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Compassionate Towards Ourselves: A Tool for Personal Recovery and Therapeutic Work of Peer Specialists

OFRA WALTER[1], BATEL HAZAN-LIRAN[2]

[1]*Tel Hai Academic College Israel.*
Email: ofraw60@gmail.com
[2]*Tel Hai Academic College Israel.*
Email: batelliran@gmail.com

Abstract

Objective. Self-compassion is part of recovery for many people who experience mental illness. Peer specialists are mental health professionals who have experienced mental illness and use their recovery experiences to facilitate the healing of others. This research explored how peer specialists view self-compassion in their work. It also examined they perceive their profession.

Methods. Seven peer specialists working in a psychiatric hospital participated in individual qualitative interviews. They were asked about their personal experiences and self-compassion and how these served to support others. They were also asked about their perceptions of the peer specialist profession. Interviews were thematically analyzed.

Results: The results showed the peer specialists were occupied with self-judgment, compared themselves to the patients and the professional team (doctors, nurses, and psychologists), and saw a disparity between their experience-based knowledge and professional knowledge. They mentioned three components of self-compassion.

Conclusions and Implications for Practice: The finding that the peer specialists had developed self-compassion during the recovery process and used it as a model for their patients indicates a need to develop guidelines and promote awareness of the importance of self-compassion in the training of peer specialists. A job definition of peer specialists who work in psychiatric hospitals should be developed.

Impact and Implications Statement

This study investigated job perceptions and personal experiences of self-compassion among peer specialists who work in psychiatric hospitals. The findings highlight peer specialists' need for greater role clarity and better training. Such guidance should be directed at helping peer specialists utilize self-compassion in their work.

Keywords: peer support, perception of the profession, self-compassion, recovery

Introduction

Over recent decades, mental health services have increasingly adopted the recovery model in the care and rehabilitation of people with mental disabilities (Davidson et al., 2006; Holter et al., 2004). In Israel, especially in the last 20 years, there has been a trend towards rehabilitative treatment and approaches that encourage recovery, integration of patients in society, and reduction of psychiatric hospitalizations. The adoption of the recovery model has spurred the involvement of peer specialists in mental health

services. Peer specialists are certified professionals who have undergone a successful process of recovery from a mental illness and are willing to identify as peers and offer support to others dealing with mental illness. Peer specialists possess knowledge from their personal experience of coping with mental illness; they must be willing to reveal this history and use what they have learned from it as tools in their work (Moran et al., 2012; Salzer et al., 2010).

Otherwise stated, peer support is a method of giving and receiving help based on understanding and empathizing with the other person's condition and a shared experience of emotional and psychological pain (Mead et al., 2001). Trust is built in the relationship between the peer specialist and the service recipient, and both parties can respectfully challenge each other. This makes it possible to try new behaviors and move beyond previous perceptions that rely on concepts of disability and psychiatric diagnoses (Davidson et al., 2006). However, empathizing with their service recipients may cause peer specialists to overidentify, which can lead to excessive self-judgment and reduced self-kindness. Accordingly, peer specialists need to develop the capacity for self-compassion. According to Neff (2016), self-compassion is compassion turned inward and refers to how we relate to ourselves in instances of perceived failure, inadequacy, or personal suffering (Neff, 2016).

The complex need for peer specialists to understand the line between overidentifying because of their similar self-experience and the need to be self-compassionate as a model to their patients is crucial for work in psychiatric hospitals, the setting for this study. We explored peer specialists' job perceptions and personal experiences of self-compassion and how these affected their peer support relationships.

Self-Compassion

Self-compassion reflects the ability to turn compassion inward, especially when encountering failure, distress, uncertainty, and suffering (Neff et al., 2007). It can be operationally defined as 'the disposition to meet distress with self-directed kindness (self-kindness vs. self-judgment), understand that one is not alone in experiencing difficulties (common humanity vs. isolation), and notice any distressing feelings without getting lost in them (mindfulness vs. over-identification)' (Neff & Vonk, 2009, pp. 25-26). A person with self-compassion treats inadequacies and difficulties as a natural part of life, knows that all people share the human experiences of making mistakes, and acknowledges distressing feelings without ignoring them or ruminating over them (Neff & Davidson, 2016).

