Peer Social Worker: Is merging the roles of peer specialist/provider and clinical social worker the next therapeutic paradigm shift in the field of social work?

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Abstract

Traditionally, the views of peer specialists/providers ("peers") and those of clinical social workers have been at odds when serving the client in their recovery journey. Peers use the recovery model to disclose their lived experience and identifies as living with a mental health condition. In addition, the services and treatment are person centered, which acknowledge that the person with a mental health condition is the expert on their own life. In contrast, clinical social workers use the medical model to disclose and build a rapport with clients, which traditionally does not include the sharing of a mental health condition. The study was conducted to understand the perspectives of therapist self-disclosure of a mental health condition from both client and therapist.

Keywords: Peer Specialist/Provider, Clinical Social Worker, Therapist Self-Disclosure, Lived Experience, Peer Social Worker

> The recovering therapist is in a unique position to help the patient. A small but growing number of psychiatrists, psychologists, social workers, and other mental health professionals who are in recovery from mental illness have decided to openly identify themselves as such. If these professionals could begin to be more open about their experiences, those of their family members and consumer advocates could better realize that mental health policy and research decisions are not being made in isolation from consumer influence as it may appear. – Fred Frese, Ph.D.
>
> (Backs, Spagnolo, Woodward, & Cronise, 2018, Self-Disclosure by Other Professional Providers Section – Slide 31, as cited in Frese, Stanley, Kress, & Vogel-Scibilia, 2001)

Introduction to the Research Problem

Peer Specialists/Providers (all italicized and bold non-heading terms are defined in Table 1) is an emerging field within mental health – as many of these professionals work side-by-side with social work clinicians and other team members – to assist with the treatment of individuals in their recovery process (Deegan, 2017). Deegan (2017) illustrates the difference between the peer specialist and clinician perspectives in Chart 1.

Chart 1

Comparison between the Peer Specialist and Clinician Perspectives

Peer Specialist Perspective	Overlap	Clinical Perspective
Work is guided by the Principle of Mutuality defined as a focus on the connection between the Peer Specialist and the peer wherein there is reciprocity.	Unconditional positive regard for the individual being served.	Clinicians are in the role of helping and supporting participants with a focus on diagnosis, identification of strengths and treatment. There is not an expectation of reciprocity in clinician/participant relationships.
Focus on learning together rather than assessing or prescribing help.	A desire to support recovery and the person's achievement of their human potential.	Focus on assessing and helping.
Emphasis on sharing and exploring life experiences where both individuals share personal experiences and perspectives.	The importance of connection, finding common ground, and respect.	Emphasis on exploring program participants' experiences, with less expectation for the clinician to share their personal experiences.
There are many ways to understand the experience of what gets diagnosed as mental illness: bio-psycho-social; spiritual; cultural; distress as teacher; altered states; a natural variation of human experience, etc.	A commitment to support the person in making meaning of their experience.	The bio-psycho-social approach is the main framework for diagnosis and treatment while utilizing a cultural competency framework.
Do not participate in the delivery of involuntary interventions such as commitment to a hospital or outpatient commitment.	Both clinicians and Peer Specialists recognize the importance of choice and self-determination in the recovery process.	Involuntary interventions such as commitment to a hospital can be justified as clinicians struggle to balance the Duty to Care with the Dignity of Risk.
Trained to be advocates for and with participants. Advocacy may include speaking up about participant's needs and goals, and/or coaching participants in speaking for themselves. Advocacy may also include advocating for participant's legal rights, civil rights and human	Both clinicians and Peer Specialists strive to listen carefully to the needs, preferences, goals and aspirations of participants.	Many are trained in recovery oriented practice which is strengths based, person-centered and aimed at supporting participants in achieving their unique goals.

rights.		
Peer Specialists are members of a socially devalued group often referred to as "the mentally ill". As such they are keenly attuned to stigma, dehumanizing practices, objectifying language, prejudice, discrimination and even offensive or traumatizing practices in mental health, health and social service systems. As advocates, Peer Specialists will speak up if clinicians slip into language or practices that (often unintentionally) devalue participants or reinforce the status of being socially devalued.	Together, clinicians and Peer Specialists strive to create a culture of respect throughout behavioral health systems and in the general public.	Clinicians who have not self-disclosed a personal psychiatric history, are not part of the socially devalued group known as the mentally ill.

(Deegan, 2017, para. 3, Peer Specialist and Clinical Perspectives)

Patricia Deegan is a highly regarded and respected member of the peer community. Many believe that she is an innovator and thought leader in the field of mental health recovery. Deegan (2017) also expresses that, "in my opinion, it is imperative that Peer Specialists remain peer" (para. 2). As a New York Certified Peer Specialist, this researcher was trained in this ideology and agrees with Dr. Deegan that ***peer specialists/providers*** should not take a clinical role in the treatment of clients. Therefore, this research study is specifically geared towards individuals with diagnosed mental health conditions (as designated by the DSM-5) where they are seeking assistance from other ***clinical social workers*** with ***lived experience***.

This researcher argues that although "peers should remain peer" – it is important to evolve and shift to the designation of ***Peer Social Worker*** – for the betterment in the treatment of clients. Consequently, this study will address the issue of "clinicians being peer." More specifically – clinicians (who identify as being peer) can move from the ***traditional disclosure/calculated vulnerability*** approach to the ***peer disclosure/intentional disclosure*** model, which embraces the Peer Social Worker paradigm. Hence, my research question is as

follows – Peer Social Worker: Is merging the roles of peer specialist/provider and clinical social worker the next therapeutic paradigm shift in the field of social work?

