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Boundary Ethics in Peer Support: A Case Study

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Abstract

Mental health peer support is a growing modality of care, in which people with lived experience of mental illness aid others with the same conditions. Despite the rising prominence of peer support, little literature has explored ethics in the provision of care between people with mental illness. Drawing on a case narrative from a larger empirical study on peer support in the United States, this paper will reflect on boundary ethics: that is, the physical, emotional, and social parameters that people engaged in peer support set in relationships with one another. The case will highlight the implications of situations in which people leading peer support programs experience a psychiatric relapse during provision of services. The paper will conclude with a discussion of the implications of boundary ethics in peer support for both bioethics and clinical mental health practice.

Key Words

Peer support, boundaries, boundary ethics, psychiatric services

Introduction

Formalized peer support is a growing modality of mental health care in the United States (Myrick and del Vecchio 2016, Faulkner and Basset 2012, Repper and Carter 2011), in which people

with mental illness[1] provide psychological support and education to fellow individuals impacted by the same conditions. Peer support can take the form of support groups as well as one-on-one case management and classes on coping skills for mental health challenges. These programs are typically led by "peers" or individuals with mental illness who have been trained to meaningfully support others, while drawing on their own lived experience to inform individuals about mental health recovery (SAMHSA 2022). Despite the rising utilization of peer support, and the growing professionalization of peer practice (Voronka 2017, Adams 2020), limited bioethics research has explored the ethical nuances of this form of mental health care. In particular, peer support invites us to revisit existing notions of boundaries in the relationships between those who provide care and those who receive it (Reamer 2015).

This paper will demonstrate that peer support, premised on mutual and bidirectional relationships between people with mental illness, presents different ethical considerations on boundaries than in biomedical treatment, where the roles of clinicians and patients are more distinct and less interdependent. "Boundaries" here refer to the physical, emotional, and social parameters that mediate interpersonal relationships. The case presented in this paper is drawn from a larger, ongoing qualitative study on boundary ethics in peer support, conducted with peers at Ohio offices of non-profit mental health organizations. The paper will begin with a discussion of how the history of peer support in the United States foregrounds boundary ethics in this form of care, followed by presentation and analysis of a telling case, and the value of examining peer support for bioethicists and clinicians in mental health. As the following sections will demonstrate, studying boundary ethics in peer support takes seriously that lived experience of mental illness forms the basis of legitimate healthcare practice (Kalathil and Jones 2016).

Peer support as a modality of care was historically designed in ways that resist traditional notions of the relationships between those who provide care and those who receive it, framing boundaries in ways that diverge from contemporary biomedicine (Miyamoto and Sono 2012). Peer support was a historical response to the abuse that many patients experienced in American psychiatric

[1] In this paper, I use the term "people with mental illness" to reflect the language used by staff and peer facilitators at the study fieldsite. However, others prefer phrases like "mentally ill person" or "schizophrenic" to suggest that their personhood cannot be understood without first acknowledging their disability.

hospitals in the mid-20th century, coupled with a desire to reclaim lived experience of mental illness as a form of expertise that differed from the biomedical knowledge of clinicians (Maisel 2017, Rowland 2015). Peer support has since drawn upon more equal power dynamics between those who provide care and those who receive it, framing people with lived experience as 'experts' with knowledge to share about recovery (de Bie 2019, Howell and Voronka 2013, Beresford 2005), albeit with recognition that some individuals (like peers) may have additional experience and training to lead programs for others. Some "psychiatric survivors" engaged in peer support programs today continue to resist biomedical modes of treatment for mental illness, arguing that the mutual provision of support between mentally ill people liberates them from the paternalism and epistemic injustice of traditional biomedicine (Russo and Wooley 2020, Voronka 2017). Peer support continues to be modeled on mutual relationships between people with mental illness, in which individuals exchange wisdom on how to cope with episodes, set boundaries with people in their daily lives, and share where to access mental health resources in the community.

This model of care diverges from clinical practice, where clinicians have greater authority to direct care, and are expected to focus on others' needs rather than their own: even to the extent that they engage in clinical detachment, or an interpersonal separation of their own lived experience and emotions from those of the patients they treat (Halpern 2001). Consequently, boundaries in mental health peer support are more flexible than in professional relationships between patients and clinicians. While boundary crossings do occur between clinicians and patients, such as a physician accepting a small gift from a patient, providing patients with a nominal amount of money for bus fare, or disclosing their own health challenges to patients (Schiff 2013, Kaonga 2015, Zur 2004, Roman and Whiteman 2012), they are particularly salient in peer support, based upon greater reciprocity in the relationships between peers and the people they serve. Mr. Brown's case in the next section will illustrate some of the boundary complexities that arise in peer support for mental illness.

