

Research Article

Carer Peer Workers in Borderline Personality Services: Providing Reciprocal Understanding and Personal Strategies to Family Members

Karlen R. Barr , Michelle L. Townsend , and Brin F. S. Grenyer 

School of Psychology and Illawarra Health and Medical Research Institute, University of Wollongong, Wollongong, Australia

Correspondence should be addressed to Brin F. S. Grenyer; grenyer@uow.edu.au

Received 1 December 2022; Revised 6 July 2023; Accepted 17 October 2023; Published 26 October 2023

Academic Editor: Mucahit Aydin

Copyright © 2023 Karlen R. Barr et al. This is an open access article distributed under the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

The value that carer peer workers may offer family members with lived experience of BPD has not been investigated thoroughly to date. This study aims to investigate the unique contributions of carer peer workers in supporting family members who care for consumers with BPD. Mixed method questionnaires were completed by family members, consumers, carer peer workers, and clinicians ($N = 24$) at five mental health services. Qualitative responses were analysed using thematic analysis. Family members felt understood due to the personable, reciprocal approach of carer peer workers, which differentiated carer peer workers from clinicians. Carer peer workers benefitted from their role by finding purpose and found hearing about similar experiences of family members challenging. Through interactions with carer peer workers, clinicians gained insight to the carer role. This study provided evidence that carer peer workers may play a unique role in supporting family members with lived experience of BPD.

1. Introduction

Peer support occurs when a person with lived experience of mental health problems supports another person with similar problems [1, 2]. Peer support can be provided by consumer peer workers with lived experience of mental health difficulties and carer peer workers with lived experience of supporting a consumer with mental health difficulties [3]. Carer peer workers predominately provide support to family members supporting consumers with mental health problems, but they can also support consumers. Principles have been developed that propose that peer support is based upon mutuality, including mutual respect and equal value in relationship, reciprocity, including openness to give and receive support, and shared lived experiences, including respecting diversity of lived experience voices. Other principles are experiential knowledge or placing value on lived experience and peer workers having choice over the support provided [2, 4]. Consumer and carer peer workers can hold voluntary or paid positions and may work alongside clinicians [1, 5]. The

support provided by peer workers varies and may include advocacy, education, or emotional support [6, 7]. Peer support may help improve outcomes for people with lived experience of borderline personality disorder (BPD) due to the experiential knowledge and reciprocal approach provided by peer workers [8, 9]. Carer peer workers may play a particularly valuable role in supporting family members [10]. Previous research on peer support predominately focuses on consumer peer workers and their role in supporting consumers with severe mental illness [11, 12]. The purpose of the current study is to investigate the carer peer worker role in supporting family members who care for consumers with BPD.

BPD is a complex mental health problem affecting approximately 2% of the population [13] marked by challenges with identity, relationships, affect, and impulsivity that can respond well to psychotherapies [14]. The prevalence of BPD is higher in outpatient service settings, highlighting the importance of providing effective treatment to this population [15]. High stress and poor wellbeing are often found in family members supporting consumers with BPD [16].

Family members supporting a consumer with BPD may not receive support from clinicians [17, 18]. Studies recommend that family members are acknowledged by clinicians and involved in consumer treatment to increase empowerment and reduce isolation in family members [8, 18, 19]. Including family members in consumer treatment is also beneficial for consumers as family members may improve their responses to consumers and practitioners may be better informed about a consumer's condition [20, 21].

Several studies have investigated support provided by carer peer workers. Family members who received support from a carer peer worker reported feeling reassured and receiving education about mental health [7]. Group programs facilitated by clinicians or carer peer workers have been developed for family members supporting consumers with BPD [22–24]. Such programs provide psychological education about BPD, skills to help family members interact with their relative, and support from other group members. Group programs have been demonstrated to improve carer stress, depression, and relationships with consumers [22, 24, 25]. In a randomised control trial, relationship quality, family empowerment, and emotional overinvolvement significantly improved in family members receiving a group program, compared to a waitlist condition [23]. It is unclear from studies conducted to date which variables are accounting for these effects, such as the specific skills taught or having a clinician or peer worker facilitator.