Table 1

Glossary

Clinical Social Worker – a person with a Master of Social Work degree in addition to being licensed (LMSW or LCSW or their equivalents). This individual can either provide full therapeutic services to the client; however, they can also deliver traditional social work support where peer disclosure/intentional disclosure may be required.
Lived Experience – the total experiences a person living with a mental health condition acquires. These can be more universal in nature (such as textbook knowledge) or more unique to the specific individual (such as their experience of psychiatric in-patient hospitalization, medication management and side-effects, self and societal stigma, etc.).
Peer Disclosure/Intentional Disclosure – purposely sharing sensitive information specifically for the benefit of the client. This usually relates to the disclosure of a mental health condition. The purpose of this technique is to first and foremost give the best possible care to the client. However, the added benefits include acquiring credibility – "a real-world, non-textbook perspective" – as well as providing a different point of view from the side of the therapist/licensed clinical social worker based on their individual lived experience.
Peer Social Worker – a licensed social worker (LMSW or LCSW and their equivalents) who identifies with having and living with a mental health condition and uses this lived experience in their social work practice. This mental health professional is also a certified peer specialist/provider with their respective state of residence.
Peer Specialist/Provider – a person with a mental health condition who chooses to use and share their lived experience to work with others who have mental health conditions on their recovery journey.
Traditional Disclosure/Calculated Vulnerability – sharing in the same context with a client to get their attention so they will be more involved and interested in the conversation. This sharing usually relates to all issues except for the disclosure of mental health conditions.

Literature Review

Historical Context

Traditionally, self-disclosure has been both a controversial and misunderstood facet of social work practice – which unintentionally leads to a reduced therapeutic approach from service providers that may potentially diminish the treatment outcome for clients (Knight, 2012). Although Jourard was not officially recognized with being the first to coin the term "self-

disclosure" until 1958, the debate about its use with clients in psychotherapy has been going on for decades regarding how this provocative technique can either positively or negatively affect the individuals being served through therapy (Henretty & Levitt, 2010; Henretty, Currier, Berman, & Levitt, 2014; as cited by Gallucci, 2002). For instance, Ziv-Beiman (2013) expresses that "classical psychoanalysis imposed a taboo on therapist self-disclosure, believing that the creation of an interpersonal void between analyst and patient leads to the emergence of unconscious conflicts and urges that the patient then transferentially projects onto the analyst/therapeutic alliance" (p. 60). More specifically, researchers on both sides of the debate – point to both ethical considerations as well as boundary issues – when considering the appropriateness of therapist self-disclosure to their clients (Knight, 2012).

From an ethical perspective, even though therapist self-disclosure has been debated in the framework of a boundary crossing or violation – many therapists have used this technique regardless of its unorthodox views (Audet, 2011). For example, Henretty and Levitt (2010) indicate that "although therapist self-disclosure is one of the rarest techniques, comprising an estimated average of 3.5% of therapist interventions (Hill & Knox, 2002), over 90% of therapists report that they have self-disclosed in therapy" (p. 64, as cited in Edwards & Murdock, 1994; Mathews, 1989; Pope, Tabachnick, & Keith-Spiegel, 1987). Practitioners need a better understanding of therapist self-disclosure to determine if this is a technique they would like to confidently use when therapeutically appropriate with the individuals they are treating (Henretty & Levitt, 2010; Pinto-Coelho et al., 2018).

Contemporary Review

The tide has changed regarding the mindset of therapeutic self-disclosure. Audet and Everall (2010) specify that "therapist self-disclosure is gaining empirical attention amidst theoretical

discourse and ethical debate, particularly with regards to its influence on the therapeutic relationship" (p. 327). To put things into perspective, sixty-nine percent of mental health professionals reported that they 'sometimes' or 'very often' used self-disclosure as a therapeutic technique when providing services to their clients (Audet, 2011). Therapist self-disclosure is often usually discussed only by its influence on the client-therapist relationship, but much less is known about how clients respond to the self-disclosure of the therapist and how it relates to their therapeutic session (Audet & Everall, 2010). In addition, many clients do not reflect on their own personal perceptions to the self-disclosure of the therapist and the practical implications of this information based on their response to the clinician and their own inner feelings about the interaction (Audet & Everall, 2010).

Therapist Disclosure

Disclosure has taken a different view over the years as more and more mental health professionals are open to new ways of looking at this therapeutic tool. However, there are many factions from numerous researchers on why disclosure is necessary as well as effective when performed professionally. More specifically, Somers, Pomerantz, Meeks, and Pawlow (2014) specify that "opinions differ widely about many other questions surrounding self-disclosure, such as *how much*, *when*, *towards whom*, and perhaps most importantly, *what* to self-disclose" (p. 249, as cited in Henretty & Levitt, 2010; Norcross, 2010). Therefore, to make things simple and uniform, the following types of disclosure and their effects will be listed as foundation for the reasons mental health professionals would want to disclose to clients. They include: "(a) *forming a connection* with the client in the early stages of therapy; (b) the therapist *conveying presence* through attentiveness and responsiveness to the client in the therapy process; and (c) *engaging the client* in a meaningful working relationship" (Audet & Everall, 2010, p. 338).

