engaged in procurement, banking or transportation of organs, eyes or tissues to facilitate organ, eye or tissue donation and transplantation.

**Military and Veterans.** If you are a member of the armed forces, we may release PHI as required by military command authorities. We also may release PHI to the appropriate foreign military authority if you are a member of a foreign military.

**Workers' Compensation.** We may release PHI for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

**Public Health Risks.** We may disclose PHI for public health risks or certain occurrences. These risks and occurrences generally include disclosures to prevent or control disease, injury or disability; report

births and deaths; report child, elder or dependent adult abuse or neglect; report reactions to medications or problems with products; notify people of recalls of products they may be using; a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; and the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence (we will only make this disclosure when required or authorized by law).

**Health Oversight Activities.** We may disclose PHI to a health oversight agency, such as the California Department of Health and Human Services or Center for Medicare and Medical Services, for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

**Data Breach Notification Purposes.** We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of PHI.

**Lawsuits and Disputes.** If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other lawful request by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to allow you to obtain an order protecting the information requested.

**Law Enforcement.** We may release PHI if asked by a law enforcement official if the information is: (1) in response to a court order, subpoena, warrant, summons or similar process; (2) limited information to identify or locate a suspect, fugitive, material witness, or missing person; (3) about the victim of a crime even if, under certain very limited circumstances, we are unable to obtain the person's agreement; (4) about a death we believe may be the result of criminal conduct; (5) about criminal conduct on our premises; and (6) in an emergency to report a crime, the location of the crime or victims, or the identity, description or location of the person

who committed the crime.

**Coroners, Medical Examiners and Funeral Directors.** We may release PHI to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We also may release PHI to funeral directors as necessary for their duties.

**National Security and Intelligence Activities.** We may release PHI to authorized federal officials for intelligence, counter-intelligence, and other national security activities authorized by law.

**Protective Services for the President and Others.** We may disclose PHI to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state, or to conduct special investigations.

**Inmates or Individuals in Custody.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release PHI to the correctional institution or law enforcement official. This release would be necessary if: (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.

**USES AND DISCLOSURES THAT REQUIRE US TO GIVE YOU AN OPPORTUNITY TO OBJECT/OPT OUT: Individuals Involved in Your Care or Payment for Your Care.**

Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.

**Disaster Relief.** We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care, or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practically can do so.

**Fundraising.** We may notify you about fundraising events that support Pepperdine University.

**YOUR WRITTEN AUTHORIZATION IS REQUIRED FOR OTHER USES AND DISCLOSURES:**

The following uses and disclosures of your PHI will be made only with your written authorization:

1. Uses and disclosures of PHI for marketing purposes;
2. Disclosures that constitute a sale of your PHI; and
3. Disclosures of psychotherapy notes.



Other uses and disclosures of PHI not covered by this NPP or the laws that apply to us will be made only with your written authorization. If you do give us authorization, you may revoke it at any time by submitting a written revocation to our Compliance Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked it will not be affected by the revocation.

**YOUR RIGHTS REGARDING YOUR PHI: Right to Inspect and Copy.** You have a right to inspect and copy PHI that may be used to make decisions about your care or payment for your care. This includes medical and billing records, other than psychotherapy notes. To inspect and copy your PHI, you must make your request, in writing, to the Department in which your care was provided. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing or other supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.

**Right to Get Notice of a Breach.** Pepperdine University is committed to safeguarding your PHI. If a breach of your PHI occurs, we will notify you in accordance with state and federal law.

**Right to Amend, Correct or Add an Addendum.** If you feel that the PHI we have is incorrect, incomplete, or you wish to add an addendum to your records, you have the right to make such request for as long as the information is kept by or for our office. You must make your request in writing to the Department in which your care was provided. In the case of claims that the information is incorrect, incomplete, or if the record was not created by Pepperdine University, we may deny your request. However, if we deny any part of your request, we will provide you with a written explanation of the reasons for doing so within 60 days of your request.

**Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures we made of PHI for purposes other than treatment, payment, health care operations, certain other purposes consistent with law, or for which you provided written authorization. To request an accounting of disclosure, you must make your request, in writing, to the Department in which your care was provided. You may request an accounting of disclosures for up to the previous six years of services provided before the date of your request. If more than one request is made during a 12 month period, Pepperdine University may charge a cost based fee.