Research has found that people with high levels of self-compassion tend to cope better with stressful events and rely heavily on positive cognitive coping strategies (Allen & Leary, 2010). Self-compassion has been found to correlate with psychological health and reduced psychopathology (Germer & Neff, 2013). Self-compassion has been associated with lower levels of symptoms of mental illness and better mental health (MacBeth & Gumley, 2012; Neff et al., 2007) and with decreased depression and anxiety symptoms among adolescents. Research in adult samples suggests higher levels of self-compassion may play a significant role in the subjective well-being (Marsh et al., 2018) and are linked to less psychopathology (Barnard & Curry, 2011). Conversely, the three negative subscales of self-compassion (self-judgment, isolation, and overidentification) positively relate to anxiety, depression, worry, stress, and paranoid beliefs (Brooks et al., 2012; Van Dam et al., 2011).

Peer Specialists and Self-Compassion

The definition of peer specialist includes principles of authentic empathy and validation, the use of knowledge from personal experience, and reciprocal relationships (Mead & MacNeil, 2006). Peer specialists play an essential role with the peers they support, based on an intentional relationship between individuals with similar experiences and the open acknowledgment and sharing of these experiences (Salzer et al., 2010).

Studies have shown that integrating peer specialists into recovery helps service recipients and the peer specialists form better social relationships and feel a sense of identification, lasting recovery, and empowerment (Moran et al.,

2012). Both use the relationship to look at things from a new perspective, develop greater awareness of personal and social patterns, and support and challenge each other (Salzer et al., 2010). Peer support has been widely recognized as an evidence-based practice. In Israel, peer specialists fill various positions in the field of mental health.

Outcome studies have demonstrated the impact of peer support services, but little research has examined the factors associated with effective peer support relationships and outcomes. We discussed how peer specialists understand self-compassion in their own lives and actively utilize it in their peer support services. Most therapists assume self-compassion is an essential part of psychotherapy and a skill that can be learned (Germer & Neff, 2013). It is especially important in the work of peer specialists because they use their lived experiences to help others cope with serious mental illness in clinical settings.

Peer Specialist Professional Perception

Peer specialists vary widely in their roles, settings, and theoretical orientations, as well as the theoretical models or orientation of their services (Chinman et al., 2017). Previous research has found that peer specialists often lack clarity about their role within their organization and care team (Cabral et al., 2013). There have been efforts in many countries to develop models and tools that support the work of peer specialists in the mental health system (Altman et al., 2018). Still, little research considers the acquisition of tools and skills by peer specialists, and there are no uniform instructional models (Yerushalmi, 2012). The need for models and guidance is important for peer specialists, who are professionals working in psychiatry departments with people coping with complex mental conditions (Shulman, 2006).

The lack of appropriate and uniform instructional models has led to role ambiguity among peer specialists and resistance among professional staff members to integrate them into the clinical team (Chinman et al., 2008). Empirical studies with peer specialists have indicated associations of role clarity and perceptions that their supervisors have similar clarity with job satisfaction (Cronise et al., 2016; Jenkins et al., 2018).

Another challenge in the work of peer specialists is their mental health; each person experiences specific challenges (Moran et al., 2013). Coping with these issues requires awareness that the relationships between peer specialists and patients are not reciprocal; that is, peer specialists are expected not to assume the role of individuals in need of support (Chinman et al., 2017).

Despite the challenges, studies have consistently demonstrated that peer specialists can achieve results identical to those of comparison groups (comprising only therapeutic staff). Two studies even found slightly better results in response to treatment among teams that included peer specialists (Clark et al., 2000; Solomon & Draine, 1995). Research on the direct impact of peer specialists found they could empower patients, provide them with hope and social support, reduce their sense of self-labeling, and help them integrate into society and employment (Yam et al., 2018).

The work of peer specialists has also been shown to lead to significant breakthroughs for professional staff members, in terms of both professional perceptions and the ability to make room for other professionals who bring knowledge from different content worlds (in this case, personal experience) (Davidson et al., 2012). Many concerns accompany the addition of peer specialists, but research findings indicate widespread agreement on the contribution of their knowledge and the ability of peer specialists to promote change among patients in situations where 'traditional' professionals have not always succeeded (Cabassa et al., 2017; Mahlke et al., 2017).