Clients had positive perceptions of disclosing counselors and they were more likely to disclose something about themselves to the disclosing mental health professional during the therapeutic process (Henretty, Currier, Berman, & Levitt, 2014). In addition, it has been discovered that it is "impossible", if not "detrimental," for therapists to never self-disclose during therapy in order to provide professional services to clients (Audet, 2011; as cited in Peterson, 2002; Zur, 2007). Furthermore, therapists should contemplate on using self-disclosure techniques because there is evidence that supports its use, and suggests that it is a helpful intervention when working with individuals (Pinto-Coelho et al., 2018; Henretty and Levitt, 2010; as cited in Hanson, 2005; Knox & Hill, 2003).

Additionally, Kaufman (2016) reports that there is "evidence suggesting that when implemented according to guidelines outlined in research, experiential therapist self-disclosure of a mental health condition enhances client perceptions of the therapist's level of empathy and professional attractiveness versus therapist non disclosure" (p. 85). Furthermore, therapist self-disclosure can help mental health professionals appear more "relatable" and "human" to clients as well as provide hope and inspiration to those with similar conditions, backgrounds, and/or lived experiences for a variety of individuals on their recovery journeys (Kaufman, 2016). Therefore, the issue at hand is not whether it is ethical to disclose – but under what circumstances can a mental health professional disclose? (Audet, 2011).

Therapist Disclosure – When Not to Self-Disclose

Therapists may have some internal conflict when it comes to how they want to disclose with their clients. However, therapists should never self-disclose due to the following reasons:

> (a) to control or manipulate clients (Rachman, 1998); (b) to attack or assault clients (Rachman); (c) to gratify clients when not therapeutically appropriate (Tillman, 1998); (d) to emphasize dissimilarities between therapist and client unless therapeutically indicated (Berg-

> Cross, 1984), and (e) to satisfy therapists' needs (Anderson & Mandell, 1998; Hill & Knox, 2001; Knox & Hill, 2003; Mahalik et al., 2000; Welt & Herron, 1990).
> (Henretty & Levitt, 2010, p. 73)

Therapist Disclosure – When to Self-Disclose

> Therapists should use the following guidelines when they self-disclose to clients:
>
> (a) The first guideline is that therapists should self-disclose infrequently (Gabbard & Nadelson 1995; Hill & Knox, 2001; Knox & Hill, 2003; Mann & Murphy, 1975; Simonson, 1976); (b) The second guideline is to use therapist self-disclosure with deliberation; (c) The third guideline encourages therapists to choose their wording carefully when disclosing (Mulcahy, 1998); (d) The fourth guideline refers to therapists being responsive to their clients before, during, and after a self-disclosure (Rachman, 1998); and (e) The fifth and final guideline is that it is likely to be beneficial for therapists to return the focus to the client immediately after a disclosure. (Henretty & Levitt, 2010, pp. 73-74)

Additionally, therapist self-disclosures should contain the necessary information to propel the therapeutic process in the right direction (as cited in Rachman) and specific details do not need to be shared for illustrative purposes (Henretty and Levitt, 2010; as cited in Balint, 1968).

Disclosure from the Client Perspective

The sharing of personal information from the therapist can, but does not always, cause concern from the client about therapeutic boundaries in this professional dyad (Audet, 2011; Pinto-Coelho et al., 2018). However, this professional relationship needs to be explored at a deeper level to uncover the intricacies of this bond. There are some clients who express concern that therapist self-disclosure can morph the professional relationship into a more casual one – a relationship that some may describe as a friendship (Audet, 2011). However, according to Kaufman (2016), "the current findings lend additional support to previous research that suggests counselors' perceived levels of expertness or competency are not necessarily compromised by disclosure of a mental health condition" (p. 85). This deems good news for those therapists who wish to share their lived experiences with clients to better support them, and assist them in reaching their next level in life.

Nonetheless, as Audet (2011) informs, "therapist disclosure and its impact on boundaries and professional attributes have rarely been examined from the client perspective" (p. 89). In addition, clients appear to evaluate the disclosure of a therapist based on its relevance and therapeutic intent; therefore, clinicians must disclose carefully and evaluate when to use this tool on a case-by-case basis (Audet & Everall, 2010). Consequently, this area needs to be addressed and examined in greater detail. Thus, fine tuning the therapeutic process in determining when to disclose, may result in greater benefits for client outcomes in all aspects of their lives.

Disclosure from the Therapist Perspective

The wounded healer construct – the concept of where the healing power emerges from the healer's own wounds (or lived experience) – is already recognized in many mental health interventions such as alcohol and substance abuse, eating disorders, sexual abuse, and gender identity in the treatment of clients who need assistance with these areas (Kaufman, 2016; Zerubavel & Wright, 2012). Unfortunately, there has been very limited research that addresses how therapists' own recovery processes influence the work they do with clients, and how this type of therapeutic intervention assists with the recovery journey of individuals with mental health conditions (Zerubavel & Wright, 2012). According to Audet (2011), "perhaps the greatest challenge facing therapists in this regard is providing disclosure that conveys some similarity to clients on a personal dimension while simultaneously differentiating them from the client on a professional dimension" (p. 98). This conundrum is a very real issue that must be evaluated to better serve peer professionals and clients alike.

Not only can this new therapeutic approach propel the social work field in a new direction, but this methodology can give new meaning and a renewed purpose to those therapists who happen to have lived experience. This sharing of information may have the potential of not only

creating a stronger professional bond between therapist and client – this new approach may actually shorten the treatment time for clients. For example, there has been a significant finding which suggests that psychotherapist self-disclosure that incorporates similar experiences as the client, makes a more beneficial contribution to the therapeutic process and ultimately leads to a better outcome for individuals (Somers et al., 2014; Pinto-Coelho et al., 2018). Therefore, it may be possible for clients to actually work through more issues in less time than previously thought due to a new perspective that peer social workers can uniquely provide to these individuals.