**Right to Request Restrictions.** You have the right to request a restriction or limitation on the PHI we use or disclose for treatment, payment, or health care operations. You also have the right to request a

limit on the PHI we disclose to someone involved in your care or the payment for your care, like a family member or friend. For example, you could ask that we not share information about a particular diagnosis or treatment with your spouse. To request a restriction, you must make your request, in writing, to the Department in which your care was provided. We are not required to agree to your request unless you are asking us to restrict the use and disclosure of your PHI to a health plan for payment or health care operation purposes and such information you wish to

restrict pertains solely to a health care item or service for which you have paid us out-of-pocket in full. If we agree, we will comply with your request unless the information is needed to provide you with emergency treatment or to comply with law. If we do not agree, we will provide an explanation in writing.

**Out-of-Pocket-Payments.** If you paid out-of-pocket (or in other words, you have requested that we not bill your health plan) in full for a specific item or service, you have the right to ask that your PHI with respect to that item or service not be disclosed to a health plan for purposes of payment or health care operations, and we will honor that request.

**Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you by mail or at work. To request confidential communications, you must make your request, in writing, to the Department in which your care was provided. Your request must specify how or where you wish to be contacted. We will accommodate reasonable requests.

**Right to Choose Someone to Act for You.** If you give someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your PHI. We will use our best efforts to verify that person has authority to act for you before we take any action.

**Right to a Paper Copy of This NPP.** You have the right to a paper copy of this NPP. You may ask us to give you a copy of this NPP at any time. Even if you have agreed to receive this NPP electronically, you are still entitled to a paper copy of this NPP. You may obtain a copy of this NPP on our web site at, [http://www.pepperdine.edu/provost/content/policies/hipaa\\_manual\\_5\\_2012.pdf](http://www.pepperdine.edu/provost/content/policies/hipaa_manual_5_2012.pdf). To obtain a paper copy of this NPP, contact the Department in which your care was provided.

## **CHANGES TO THIS NPP:**

We reserve the right to change this NPP and make the new NPP apply to PHI we already have as well as any information we receive in the future. We will post a copy of our current NPP at our office. The NPP will contain the effective date on the first page, in the top right-hand corner. You will be sent information regarding the changes via e-mail or via mail on how you can obtain a new copy. You will be asked to sign off on the new Notice of Privacy Practices at your next scheduled appointment.

## **COMPLAINTS:**

If you believe your privacy rights have been violated, you may file a complaint with Kim Miller, HIPAA Compliance Officer, 24255 Pacific Coast Highway, Malibu, CA 90263, 310.506.4208. All complaints must be made in writing. You may also contact the Secretary of the Department of Health and Human Services or Director, Office of Civil Rights of the U.S. Department of Health and Human Services. Please contact our Compliance Officer if you need assistance locating current contact information. You will not be penalized or retaliated against for filing a complaint.

## Acknowledgement of Receipt of Notice of Privacy Practices

Name: \_\_\_\_\_

\_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Facility

Name: \_\_\_\_\_

\_\_\_\_\_

I acknowledge that I have received or been offered a copy of Pepperdine University's NPP which describes how my PHI is used and shared. I understand that Pepperdine University has the right to change this NPP at any time. I may obtain a current copy by contacting the Department in which my care was provided or by visiting Pepperdine University's website at [http://www.pepperdine.edu/provost/content/policies/hipaa\\_manual\\_5\\_2012.pdf](http://www.pepperdine.edu/provost/content/policies/hipaa_manual_5_2012.pdf).

**My signature below acknowledges that I have been offered a copy or provided with a copy of the NPP:**

Signature of Patient \_\_\_\_\_

\_\_\_\_\_Date

Print Name \_\_\_\_\_

Personal Representative's Title (*e.g., Guardian, Executor of Estate, Health Care Power of Attorney*) \_\_\_\_\_

**For Department Use Only: Complete this section if you are unable to obtain a signature.**

1. If the patient or personal representative is unable or unwilling to sign this *Acknowledgement*, or the *Acknowledgement* is not signed for any other reason, state the reason:

2. Describe the steps taken to obtain the patient's (or personal representative's) signature on the *Acknowledgement*:

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## APPENDIX G

### Informed Consent

**PEPPERDINE UNIVERSITY**  
*Graduate School of Education and Psychology*

**INFORMED CONSENT FOR PARTICIPATION IN RESEARCH ACTIVITIES**

**A STUDY OF PROJECT RETURN PEER SUPPORT NETWORK (PRPSN) PEER SUPPORT GROUPS**

You are invited to participate in a research study conducted by **Natasha Thapar-Olmos, Ph.D. Assistant Professor of Psychology** at Pepperdine University, because you are **involved with Project Return Peer Support Network (PRPSN)**. Your participation is voluntary. You should read the information below, and ask questions about anything that you do not understand, before deciding whether to participate. Please take as much time as you need to read the consent form. You may also decide to discuss participation with your family or friends. If you decide to participate, you will be asked to sign this form. You will also be given a copy of this form for your records.