Objectives

Based on the literature review the study had two main objectives:

1. To explore peer specialists' perceptions of their role;

2. To explore the experience of self-compassion among peer specialists and its impact on their patients.

Methods

The research method

In this study, a qualitative method and a phenomenological approach by semi-structured interviews were used to enable a uniform interview structure and to ensure reliability. Peer specialists were allowed to share their experiences and stories in the psychiatric hospital.

Study Sample

At the start of 2021, after receiving approval from the Helsinki Ethics Committee for conducting human trials, we approached a mental health hospital in Israel for approval of a study with peer specialists. The hospital and the Ministry of Health authorized the study, and seven peer specialists, three men, and four women, aged 35-55, consented formally to participate, including recording and transcription of the interviews. Throughout the research process, we preserved the privacy and confidentiality of participants. They were told they could decline to answer any questions at any time, and some opted to speak off-protocol to provide context for certain issues without being recorded. The questions asked were validated by all researchers prior to establishing a final interview draft. The researchers identified the main themes and categories in a group discussion, which were further analyzed.

The research subjects were recruited in the hospital based on the following inclusion criteria: the individual had been employed as a peer specialist for at least two years in a mental health program, was currently working at least 15 hours per week as a peer specialist in the hospital, and self-identified as a person coping with a schizophrenia-spectrum disorder, bipolar disorder, or major depression.

Research tool

Semi-structured interviews were employed as the research tool in this study. The interviews were conducted by a team of researchers comprising academics and medical and psychiatric staff from the hospital. The interviews involved questions concerning how peer specialists relate to SC and manifest these capabilities in their work with their patients. Also, they were asked about how they perceive their professional perception.

Procedure

Upon receiving approval from the Helsinki Ethics Committee for conducting human trials, we approached a mental health hospital in Israel for approval of the study with Seven peer support professionals. Authorization of the institute and the ministry of health were given, as was the formal consent of the Seven research subjects to be recorded and transcribed. We kept the privacy and confidentiality of all subject, and they were given autonomy to decline to answer certain questions at any time; some answered off-protocol to provide the context of certain issues without being recorded. All research staff performed validation of the questions asked prior to establishing a final interview draft. Recordings were transcribed word-for-word by the researcher who had conducted the interview. After discussion, the researchers recognized and categorized main themes to be analyzed further in-depth.

Qualitative Thematic Analysis

The interviews were conducted face-to-face, transcribed, and subjected to thematic analysis. The most frequent or significant codes were synthesized to explain larger segments of the data and organize the data into categories. Later, the researchers reviewed and discussed the coding. Finally, the themes were reviewed by an advisory committee of peer specialists who were not involved in the study.

Results

Perceived Role of Peer Specialists

The content analysis revealed how the peer specialists in the psychiatric hospital perceived their role. It shed light on the difficulty they had describing their self-perceptions as peer specialists, as well as the perceptions of the medical and therapeutic staff (nurses, doctors) and patients. From the analysis results, we created subcategories for perceptions of their role that were associated with compassion: self-judgment, critical comparison, and knowledge from experience.

Self-Judgement

The peer specialists said their vast personal knowledge helped them understand the patients. Despite this awareness of their experience, self-judgment was also evident. G. explained:

I am very critical of myself. I'm always laughing about the large gap between my role, conduct, and confidence here and outside of working hours. A part of me remains outside the gate when I enter, and I collect it when I leave the hospital.

Yet the desire of the peer specialists to overcome self-judgment by working on themselves was equally apparent. N. said, 'I think this is mainly a question of how complex it is to be involved in looking inward. A person raises an issue, and you search for where it connects to you. In contrast, B. suggested self-judgment led to the development of awareness of personal difficulties, as well as a desire to improve personal skills, such as mindfulness: 'I want to help, but the mindfulness is not total. I think this is something I always try to improve…to be there in this experience is a challenge every day.

Critical Comparison

The peer specialists were aware that their personal experience was their field of expertise; they were experts on coping with mental processes and on the tools they had acquired through their coping. However, they found themselves being critical, comparing their recovery process with that of the patients and thinking about the patients' view of them. L reported: 'The expertise is the mental experience, and there are basics of mental processe,s so that make coping with mental health possible. I don't know how they see me from their perspective'.