The Definition/Roles of Peer Specialists/Providers

There are numerous definitions of what a peer specialist/provider is within the mental health community. However, according to Mead, Hilton, and Curtis (2001), "peer support is a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful. Peer support is not based on psychiatric models and diagnostic criteria. It is about understanding another's situation empathically through shared experience of emotional and psychological pain" (p. 135). It is through this pain or lived experience where both individuals make a connection – and through this communication – the peer realizes that the peer specialist/provider is 'like them' and they grasp the fact that they actually have more in common with this individual than they originally thought (Mead, Hilton, & Curtis, 2001).

This is the point where the peer starts to share and communicate their true feelings. They are usually more open to the peer specialist/provider than to others on the medical team. This is usually the place where the peer officially starts the process of their recovery journey as they lower their "wall" and start to expel their pain so they can heal. In addition, many speculate on

the responsibilities and duties peer specialists/providers have while at work. Chart 2 includes these roles as specified by Jacobson, Trojanowski, & Dewa (2012).

Chart 2

Responsibilities and Duties of Peer Specialists/Providers

a	**Advocacy** – Advocacy is an important part of peer work. "In practice, advocacy work encompassed both the work that peers do in fighting for what clients want and the work that they do to provide clients with the where-withal to fight for themselves" (p. 208). Peer specialists/providers stand up to assist others in their recovery journey and support their progression no matter how big or small.
b	**Connecting to resources** – Being a liaison is another part of peer work. "The data showed that peers work to connect clients to resources both inside and outside the hospital" (p. 209). Referring peers to services that they themselves cannot provide is a huge assistance to those on their recovery journey.
c	**Experiential sharing** – Being able to share oneself with others is a monumental support that all peers engage in. This sharing was defined as 'sharing common experiences; listening to client's experiences and sharing one's own experiences' (p. 209). Providing peer support and self-disclosure are big opportunities to share with one another. Ultimately, sharing with peers will eventually lead to gaining the information necessary from the individual so the medical team can treat the peer more effectively.
d	**Building community** – Peer work binds individuals together. "Peers built community when they invited client participation and ran groups in ways that made people feel comfortable and welcome" (p. 209). By including everyone, all feel welcome and supported; therefore, they are more likely to share and disclose their true feelings and issues with others.
e	**Relationship building** – This is one of the most important skills a peer specialist/provider can develop and was defined as 'developing trust and rapport [with clients]' (p. 210). Relationship building can also naturally happen between peer specialist/provider and peer when more and more experiential sharing and community building are conducted.
f	**Group facilitation and group planning and development** – The collective dynamics of group facilitation are important skills for peer specialists/providers to master. "Peers planned and facilitated groups on their own, but also worked with other staff collaboratively to develop groups and group activities and to co-facilitate groups" (p. 210). It is during these times where peers learn needed skills, information, and build confidence to get their recovery to the next level.
g	**Skill building/mentoring/goal setting** – Peer specialists/providers allow peers to be the experts on themselves. They provide a space for peers to obtain skills and set goals that they think are needed for their life. "Peers worked with clients both to develop and meet clients' personal goals – for example, pertaining to housing or employment – and to set shared goals for the peer/client relationship" (p. 210). Peer specialists/providers allow peers "the dignity of risk and the right to failure" (Deegan, 1996, p. 97). They are treated no different than anyone else in the same circumstance when planning, evaluating, and deciding which path in life to take next.

h	**Socialization/self-esteem building** – This is a very important phase for peers in recovery to overcome self-stigma and stigma from society. "It was inherent in how peers [specialists/providers] initiated contact with clients and in the ways in which they worked to support and sustain their relationships with clients" (p. 210). This peer role may be quite similar to others and have some overlap; however, it is imperative for those peers to provide these services at a superior level (p. 210). The level of service and emotional support impacts whether or not a peer will be moving forward in their recovery journey.
i	**Administration** – Peer specialists/providers are also responsible for administrative tasks. "The administrative work performed by peers included activities like responding to email and telephone messages, preparing for and wrapping up after groups and special events, doing odd jobs around the office (e.g., answering phones for an absent colleague), and documenting (e.g., writing progress notes)" (p. 210). These duties are important and they are required to provide the best services possible for peers in the field.
j	**Team Communication** – Interpersonal communication between staff members (peer and non-peer roles) are instrumental in providing efficient services for peers. This was defined as 'team meetings or other communication with team members' (p. 210). This can also include emails, face-to-face impromptu meetings with colleagues, and phone calls.
k	**Supervision/Training** – Supervisor feedback such as weekly/bi-weekly supervision meetings and annual reviews are necessary tools for peer specialists/providers to fine tune their work behavior. This was defined as 'meetings to discuss [peer's] performance and role or completing hospital-mandated training' (p. 211). In addition, trainings for peer recertification as well as for personal and professional growth are required for these peer professionals to provide outstanding service to those who require it.
l	**Receiving Support** – Support from others at work – as well as at home – are necessary for everyone (not only for peer professionals) in the field to have a healthy social network/support system for efficiency. This was defined as 'help seeking from "intentional allies" and other colleagues' (p. 211). This act of seeking support can also assist each professional personally as they often cope with deep emotional issues often triggered from the peers they serve on a daily basis.
m	**Education/Awareness building** – Educating all who need it is also a part of the job. This was defined as 'education for the public and the hospital community' (p. 211). More specifically, many peer specialists/providers educate those individuals who have misconceptions about mental health conditions. Also, many peer professionals take on the role of change agent to assist in altering the myths and stigma regarding peer specialists/providers in their role in recovery and/or in providing services for those on their recovery journey. This also includes clarifying roles and information to the medical community – as many do not know the full roles of peer professionals in the workplace.
n	**Information gathering & verification** – Searching the Internet to investigate information is a big part of peer work. This was defined as 'seeking up-to-date information about policies and public benefits to better inform clients' (p. 211). This also includes escorting peers to doctors' appointments, government offices for documentation, and/or non-profits for special programs to obtain the information/services they need to assist the peer to meet their needs and accomplish their goals for a full recovery.