Case Study: Mr. Brown

Consider the following case drawn from a larger empirical study on boundary ethics in mental health peer support, carried out at offices of non-profit mental health agencies in Ohio which offer

peer-led programs. Mr. Brown[2] is a middle-aged man with a history of psychosis who volunteers as a peer support group facilitator. The agency staff recognized Mr. Brown's ability to provide thoughtful guidance to fellow individuals with mental illness in the community, and selected him to complete training through the organization that would prepare him to lead peer programs for fellow individuals with mental illness. Mr. Brown proves to be an effective peer, but over time, his health deteriorates and he begins to decompensate into psychosis. While directing one support group, Mr. Brown tells attendees that they are living in a broken computer simulation, and only he is able to enter the simulation to fix it. Mr. Brown begins to text attendees of the group multiple times in a day on their personal cell phones about the simulation. The attendees contacted the agency staff about this behavior, which disturbed and upset them. The staff responded by temporarily banning Mr. Brown from leading support groups until he recovered, suggesting that he attend rather than lead a support group to receive help. The staff also reminded Mr. Brown that he should avoid texting attendees outside of the group, unless he is providing information on community resources or updating attendees about the time and place of meetings. Mr. Brown was unhappy with this decision, but ceased to facilitate support groups while he sought psychiatric treatment.

Case Reflection

Within this case, there are numerous issues related to boundaries that require further ethical analysis. The first consideration here is whether or not, and how, mental health organizations, clinics, and agencies should utilize people with mental illness to aid others. Certainly, there is always a potential for peers to relapse and to compromise the mental well-being of the people they serve, whether by being unable to successfully lead a support program that would benefit the attendees' mental health, or by causing distress amongst people accessing peer services when confronted by another person's mental health episode. Peers experiencing a relapse may be unable to set or maintain boundaries that ensure their ethical obligation to the people they serve is met, as their own mental health needs override their ability to provide help to others. Other research has indeed indicated that peers may limit their own participation in peer-led programs if they feel their mental health would be compromised by aiding others (Hua Fletcher 2019), which could also decrease the

[2] This name is a pseudonym used to protect the individual's identity.

quality of support that people attending their programs would receive.

The boundaries that peers set with others – even as far as whether or not they are even able to lead support programs – are thus highly contextual, and based upon the peer's own dynamic mental health needs and psychological status. Peers actively experiencing an episode may be unable to make such decisions based on self-insight, making it crucial for mental health agencies to have clear guidelines for how to determine if a peer needs aid, and who should be required to report a peer: agency staff and clinicians who may themselves be people with lived experiences of mental illness to disclose (Sibbald 2021), fellow peers, or even the people they serve. Given that research has found peers' own mental health improves when they serve as facilitators aiding others in support programs (Bracke, Christiaens, and Verhaeghe 2008), barring peers from serving in the community permanently following an episode would perhaps itself amount to an unethical decision harming people with mental illness.

Relapses have more nuanced implications beyond just subverting boundaries and violating ethical obligations: indeed, even in biomedicine, flexibilities in boundaries can be both ethical and necessary (Schiff 2013). As other cases collected in the larger qualitative study have indicated, peers who relapse and cross boundaries with participants during this time have an invaluable opportunity to deepen their rapport with others and model what successful recovery might look like. This may entail the peer attending the programs they would otherwise facilitate for support, as the agency staff in the case above suggested to Mr. Brown. Further, relapses build peers' knowledge about their own recovery needs, better enabling them to help others who have experienced, or will experience, mental health episodes. Indeed, at one field site in the study, the most trusted and popular peer facilitators amongst participants have been those who are open about past and present relapses, and what they learned during these challenging times. When recruiting peers, it is unlikely that agencies can predict (or even should predict) if a potential peer will have a future episode that shapes their ability to provide services: nor should the risk of an episode be interpreted as wholly harmful to the effective and mutual provision of support between people with mental illness gaining expertise by overcoming mental health challenges.

The sharing of personal contact information in this case is also a complex ethical issue. By the standards of the mental health agency, Mr. Brown overstepped his role by calling and texting support

group members about the computer simulation. Doing so burdened support group participants who were already experiencing psychological distress, thus constituting a boundary violation or a transgression of boundaries with the potential to harm people seeking care (Gabbard 2016, Gabbard 2021). However, in other narratives gathered during this study, peer facilitators and support group attendees texted and called one another with some regularity to discuss their difficulties with depression, anxiety, loneliness, and agitation. This was not condoned by agencies, but it was not policed heavily given the perception that functional peer support might occur outside of designated peer support programs. Contact outside of support groups may not be inherently unethical when participants have capacity and a desire to mutually assist one another through mental health challenges.