**PURPOSE OF THE STUDY**

The purpose of the study is to understand if, how, and why peer support groups in PRPSN work for the people who attend them. We hope to learn about who most benefits from PRPSN groups, and how being in a PRPSN group impacts peoples' lives.

**STUDY PROCEDURES**

If you volunteer to participate in this study, you will be asked to participate in one focus group meeting which will last approximately 60-90 minutes. The date, time, and location of the focus group will be determined based on your schedule and the availability of meeting locations. If you volunteer to attend a focus group meeting, upon arrival you will be asked to complete two questionnaires before the meeting begins, so we can understand a little bit more about you and your experiences with groups in Project Return. The focus group meeting will be audio recorded to allow us to later transcribe the information and analyze the discussion. If you do not wish to be audio recorded as part of this study, you should not participate.

**POTENTIAL RISKS AND DISCOMFORTS**

You may experience some discomfort in discussing your experiences in the focus group meeting, or while hearing about others' experiences. However, these potential and foreseeable risks are no more than any risks you would encounter in daily life, or that you would encounter in attending a PRPSN peer support group.

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**FOCUS GROUP**

In the event that you experience discomfort or stress during the focus group meeting, you will be encouraged to take breaks, discuss the discomfort with the facilitator, and/or will be provided with referrals for centers where culturally appropriate support or mental health services may be available. You may also withdraw your participation from this study at any time, without any penalty.

### **POTENTIAL BENEFITS TO PARTICIPANTS AND/OR TO SOCIETY**

While there are no direct benefits to the individuals who participate in this study, there are several anticipated benefits to society which include contributing knowledge about the effectiveness of peer support, which may in turn lead to increased awareness among the public and increased funding from private and public agencies. We also anticipate that the results of this study will benefit the ongoing work on PRPSN by contributing specific recommendations to improve upon the existing services.

### **PAYMENT/COMPENSATION FOR PARTICIPATION**

You will not be paid for participating in this research study. However, food will be provided during the focus group meeting for study participants.

### **CONFIDENTIALITY**

I will keep your records for this study confidential as far as permitted by law. However, if I am required to do so by law, I may be required to disclose information collected about you. Examples of the types of issues that would require me to break confidentiality are if you tell me about instances of child abuse and elder abuse. Pepperdine's University's Human Subjects Protection Program (HSPP) may also access the data collected. The HSPP occasionally reviews and monitors research studies to protect the rights and welfare of research subjects.

**Below are the specific procedures we will use to protect your confidentiality:**

**Study questionnaires:** We are asking you to write your name on your questionnaires only for organizational purposes. When the data from your questionnaires are entered into our electronic database, your name will be replaced with a randomly assigned code. Once all the data have been entered and analyzed, I will destroy any documents that link your name to the randomly assigned code. Only I will have access to the documents that links your name to the randomly assigned code. Furthermore, the electronic database will be stored on an encrypted password-protected computer in my place of office on the campus of Pepperdine University in Los Angeles, CA. The data will be stored for a minimum of six years. Only members of the research team will have access to the de-identified data.

**Focus group:** The audio recordings of the focus group meeting will be destroyed once the research team has transcribed the information. In the process of transcription, any names used in the meeting will be replaced with initials, and there will be no way to link the initials with you or anyone else who attended or was discussed during the focus group meeting. These data will also be stored on an encrypted password-protected computer in my place of office on the campus of

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Pepperdine University in Los Angeles, CA. The data will be stored for a minimum of six years. Only members of the research team will have access to the de-identified data.

### **PARTICIPATION AND WITHDRAWAL**

Your participation is voluntary. Your refusal to participate will involve no penalty or loss of benefits to which you are otherwise entitled. You may withdraw your consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this research study.

### **ALTERNATIVES TO FULL PARTICIPATION**

The alternative to participation in the study is not participating. Your relationship with and involvement in PRPSN will not be affected whether you participate or not in this study.

### **EMERGENCY CARE AND COMPENSATION FOR INJURY**

If you are injured as a direct result of research procedures you will receive medical treatment; however, you or your insurance will be responsible for the cost. Pepperdine University does not provide any monetary compensation for injury.