The Definition/Roles of Traditional Social Worker

Social workers engage in many responsibilities and duties while on the job. For instance, according to MSWOnlinePrograms.org (2018), the following are specific roles that traditional social workers participate in on a daily basis to ensure that the needs of their clients are met (para. 10). They include:

a. Collaborate with other professionals to evaluate patients' medical or physical condition and to assess client needs.

b. Advocate for clients or patients to resolve crises.

c. Refer patient, client, or family to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, job placement or education.

d. Investigate child abuse or neglect cases and take authorized protective action when necessary.

e. Counsel clients and patients in individual and group sessions to help them overcome dependencies, recover from illness, and adjust to life.

f. Plan discharge from care facility to home or other care facility.

g. Monitor, evaluate, and record client progress according to measureable goals described in treatment and care plan.

h. Identify environmental impediments to client or patient progress through interviews and review of patient records.

i. Organize support groups or counsel family members to assist them in understanding, dealing with, and supporting the client or patient.

The Differences and Similarities between Peer Specialists/Providers and Traditional Social Workers: The Medical vs. Recovery Models

Traditionally, clinical social work has typically utilized the medical model, where the social worker and/or their team historically determine what is best for the patient/client. Nevertheless, as time has progressed, so has the lens in which these individuals have been viewed. Although not perfect, the recovery model has been deployed and is giving more and more say to the

patient/client in their recovery journey – where this individual is treated as a person (person-centered treatment) and not as a diagnosis. It is this researcher's argument that social work practitioners must view everyone in this way – including the social workers who have a mental health condition (identify as having personal lived experience and would like to disclose this to others) and provide services at a deeper and more clinical level to peers.

Merging of the Models/Roles: The Definition of Peer Social Worker

As defined in the glossary, a peer social worker is a licensed social worker (LMSW or LCSW and their equivalents) who identifies with having and living with a mental health condition and uses this lived experience in their social work practice. This mental health professional is also a certified peer specialist/provider with their respective state of residence. This researcher has compiled Chart 3, which examines the roles/tasks of both a peer specialist/provider and social worker as originally expressed above by Jacobson, Trojanowski, & Dewa (2012) and MSWOnlinePrograms.org (2018).

Chart 3

Comparison of the Roles/Tasks of Peer Specialist/Provider in Relation to Social Worker

Peer Specialist/Provider Task	Relates to	Social Worker Task
Team Communication (j)	→	Collaborate with other professionals to evaluate patients' medical or physical condition and to assess client needs (a)
Advocacy (a)	→	Advocate for clients or patients to resolve crises (b)
Connecting to resources (b)	→	Refer patient, client, or family to community resources to assist in recovery from mental or physical illness and to provide access to services such as financial assistance, legal aid, housing, job placement or education (c)
Information gathering & verification (n)	→	Investigate child abuse or neglect cases and take authorized protective action

		when necessary (d)
Experiential sharing (c) Relationship building (e)	→	Counsel clients and patients in individual and group sessions to help them overcome dependencies, recover from illness, and adjust to life (e) *
Building community (d)	→	Plan discharge from care facility to home or other care facility (f)
Skill building/mentoring/goal setting (g) Socialization/self-esteem building (h) Administration (i)	→	Monitor, evaluate, and record client progress according to measureable goals described in treatment and care plan (g)
Education/Awareness building (m)	→	Identify environmental impediments to client or patient progress through interviews and review of patient records (h)
Group facilitation and group planning and development (f)	→	Organize support groups or counsel family members to assist them in understanding, dealing with, and supporting the client or patient (i)
Receiving Support (l) Supervision/Training (k)	→	**

* Natural Transition/Progression to Peer Social Worker

** Both Peer Specialists/Providers and Social Workers get supervision and on-going training/support

Hence, based on the above, all tasks seem to be identical when they are broken down to the most common denominator. Additionally, the shift to Peer Social Worker looks like a natural and logical transition/progression to the field. Although this idea looks good on paper, this researcher wanted to see if others who identify as peer, also believe this to be true. The following is the description and background of my research study as well as the findings and analysis of the respondents.

Research Methodology

This is a quantitative study that questioned three specific populations to obtain the needed data. The survey questions were used to acquire some demographic data as well as information on attitudes/experiences towards therapist self-disclosure. This researcher obtained the information by the following nonprobability sampling methodology due to the limited nature of finding the below groups.