Even in clinical practice, some situations call for providers to cross established boundaries to aid patients (Lazarus 1994, Zur 2004, 2007), while scholars have likewise advocated for a focus on relationships rather than boundaries, which may become barriers to effective mental health care (Combs and Freedman 2002). Here, however, Mr. Brown did not engage in reciprocal interactions with the support group members he contacted, and his waning capacity during the psychotic episode meant that he was unable to account for the mental health needs of the people he otherwise served as a facilitator. While this relapse may have harmed the psychological well-being of the people Mr. Brown served, this same episode had the potential to deepen the group members' knowledge about recovery and enhance rapport between them. In this way, Mr. Brown's relapse produced the kind of lived expertise that peer support is premised on, and the participants' willingness to contact agency staff to aid Mr. Brown demonstrates the value of bidirectional relationships between people with mental illness. Put together, this case suggests that boundary ethics in peer support are highly nuanced, given the mutual nature of support and ethical obligations within peer communities.

Implications

This case example has important implications for both bioethicists and mental health clinicians. Bioethicists interested in boundaries have classically focused on the relationships between clinicians (most often physicians) and patients, where recipient/provider roles are more stringently delineated than in peer support. However, this work on boundaries does not neatly apply to peer support, or other interdependent exchanges of care between disabled people, which deserve further ethical

consideration as valid forms of aid beyond biomedicine. Further, given global shortages of mental health clinicians and services (Wainberg et al 2017), it becomes increasingly critical for bioethicists to analyze and frame ethics for practice in expanding care modalities like peer support that meet gaps in treatment, especially for patients who may be unable to access psychiatrists, medications, and professional therapeutic services. Beyond peer support, bioethics as a discipline can and should pay closer attention to lived experience as a type of medical expertise, weighing under what conditions sharing this knowledge between practitioners and patients is appropriate and ethical.

Mental health care professionals are also increasingly interfacing with peers who work alongside them in community mental health clinics and agencies (Adams 2020), and as such, these professionals can and should consider their role in supporting peers who are navigating ethically and socially complex care relationships with others. For mental health professionals who supervise peers, or work with peers in clinical settings, it is important to consider that peers may be more comfortable discussing their mental health concerns with the people they serve than with clinicians who might not have lived experience, as highlighted in Mr. Brown's case. Therefore, it is important for clinicians to encourage peers to voice their mental health concerns, to listen to these concerns without judgment, and to devise clear steps for how peers and the people they serve can alert professionals when someone in the group is decompensating. This is particularly important given that clinicians often forego shared decision making with patients who have serious mental illness (Guidry-Grimes 2020), which may translate into similarly devaluing what peers with serious mental illness have to say about providing peer support.

There are other steps that healthcare professionals might take if they engage with peers in clinical settings. Practitioners may consider pairing two peers together so that they can advocate for each other's support needs, rather than expecting the recipients of peer services to report concerns about the peers charged with their care. Additionally, mental health agencies can invite peers to debrief with the people they serve following a relapse, paving the way for more positive interactions in the future. Indeed, if Mr. Brown reflects on this relapse with the people in his support group, he may be further modeling what continuous mental health recovery looks like. Healthcare professionals should also make collaborative determinations with peers about how and when peers should contact participants outside of support programs, recognizing that not all contact beyond the clinical setting is detrimental.

Healthcare professionals who do not work alongside peers, but who recommend peer support to their patients, can also be mindful of how boundary concerns might impact their patients' recovery. While peer support can be a productive space for learning how to set and enact respectful boundaries with others, it may be inappropriate for patients who require other, initial interventions like therapy before engaging in forms of support where relationship boundaries are multidirectional. Further, health care professionals might even recommend that patients who are advanced in their recovery become peers, such that they can find meaning in supporting others while also receiving support from fellow individuals with mental illness, which is not typically replicated in biomedical settings.

Conclusion

Mental health peer support presents important ethical questions around boundaries that both bioethicists and clinicians should pay close attention to. Mr. Brown's case highlights the challenges and the opportunities of utilizing peer support for mental illness, and underscores the mutual and bidirectional nature of ethical caregiving within this expanding modality. Studying boundaries within peer support recognizes the legitimacy of peer support as a form of healthcare wherein knowledge about recovery is shared between individuals impacted by mental illness, stemming from a history of resistance to biomedical models in which such knowledge has been often undervalued. Clinicians and mental health agency staff who interface with peers should be conscious of the potential harms of boundary crossings and violations in peer support, while also acknowledging that relapses in peers' mental health may be opportunities to strengthen provider-to-recipient relationships and enabling all people involved in peer support to enhance their knowledge of coping in recovery. Future research should further explore ethics in mental health peer support, as well as revisit existing notions of harm when assessing boundary crossings and violations across clinical practice and allied health services. As Mr. Brown's case illustrates, boundary considerations within peer support – and other modalities of care that extend psychological treatment – are critically important to the advancement of current understandings of mental health ethics and, more broadly, differences in boundary ethics between forms of practice.

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