### **INVESTIGATOR'S CONTACT INFORMATION**

I understand that the investigator is willing to answer any inquiries I may have concerning the research herein described. I understand that I may contact **Natasha Thapar-Olmos, Ph.D. at (310) 568-5654 or [nthapar@pepperdine.edu](mailto:nthapar@pepperdine.edu)** if I have any other questions or concerns about this research.

### **RIGHTS OF RESEARCH PARTICIPANT – IRB CONTACT INFORMATION**

If you have questions, concerns or complaints about your rights as a research participant or research in general please contact Dr. Judy Ho, Chairperson of the Graduate & Professional Schools Institutional Review Board at Pepperdine University 6100 Center Drive Suite 500 Los Angeles, CA 90045, 310-568-5753 or [gpsirb@pepperdine.edu](mailto:gpsirb@pepperdine.edu).

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**SIGNATURE OF RESEARCH PARTICIPANT**

I have read the information provided above. I have been given a chance to ask questions. My questions have been answered to my satisfaction and I agree to participate in this study. I have been given a copy of this form.

Name of Participant

Signature of Participant Date

**SIGNATURE OF INVESTIGATOR**

I have explained the research to the participants and answered all of his/her questions. In my judgment the participants are knowingly, willingly and intelligently agreeing to participate in this study. They have the legal capacity to give informed consent to participate in this research study and all of the various components. They also have been informed participation is voluntarily and that they may discontinue their participation in the study at any time, for any reason.

Name of Person Obtaining Consent

Signature of Person Obtaining Consent

Date

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Approved by Pepperdine University Graduate & Professional Schools Institutional Review Board (GPS IRB) Informed Consent from August 2, 2016-August 2, 2017



APPENDIX H  
IRB Approval Notice



Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

## NOTICE OF APPROVAL FOR HUMAN RESEARCH

Date: April 04, 2018

Protocol Investigator Name: Natasha Thapar-Olmos

Protocol #: 16-05-271

Project Title: An examination of Project Return Peer Support Network (PRPSN) peer support groups

School: Graduate School of Education and Psychology

Dear Thapar-Olmos:

Thank you for submitting your amended expedited application to Pepperdine University's Institutional Review Board (IRB). We appreciate the work you have done on your proposal. The IRB has reviewed your submitted IRB application and all ancillary materials. As the nature of the research met the requirements for expedited review under provision Title 45 CFR 46.110 of the federal Protection of Human Subjects Act, the IRB conducted a formal, but expedited, review of your application materials.

Based upon review, your IRB application has been approved. The IRB approval begins today April 04, 2018, and expires on October 09, 2018.

Your final consent form has been stamped by the IRB to indicate the expiration date of study approval. You can only use copies of the consent that have been stamped with the IRB expiration date to obtain consent from your participants.

Your research must be conducted according to the proposal that was submitted to the IRB. If changes to the approved protocol occur, a revised protocol must be reviewed and approved by the IRB before implementation. For any proposed changes in your research protocol, please submit an amendment to the IRB. Please be aware that changes to your protocol may prevent the research from qualifying for expedited review and will require a submission of a new IRB application or other materials to the IRB. If contact with subjects will extend beyond October 09, 2018, a continuing review must be submitted at least one month prior to the expiration date of study approval to avoid a lapse in approval.

A goal of the IRB is to prevent negative occurrences during any research study. However, despite the best intent, unforeseen circumstances or events may arise during the research. If an unexpected situation or adverse event happens during your investigation, please notify the IRB as soon as possible. We will ask for a complete written explanation of the event and your written response. Other actions also may be required depending on the nature of the event. Details regarding the timeframe in which adverse events must be reported to the IRB and documenting the adverse event can be found in the **Pepperdine University Protection of Human Participants in Research: Policies and Procedures Manual** at [community.pepperdine.edu/irb](http://community.pepperdine.edu/irb).

Please refer to the protocol number denoted above in all communication or correspondence related to your application and this approval. Should you have additional questions or require clarification of the contents of this letter, please contact the IRB Office. On behalf of the IRB, I wish you success in this scholarly pursuit.



Pepperdine University  
24255 Pacific Coast Highway  
Malibu, CA 90263  
TEL: 310-506-4000

Sincerely,

Judy Ho, IRB Chairperson

cc: Dr. Lee Kats, Vice Provost for Research and Strategic Initiatives

Mr. Brett Leach, Regulatory Affairs Specialist