Peer support may also help the providers themselves. Consumer peer workers report benefits to their personal recovery as using their previous challenges to help others can be validating [26, 27]. However, consumer peer workers face some further challenges in this role, such as being stigmatised by clinicians [28, 29], despite their presence helping to change services to be more recovery-oriented [30, 31]. To the authors' knowledge, research has not yet investigated the benefits and challenges of the carer peer worker role or how carer peer workers may influence clinician practices. It remains unclear how support provided by carer peer workers is different from support provided by clinicians and how the lived experience of carer peer workers can be used to help family members supporting consumers with BPD. We aimed to study the experience and perspectives of family members and consumers with lived experience of BPD, carer peer workers, and clinicians on the carer peer worker role. We were interested to discover the benefits, pitfalls, and unique contribution of this role for consumers, family members, clinicians, and peer workers. The research aimed to fill gaps in prior research by investigating how support provided by carer peer workers is different from support provided by clinicians, benefits or difficulties carer peer workers experience, and how clinician practices may alter following interactions with carer peer workers.

2. Materials and Methods

2.1. Setting and Participants. In order to compare and contrast experiences of carer peer support, we chose five mental health services in Australia where a carer peer worker was currently engaged. Two of the services were hospital

outpatient carer peer support services which provided educational group programs and one-to-one support. Two of the services were carer-led independent peer-run services for family members which offered educational group programs and individual mentorship. Another service was a carer-led independent peer-run service providing group dialectical behaviour therapy skills to consumers with BPD and a support group for family members. The services were open to family members or consumers with a range of BPD experiences and provided contact on a weekly, monthly, or as-needed basis. The independent peer-run services operated from private premises. Overall, peer-run services for family members supporting someone with BPD are relatively new to the mental health service landscape. Carer peer workers received different training including education on dialectical behaviour therapy skills or a certificate in mental health peer work. Using purposive sampling, e-mail invitations were sent to all carer peer workers at the five services. Consumer and family member BPD networks and advocacy groups were approached to identify carer peer workers, and carer peer worker participants were asked to suggest other potential participants. Upon consenting to the study, the carer peer workers were asked to present an invitation flyer to family members or consumers they supported with lived experience of BPD. Carer peer workers at outpatient mental health services were also asked to present a flyer to clinicians with whom they worked. Consumers, family members, and clinicians who were interested in participating contacted the research team through e-mail. The final sample comprised the five carer peer workers, and commenting on their services were 14 family members, two consumers, and three clinicians ($N=24$). The carer peer worker participants ($n=5$) were female, averaged 51.2 years in age ($SD=11.2$), and had worked as a peer worker for an average of 4.2 years ($SD=4.1$). The family member participants ($n=14$) were female, with a mean age of 57 ($SD=7.9$). Family members identified as a parent ($n=10$), spouse/partner ($n=2$), sibling ($n=1$), or child ($n=1$) in relation to the person with BPD they support. The consumer participants ($n=2$) were female with an average age of 32 ($SD=9.9$). As part of the online questionnaire, consumers confirmed caseness for BPD and family members confirmed BPD in their relative via their responses to the McLean Screening Instrument for Borderline Personality Disorder (MSI-BPD) [16, 32], where scores of 7 or above indicate likelihood of meeting BPD criteria. The mean score on the MSI-BPD was 8.1 ($SD=1.7$). All clinician participants ($n=3$) were psychologists with an average of 4.3 years of experience working with consumers with BPD, two were female, and they had a mean age of 32.7 ($SD=5.5$).