Clients who identify as living with a mental health condition (HTH – Howie the Harp Peers). This sample was obtained using a convenience sampling method with current and past Howie the Harp students. An electronic survey (via SurveyMonkey) was sent to these individuals at their respective email addresses for their participation. The director of HTH gave permission for these students/alumni to be included in the study and she emailed them encouraging their participation in completing the online survey (if they wished). A paper copy option was also offered for those who were not comfortable with their computer skills. The intention was to get at least 30 individuals to complete this survey for an overall perspective on how peers view this issue in New York City.

Clients who identify as living with a mental health condition (Nationwide Peers). Due to the difficulty in identifying this group, this population was obtained using a snowball sampling method on Facebook.com and LinkedIn.com. An electronic survey (via SurveyMonkey) was self-administered by these individuals, providing their participation as they self-identify as peer on their profile pages. It was also encouraged for these individuals to pass on this link to other friends and colleagues for their participation in the study. The intention was to get at least 30 individuals to complete this survey for an overall perspective on how peers view this issue nationwide.

Clinicians who identify as living with a mental health condition and who are willing to professionally disclose this information to clients during therapeutic sessions (Peer Social Workers – Nationwide). This sample was both extremely hard to identify and access. This difficulty is primarily due to the fact that although this population is growing in number – there are not many mental health professionals who have gained the credentials of Certified Peer Specialist/Provider and Licensed Social Worker (Peer Social Worker). Therefore, this group was obtained using a snowball sampling method on Facebook.com and LinkedIn.com. An electronic survey (via SurveyMonkey) was self-administered by these individuals, thus getting their participation as they self-identify as Peer Social Worker on their profile pages. It was also encouraged for these individuals to pass on this link to other friends and colleagues for their participation in the study. The intention was to get at least 30 individuals to complete this survey for an overall perspective on how Peer Social Workers view this issue nationwide.

Study Results: Descriptive Statistics of Both Peer Specialist/Provider Groups

The descriptive statistics of my study has a total population of 258 participants. There are 54 individuals in group 1 – Howie the Harp Peers, 170 individuals in group 2 – Nationwide Peers, and 34 individuals in group 3 – Nationwide Peer Social Workers. However, I will first be looking specifically at the two peer specialist/provider groups in Table 2 below.

Table 2

Descriptive Statistics – HTH Peers vs. Nationwide Peers

Demographic	HTH Peers	Nationwide Peers
Gender	51% Identified as Male 47% Identified as Female 2% Identified as Other	31% Identified as Male 65% Identified as Female 4% Identified as Other
Age	Mean Age: 49 (*SD=10.0*) Median Age: 50 Mode Age: 53 Age Range: 37 (age 28-65)	Mean Age: 48 (*SD=11.0*) Median Age: 49 Mode Age: 49 Age Range: 53 (age 20-73)

Certification	33% - Not Certified 50% - Provisional Certification 17% - Standard Certification	10% - Not Certified ***Refer to Table 3 for Details on Certified Peers***
Experience with Therapy	67% - Current Experience 31% - Past Experience 2% - Zero Experience	49% - Current Experience 49% - Past Experience 2% - Zero Experience

Table 3 lists the respondents from 33 states who identified as certified peer specialists.

Table 3

Nationwide Certified Peer Specialists/Providers within State of Residence

Alabama – 1 (<1%)	**Kentucky** – 1 (<1%)	**Ohio** – 1 (<1%)
Arizona – 5 (4%)	**Maine** – 3 (2%)	**Oklahoma** – 1 (<1%)
California – 2 (1%)	**Massachusetts** – 4 (3%)	**Oregon** – 14 (10%)
Colorado – 6 (4%)	**Michigan** – 4 (3%)	**Pennsylvania** – 5 (4%)
Connecticut – 2 (1%)	**Minnesota** – 3 (2%)	**Rhode Island** – 6 (4%)
Delaware – 1 (<1%)	**Missouri** – 1 (<1%)	**Tennessee** – 2 (1%)
Florida – 1 (<1%)	**Nevada** – 1 (<1%)	**Texas** – 9 (6%)
Georgia – 1 (<1%)	**New Jersey** – 3 (2%)	**Vermont** – 1 (<1%)
Idaho – 2 (1%)	**New Mexico** – 2 (1%)	**Virginia** – 1 (<1%)
Indiana – 1 (<1%)	**New York** – 28 (20%)	**Washington** – 6 (4%)
Kansas – 1 (<1%)	**North Carolina** – 8 (6%)	**Wisconsin** – 1 (<1%)

For those individuals currently in therapy, the following questions were asked of them based on this definition of self-disclosure: **Therapist Self-Disclosure** – the revealing of personal information about one's own mental health condition to benefit/educate the client in that moment to advance the therapeutic conversation. All responses are listed in Table 4.

Table 4

Attitudes Toward Therapist Self-Disclosure (Experienced Peers) – HTH vs. Nationwide