Some believed in their ability to help based on the self-confidence they drew from their personal experience. However, they noted that the therapy process depended on the patients; they couldn't help those who didn't want to help themselves. B explained: 'You can't really help someone who doesn't want to help himself….Towards the end of the work with her, I said, "Okay, that's hers." I can give examples of myself; I can explain how it helped me, but I can't really take the path instead of her'.

Knowledge from Experience vs. Professional Knowledge

Some peer specialists said difficulties arising during their work at the psychiatric hospital could be associated with the right way to address issues raised by patients. They described a disparity between the solutions proposed by the medical staff and those they suggested. This sometimes affected their feelings. G. provided an example:

There was a hospitalized woman who wanted to start academic studies as part of her recovery, and I strongly believed in this choice for recovery [through studying]. However, at a multidisciplinary staff meeting about her case, the psychiatrist tried to get her to defer this plan and do something else first. I overidentified with her and therefore, I said that I didn't agree as soon as he left the room, instead of waiting for my turn and perhaps speaking in a more moderate tone.

One of the ways of coping with differences in solutions was to discuss them during supervision sessions. The peer specialists noted the importance of these meetings. Y. said it was necessary to talk about difficulties in discussions with the professional staff (doctors and nurses): 'I attend supervision sessions in which I talk about this, so they can remind me, "realize that it's not you", or "notice how you reacted in a that

situation". The sessions help me,' E. emphasized the importance of learning to cope with difficulties to maintain an inner balance while also building a bridge between the opinions of the medical staff and the solutions suggested by peer specialists:

In most cases I can take a deep breath, remind myself where I am and what my role is here. Some people simply annoy me, so I get annoyed *(laughing)*….Sometimes you do it automatically. You have to think about it and say, 'Okay, we're really in an unknown situation'. Two conflicting extreme forces that came into the room, and you have to do something with this and somehow work with it.

The participants described specific difficulties arising from their role as peer specialists in a psychiatric hospital. They had to deal with differing views of the professionals, on the one hand, and intrapersonal gaps among the peer specialists, on the other hand.

The Role of Compassion

The research participants said they had the same experience of hospitalization as their patients. They noted that although they had recovered and their job relied on this experience as a source of support and help for others like them, they still perceived themselves as coping. Three subthemes emerged from the content analysis of the theme of compassion: self-kindness versus self-judgement; mindfulness versus overidentification; and common humanity versus isolation.

Self-Kindness versus Self-Judgment

The peer specialists recognized the importance of self-kindness and forgiving themselves. Some demonstrated the ability to convey the importance of self-kindness to patients while working with them. They recalled terrible and injurious things that they had done as patients themselves, but said they had come a long way and could talk about the ability to forgive themselves. E. emphasized the important of self-kindness in the recovery process:

I think that somehow, I had to develop this at some stage. A person with a background of many years of drug use, periods of being out of control, terrible things I did to other people and to myself, must have some degree of forgiveness and acceptance that he is entitled…to live in happiness.

They also mentioned the ability to overcome being judgmental and become kind and forgiving of themselves. As A. explained, 'I forgive myself. Are you familiar with the cycle of change? It talks about two significant things: the ability to contain failure and the ability to contain it not as a negative place, but as a place of regrowth and learning lessons'. N. emphasized her new ability to understand herself and to be more forgiving of herself:

I think I learned the most about myself through the darkest places. I … told myself things like 'it'll be okay like this' and 'everything's all right' and 'it's okay sometimes not to succeed in managing this' and judged myself less for not catching myself in time.

Some peer specialists were able to transfer their kindness and balance to the patients, as well. N. said:

Let's say I know that there's a patient from whom the whole issue of management and recovery is not so balanced. [His] life is a sort of mix of inertia with no talk about what really gives him strength and what drains his strength. So, I share things that I do with him, things that I learned can give you such balance.

B. addressed the importance of awareness of the ability to forgive and of self-compassion, insights she gained from the recovery process and the training she received as a peer specialist:

I think this is something that didn't always exist, it's something that developed. I really need to be compassionate with myself and not judge myself. Not to criticize myself when I fall, not to criticized myself when it's hard for me, not to criticize myself when I despair, and this is really work. I think we need compassion in our job. We can't conduct ourselves without compassion. It's impossible.