2.2. Procedure. Ethical approval was received from the University of Wollongong Social Sciences Human Research Ethics Committee (2019/350). Participants received a participant information sheet and provided written informed consent. We chose a comparative case study design using qualitative methods as recommended for studies of this type [11, 33]. Monetary compensation was provided to all lived

experience participants, as seen in similar studies [26]. Online questionnaires were completed by all participants in their own time using SurveyMonkey. Questionnaires were used to increase participant comfortability and for logistical reasons [34, 35]. Consumers and family members completed quantitative questions regarding the peer support they received (e.g., “How often did you meet with the peer?”) with categories provided to choose from (e.g., “Multiple times a week, Once a week, Once a fortnight, Once a month, Other”). Another quantitative question for consumers and family members listed possible types of support they received from their peer worker (e.g., “Shared experiences of social and emotional distress”) and required a yes/no response. Qualitative questions regarding experiences of peer support were developed by the authors and informed by previous research [36, 37]. All participants responded to seven or eight qualitative questions, which differed slightly based on the participant type. Questions explored what was helpful or unhelpful about carer peer support (e.g., “What have you found helpful about the peer support services you have received from your peer worker?”), how carer peer support was similar or different from the support received by clinicians (e.g., “In what ways was your peer worker’s role different to the role of other health professionals?”), how providing peer support influenced carer peer workers (e.g., “What challenges have you experienced when providing peer support to consumers with BPD or carers supporting someone with BPD?”), and how peer support influenced clinicians (e.g., “How does the peer worker at your service influence the way you practise as a mental health professional?”). Qualitative questions were open ended and responded to with free text responses. Summing all questions together per participant, qualitative response length ranged from 21 to 450 words with a median of 147 words.

2.3. Data Analysis. A qualitative approach was used to explore and describe the carer peer worker role in BPD services [38]. This approach was taken due to the novelty of the topic area and the complexity of the peer support relationship that cannot be fully understood using quantitative methods [33, 39]. Qualitative questionnaires were analysed using a constructivist orientation to investigate participants’ perspectives and subjective meanings of the carer peer worker role [40–42]. A constructivist approach focuses on language in understanding meaning, and during thematic analysis, a constructivist approach is used to understand the meaning within participant responses [40]. The questions and online format used to ask the questions may have shaped the participant responses and the qualitative analysis. For example, because authors could not seek elaboration on the responses, they used their preexisting knowledge of peer support and clinical experience to interpret responses. All participant responses were collected prior to qualitative analysis. Reflexive thematic analysis occurred following several steps [43]. Personally identifying information was removed from participant responses. Immersion in the data occurred by repeatedly reading participant responses. Using NVivo 12, the first author coded statements into nodes and

generated candidate themes from an in-depth analysis of the data [44]. Next, themes were reviewed and altered as necessary to best reflect the data and to ensure themes did not overlap. Discussions occurred within the research team that ensured that the codes and themes depicted participant responses. The research team included two clinicians and one researcher without a clinical background, all with experience in the field of personality disorders. Data were triangulated within and between cases to gain a comprehensive understanding of responses from individual cases [45]. A “case” referred to a service and included all participant responses within the service. Triangulation occurred by analysing cases individually and all together to investigate whether the cases had a different experience or perspective of the carer peer worker role.

3. Results

The characteristics of the peer support provided by carer peer workers are outlined in Table 1. The most frequent types of peer support provided by carer peer workers included sharing personal use of skills and coping strategies and providing information about resources. Forty-four percent of consumers and family members had between 1 and 3 meetings with a carer peer worker. The majority of consumers and family members met with their carer peer worker once a week or once a month, and how time was spent (i.e., what consumers and family members did with their carer peer worker) was most often collaboratively chosen between the carer peer worker and the family member or consumer.

3.1. Qualitative Findings. The qualitative findings are presented in two categories, including perspectives shared by all participant groups and perspectives of clinicians and carer peer workers. The findings will be presented in this way because there were some responses that were unique to clinicians and carer peer workers, such as how clinicians were influenced by carer peer workers.

3.1.1. Perspectives Shared by Consumers, Family Members, Carer Peer Workers, and Clinicians. Four themes were recognised by all participant groups as described below.

(1) Family Members Felt Their Role and Experiences of Borderline Personality Disorder Were Understood due to the Lived Experience of Carer Peer Workers. Through the lived experience of carer peer workers, family members experienced feeling understood in their unique role as a carer and in their experiences of caring for someone with BPD. Due to similar experiences, family members felt that carer peer workers had greater insight and understanding of their difficulties compared with clinicians.