Question	HTH Peers	Nationwide Peers
My therapist used self-disclosure with me in our sessions(s)	27% Strongly Disagreed 13% Disagreed 10% Neutral 31% Agreed 19% Strongly Agreed	18% Strongly Disagreed 24% Disagreed 12.5% Neutral 35.5% Agreed 10% Strongly Agreed
This self-disclosure helped or advanced the therapeutic process	13% Strongly Disagreed 6% Disagreed 25% Neutral 23% Agreed 33% Strongly Agreed	5% Strongly Disagreed 7% Disagreed 32% Neutral 34% Agreed 22% Strongly Agreed
I was comfortable with this type of self-disclosure	6% Strongly Disagreed 2% Disagreed 31% Neutral 25% Agreed 36% Strongly Agreed	4% Strongly Disagreed 3% Disagreed 33% Neutral 35% Agreed 25% Strongly Agreed
My therapist was the same gender as me	16.5% Strongly Disagreed 21% Disagreed 2% Neutral 23% Agreed 37.5% Strongly Agreed	11% Strongly Disagreed 17% Disagreed 10% Neutral 31% Agreed 31% Strongly Agreed
I was more comfortable with this type of self-disclosure because my therapist was the same gender as me	14.5% Strongly Disagreed 14.5% Disagreed 43% Neutral 8% Agreed 20% Strongly Agreed	10.5% Strongly Disagreed 16.5% Disagreed 50% Neutral 14% Agreed 9% Strongly Agreed
I responded well and would recommend this therapeutic technique to those who identify as peer	6% Strongly Disagreed 0% Disagreed 28% Neutral 30% Agreed 36% Strongly Agreed	2% Strongly Disagreed 4% Disagreed 24% Neutral 32% Agreed 38% Strongly Agreed

For those individuals who are not currently in therapy, or have not experienced therapy, the succeeding questions were asked of them. Please note that there were very few respondents because these questions mainly did not apply. More specifically, the vast majority of peers have experienced therapy in some point in their life cycle. There was only one respondent that

represented Howie the Harp Peers and three respondents that represented Nationwide Peers. The responses can be seen in Table 5.

Table 5

Attitudes Toward Therapist Self-Disclosure (Non-Experienced Peers) – HTH vs. Nationwide

Question	HTH Peers	Nationwide Peers
It is hard for me to find a therapist I can connect with	1 Person was Neutral	1 Person Disagreed 1 Person was Neutral 1 Person Agreed
I would be open to a therapist who self-discloses	1 Person Strongly Agreed	2 People Agreed 1 Person Strongly Agreed
I believe I would respond well to this type of therapeutic technique	1 Person was Neutral	2 People Agreed 1 Person Strongly Agreed
I would be more open to this type of self-disclosure if the therapist was the same gender as me	1 Person was Neutral	2 People were Neutral 1 Person Agreed
I would be more inclined to participate in therapy knowing that my therapist would use this technique	1 Person was Neutral	1 Person Strongly Disagreed 2 People Agreed
Having a therapist who identifies as a peer is important to me	1 Person was Neutral	3 People Agreed

Study Results: Descriptive Statistics of Peer Social Workers

This researcher will now be looking specifically at the Nationwide Peer Social Worker group with the below questions/variables for analysis. The descriptive statistics for these respondents can be viewed in Table 6.

Table 6

Descriptive Statistics – Nationwide Peer Social Workers*

Demographic	Nationwide Peer Social Workers
Gender	31% Identified as Male 69% Identified as Female
Age	Mean Age: 47 (*SD=10.0*) Median Age: 48 Mode Age: 48 Age Range: 37 (age 27-64)

Peer Certification	California – 2	Indiana – 1
	New York – 5	North Carolina – 3
	Pennsylvania – 2	Tennessee – 1
	Texas – 1	
Licensure	California – 1	Indiana – 1
	New York – 3	North Carolina – 1
	Pennsylvania – 1	Texas – 1
Type of License for Therapeutic Practice	75%: LMSW or equivalent 12.5%: LCSW or equivalent 12.5%: Other	
Years Providing Mental Health Therapeutic Services	2-3 years of experience – 1 3-4 years of experience – 1 4-5 years of experience – 1 6-7 years of experience – 1 7-8 years of experience – 1 10-15 years of experience – 2 20+ years of experience – 1	

*Please note that the findings are based on 8 participants (not all 34) due to the fact that these questions did not apply to 26 respondents.

The following questions were asked based on the above definition of therapist self-disclosure. All responses can be seen in Table 7.

Table 7

Attitudes Toward Therapist Self-Disclosure – Nationwide Peer Social Workers

Question	Nationwide Peer Social Workers
I self-disclose with my clients when professionally appropriate	1 Person was Neutral 3 People Agreed 4 People Strongly Agreed
I see greater progress with clients when I utilize self-disclosure	2 People were Neutral 5 People (62.5%) Agreed 1 Person Strongly Agreed
I wish there was less stigma around self-disclosure	5 People (62.5%) Agreed 3 People Strongly Agreed
I would like to see a professional Peer Social Worker credential in the field	2 People Strongly Disagreed 2 People were Neutral 2 People Agreed 2 People Strongly Agreed

What are the Respondents telling us?

When comparing both groups of peer specialists/providers, their mean age of 49 vs. 48 and median age of 50 vs. 49 (HTH vs. Nationwide, respectively) were almost identical. As to therapy, 67% vs. 49% (HTH vs. Nationwide, respectively) are currently in therapy, while 31% vs. 49% (HTH vs. Nationwide, respectively) participated in therapy in the past. In addition, both groups had respondents (2%) who identified as never experiencing therapy.

Half (50%) of HTH Peers and 46% of Nationwide Peers stated that they have experienced therapist self-disclosure as it relates to a mental health condition. More than half (56%) of both HTH and Nationwide Peers indicated that they believe this type of self-disclosure helped or advanced the therapeutic process. Furthermore, 61% vs. 60% (HTH vs. Nationwide, respectively) specified that they were comfortable with this type of self-disclosure.

Slightly less than two-thirds (61%) of HTH Peers and 62% of Nationwide Peers stated that their therapist was the same gender as they identify. Only 28% vs. 23% (HTH vs. Nationwide, respectively) expressed that they were more comfortable with therapist self-disclosure due to the fact that their therapist was the same gender as they identify with. Therefore, gender may not be a big issue as 43% vs. 50% (HTH vs. Nationwide, respectively) designated neutrality over this matter.