Y. was at a stage where she could integrate self-kindness into her work by sharing her personal experience:

A while ago, I visited a patient [in] a closed ward, who moved from our open ward to this closed one (in other words, his condition worsened). I asked him, 'Is there something you want to tell me?' He said, 'I don't like myself.' So I told him, 'You know, when I was in a closed ward, I didn't like myself, either, and I felt I was a failure and that's natural. So I told myself "That's natural" and moved to this kinder place towards myself.'

Mindfulness versus Overidentification

The analysis of the interviews revealed the peer specialists' view of being mindful and identifying less with those around them. They claimed mindfulness enabled them to be more balanced within themselves and with the patients. G. described his work with patients whose cases were similar to his own and the challenge of being mindful and not overidentifying: 'If a patient talks to me about the difficulty getting up in the morning, it takes me back to the period when it was hard for me to get up in the morning'. Y. noticed and identified the aspects of her work in which she overidentified with patients:

I overidentified with that patient who went to study was because I was released from the hospital and after a short time, I did my bachelor's degree in education. In retrospect, knowing I had a bachelor's degree helped me a lot with my self-esteem, so I very much wanted the same for her and understood why she wanted to change through her cognitive and intellectual abilities. In that, I identified with her too much.

E. offered an example of the contribution of experience to differentiating between mindfulness and overidentification:

With time I learned to really be mindful about things….Many times there was overidentification in my job, and this was not as good. But I say again, practice increases my awareness of all sorts of things, [so that] sometimes I immediately know that I am identifying. I think this happens less now because I have practice and I am more in the role, so I know to put the overidentification aside a bit.

Common Humanity versus Isolation

The peer specialists had the ability to sense common humanity, both on a personal level and as part of the therapeutic process with the patients. G. described this:

When you talk about side-effects of the medications, I have a sort of saying that is half joking, that all the side-effects that are said to be 'rare' are the ones I need to put my picture on *(laughing)* … so there is this feeling that I am the only one and special and there is also an understanding that that's not true, that they write about this side-effect because it's not only me. I'm not alone and other people experience this, so I can, too.

Y. spoke about the importance of common humanity in the process of recovery:

So I recognize this humanity of all of us, of those who are coping and of the staff.…I could say to the staff…'Is anyone here immune to psychiatric hospitalization in his life?' In other words, I don't come to put an unpleasant mirror in front of their eyes, but [to say] that they should think again, because none of us are immune.

L. elaborated on the importance of common humanity as a tool in work with patients, in this case, using a personal story to support the peer specialist's work: 'My main tool is telling my personal story about what helped me cope and develop resilience to an audience. It shows them that an emotional crisis can happen to anyone'.

According to the peer specialists, it was hard to reach a sense of common humanity because of the stigma attached to their illness. Being tagged as having an illness made it difficult for them to feel common humanity. They also said common humanity is not acquired spontaneously but requires the development of awareness. L. said:

There's anger at human society and for many years I stigmatized myself: 'You are healthy, and I am ill'. I couldn't connect to the healthy people

because of this stigma. It took many years for me to tell myself that I belong to society and not only to the mental health category.

E. highlighted the difference between a sense of common humanity and isolation:

You are stigmatized and you can't expose it, you understand? I stay masked sometimes and sometimes it's hard for me to connect because they don't understand what I went through. And it takes a long time before I trust someone. It's unexplained fear – what's so frightening?…The loneliness is terrible.

B. emphasized the importance of common humanity in her personal recovery process: 'We're all humans, we're all part of society even if we did terrible things, we are part of society. It's true that it's defined less often as normal'.

Discussion

In our study, we examined how peer specialists perceived their profession and how they understood the impact of self-compassion on their relationship with their peers. The thematic analysis showed the peer specialists were self-judgmental, compared themselves with their peers and the professional staff (doctors, nurses, psychologists), and recognized disparity between their experience-based knowledge and professional knowledge. Their self-judgement created a sense of emptiness and a perceived gap between their job definition and their performance. It also affected their sense of self-confidence. These findings are consistent with those of Moran et al. (2013) and Salzer et al. (2009), who found peer specialists had difficulty defining their professional role in work settings and needed more clarity.