Two-thirds (66%) of HTH Peers and 70% of Nationwide Peers specified that they responded well to this therapeutic technique and would recommend it to those who identify as peer. Unfortunately, the data sets were too small for statistical significance regarding those peers who are not currently in therapy or have not participated in therapy in the past – 1 respondent vs. 3 respondents (HTH vs. Nationwide, respectively).

As for the Peer Social Workers, the mean age was 47 and the median age was 48. Most respondents (75%) had the LMSW or equivalent credential. The range of experience in this group spanned 2 – 20+ years in the field. Unfortunately, the data sets were also too small for statistical significance as only 8 respondents had both peer specialist/provider certification and social worker licensure.

The above data suggests that the merging of both roles (peer specialist/provider and clinical social worker) is the next logical step for the therapeutic support of clients. This is especially true when speaking about the role of therapist self-disclosure in the therapeutic process as it relates to a mental health condition. However, the following also must be considered when analyzing this issue.

Limitations to the Study

This quantitative study is a cross-sectional, descriptive survey designed to get a better idea of what the larger population looks like based on the above three units of analysis. However, as in all research studies, there were limitations in its design. First, although all 50 states were included when constructing the survey, this researcher did not realize that Washington, DC had a certification for peer specialist/providers. Therefore, more specific information could have been obtained through this study.

Second, obtaining data from HTH may have skewed the information collected due to bias. HTH is the premier peer training program in the country, if not the world, due to in-depth curriculum and program length. Therefore, the peers trained in this program are very progressive in their views and peer practices – particularly with person-centered techniques. This orientation and training may have the potential to over represent this viewpoint in the findings.

Third, it was difficult to obtain data from peer social workers on a nationwide level. Although, the number of these individuals are growing in the field – these individuals are difficult to identify because many do not self-disclose due to stigma in the mental health community. In addition, the qualifications for survey respondents may have been too strict for this subset of the population. This is because many certified peer specialists: (1) Choose to only hold their MSW credential and not obtain licensure, (2) Are currently in graduate school for their MSW, and (3) Have recently graduated with their MSW and did not yet have the opportunity to acquire licensure. Therefore, the peer social worker population, as defined in this study, will grow in the next five years.

Fourth, the information was obtained by nonprobability sampling methods due to the limited nature of finding the above groups. Snowball sampling is hard to monitor and control. For instance, this researcher could identify some peers and peer social workers on a nationwide basis; however, it was very hard to make sure these individuals completed the survey and/or forward the survey to eligible friends and colleagues. Additionally, when peers of either group filled out a survey, it had the potential to be forwarded to individuals with the same mindset of the initial respondent. Therefore, the results may be unintentionally skewed to a certain outcome. Furthermore, even though this researcher could contact HTH students, it would have been just as difficult to ensure that these individuals completed the survey, without being seen as violating their rights.

Future Research Topics and Implications to the Field of Social Work

These findings contribute toward building a foundation to change the landscape of clinical social work in regards to service delivery. More research may need to be conducted for this type of therapeutic approach to be seriously considered in social work practice. For instance, there

are inconsistent views of self-disclosure – between both researchers and practitioners – which make study comparisons very difficult to relate and interpret (Ziv-Beiman, Keinan, Livneh, Malone, & Shahar, 2017). More specifically, additional research is needed to identify the difference between therapist non-mental health versus mental health disclosures during therapeutic sessions.

An aspect that practitioners need to be aware of is that therapist self-disclosure can alter the outcome of therapeutic sessions with clients (Barrett & Berman, 2001; Pinto-Coelho et al., 2018). For instance, when patients were in environments where they were exposed to intense therapist self-disclosure – they had an increase in symptom reduction and had more fondness toward their therapist than individuals who had a more restricted self-disclosure atmosphere (Barrett & Berman, 2001; as cited in Ziv-Beiman & Shahar, 2016). Conversely, in some instances where therapists were poorly trained in self-disclosure – there have been ruptures in the therapeutic alliance – and the professional relationship needed to be repaired (Pinto-Coelho et al., 2018). Nevertheless, therapist self-disclosure is believed to be at the center of relational practice – as peer work shares this foundation – and often creates the space for comparable and authentic communication (Tanner, 2017). Therefore, studies such as this can help to prove that therapist self-disclosure in regards to a mental health condition can be beneficial and more efficient in treating clients – which ultimately leads to better outcomes for those on their recovery journey.

Consequently, this study has the potential to alter the consciousness of the mental health profession, and society at large, when it comes to mental health – as this is a social justice issue. For instance, in many developed nations, those who have lived experience and identify as peer, are often not fully accepted by the larger mental health workforce – which fuels employee

inequality (Byrne, Stratford, & Davidson, 2018; as cited by Davidson, 2015; Silver & Nemec, 2016). Furthermore, in general, the mental health community (trained in the medical model) often takes the view of a mental health condition as a deficit; therefore, there is often stigma attached to a clinician with a mental health diagnosis. However, peers (trained in the recovery model) view having a mental health condition as an asset to assist the client in their recovery. Hence, this research study is a way to move the current paradigm forward to proactively transform the social work field to be inclusive to all those who have earned the letters – BSW, MSW, PhD, LMSW, LCSW, and their equivalents throughout the country and world – after their name.

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