The peer specialists said they judged themselves and compared their recovery process to that of the patients they worked with. They were also preoccupied with what the patients and their professional colleagues thought of them. The tendency of peer specialists to compare themselves with patients underscores the importance of heightening their awareness of their role in recovery (Chinman et al., 2017). Appropriate guidance could help improve individual skills and promote a shift from self-judgement to self-acceptance. A better understanding of their role could also help them integrate into the clinical team. Chinman et al. (2008) claimed a lack of appropriate and uniform instructional models leads to resistance to integrating peer specialists into clinical teams.

A related issue was the gap between the solutions suggested by peer specialists and those proposed by the medical staff. Moran et al. (2012) and Salzer et al. (2010) noted the need to create a bridge between personal experience and professional practices by means of team conversations. Peer specialists possess valuable knowledge based on their experience; they must be prepared to reveal these experiences, not just to patients but also to their team. Such knowledge enables new perspectives, raises awareness of personal and social patterns, and promotes social support and the ability to cope with challenge (Salzer et al., 2010) among therapeutic staff and promotes the service they provide.

We explored how peer specialists experienced self-compassion in their personal lives and in their relationships with patients. The participants referred to three components of self-compassion: self-kindness versus self-judgment; common humanity versus isolation; and mindfulness versus overidentification (Neff & Davidson, 2016).

First, they recognized the importance of self-kindness and described the long journey to forgive themselves. They also mentioned the ability to overcome judgementalism and be kind and forgiving towards themselves and others. Consistent with Neff's (2016) model, they described initial feelings of emptiness and uncertainty that could lead to over-identification with patients. They also felt that in some cases, their relationships with patients led to greater self-judgement and less self-kindness. In the course of the recovery process and working in the psychiatric hospital, they developed awareness of the importance of self-kindness when encountering failure, inadequacy, or personal suffering, either their own or their patients'. Some demonstrated the ability to convey the importance of self-kindness to their patients; it served as a tool

to support patients' recovery based on sharing personal experiences.

Second, they emphasized the importance of using common humanity as a tool when working with patients, for instance, by sharing their personal stories in the therapeutic process. A major obstacle to promoting a sense of common humanity was their awareness of the stigma attached to their illness; this isolated them and forced them to cope with their illness alone. This suggests that a sense of common humanity is not acquired spontaneously but requires the development of awareness.

Third, the peer specialists indicated the importance of being more mindful and overidentifying less. Being mindful supported their ability to be more balanced within themselves and towards their patients. They emphasized the role of experience and guidance in promoting mindfulness and the ability to detect situations of overidentification.

According to Allen and Leary (2010), people with high levels of self-compassion tend to cope better with stressful events and to use positive cognitive coping strategies. The peer specialists we interviewed indicated the development of all the components of self-compassion. They reported that they suffered less stress and depression and felt they effectively supported the patients. Germer and Neff (2013) found that self-compassion correlated with psychological flourishing and reduced psychopathology. Self-compassion has also been associated with better mental health (MacBeth & Gumley, 2012; Neff et al., 2007).

Limitations and Recommendations for Further Research

The study focused on the personal experiences of peer specialists working in a psychiatric hospital in an effort to learn how they perceived their professional role and their use of self-compassion. The study sample was small (there are only 12 peer specialists in Israel). Future research should examine the experiences of peer specialists in other countries and in different health facilities using larger samples.

The findings highlight peer specialists' need for greater role clarity and better training. Uniform instructional models and tools could help them maximize their work, especially the use of personal knowledge. It could also improve their interaction with clinical teams by minimizing the gap between the solutions they offer and those promoted by medical professionals.

In addition, emotional guidance from supervisors and professionals could empower peer specialists and promote their development of self-awareness, thus optimizing the service they provide. Such guidance should be directed at helping peer specialists deal with the stigma attached to their illness; this would reduce their isolation, promote their sense of common humanity and recovery, and support their ability to be more balanced within themselves and towards their patients.

Declarations

Funding: No funding was received for this study.

Conflicts of Interest: The authors have no conflicts of interest to declare.

Ethical Standards and Informed Consent: All procedures followed were in accordance with the ethical standards of standards IRB of the Tel Hai College institutional and national committee and with the Helsinki Declaration of 1975, as revised in 2000. Informed consent was obtained from all patients included in the study.

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