“Others can be empathic and know all the theory, but until they have found their loved one unconscious from an overdose or mopped up the blood from self-harming . . . they can’t understand what it is like” (Carer Peer Worker 2).

TABLE 1: Characteristics of peer support provided to family members and consumers.

| | Total (n = 16) n (%) or M (SD) |
|---|-----------------------------------|
| Types of peer support provided | |
| Shared experiences of social and emotional distress | 13 (81.3) |
| Shared personal use of skills and coping strategies | 14 (87.5) |
| Information about services (e.g., psychologist) | 8 (50.0) |
| Information about resources (e.g., websites) | 14 (87.5) |
| Social activities (e.g., exercising) | 4 (25.0) |
| Education about BPD | 13 (81.3) |
| Number of meetings with carer peer worker mean (SD), range | 10.9 (13.9), 1–50 |
| Frequency of time spent with carer peer worker | |
| Multiple times a week | 1 (6.3) |
| Once a week | 6 (37.5) |
| Once every two weeks | 1 (6.3) |
| Once a month | 6 (37.5) |
| Other | 2 (12.5) |
| How time spent with carer peer worker was chosen | |
| Carer peer worker decided | 3 (18.8) |
| Family member/consumer decided | 2 (12.5) |
| Carer peer worker and family member/consumer decided together | 9 (56.3) |
| Group meetings were scheduled by organisation | 2 (12.5) |

One carer expressed how her relationship with the carer peer worker was different from relationships with clinicians because the carer peer worker was “*more understanding and did not run down the person with BPD*” (Carer 4). In addition, family members described how interacting with the carer peer worker helped them feel less alone. “*Listening to my concerns when there is no one else who actually ‘gets’ BPD. It is very lonely for family members supporting a loved one as you feel you can’t burden others with your ‘woes’*” (Carer 14). Another family member expressed how the carer peer worker’s lived experience allowed her to be more open. “*You feel you can be more honest and won’t be judged, especially about some of the negative emotions you can feel as a carer*” (Carer 1). Many family members commented that they could not identify any unhelpful aspects of carer peer support.

(2) *The Carer Peer Worker’s Lived Experience Allows a Warm, Reciprocal Approach.* Family members, consumers, and carer peer workers described how a carer peer worker’s lived experience provides a different, more equal approach compared with clinicians. “*More of an equal approach rather than a worker/client situation. . . The information and services provided were the same but the approach made all the difference*” (Consumer 2). While some participants acknowledged how both carer peer workers and clinicians provide support and empathy, the approach of carer peer workers was described as more warm and nurturing, including use of everyday language. “*The relationship with health professional(s) is very sterile and professional, with my (carer) peer worker it is much more informal, with a nurturing caring touch*” (Carer 7). Other family members did not think the relationship with a clinician was similar to a relationship with a carer peer worker, including one family member reporting that her relationship with her carer peer worker was differentiated from her relationship with clinicians due to the support and trust she experienced.

Consumers and family members described how they felt that carer peer workers were genuinely interested in them, compared with a more clinical, power imbalanced relationship held with clinicians. “*I ran out of funding and I realised [my carer peer worker] cared about me as a person rather than the money she got off me*” (Consumer 1). Family members reported that carer peer workers were able to spend more time with them compared with clinicians, allowing them to talk openly, ask questions, be listened to, and feel valued. “*[The carer peer worker] had more time to sit with me and be available*” (Carer 8). One carer described valuing how her carer peer worker initiated contact with her. “*I appreciated that [the carer peer worker] contacted me first. Out of the blue came a phone call reaching out to me. . . Here was someone ringing to say can I help you*” (Carer 11). Participants expressed how the carer peer worker’s lived experience also provided inspiration and “*hope that the situation can improve*” (Carer 2). Relaxed boundaries used by a carer peer worker were unhelpful at times, such as peer workers sharing their own personal distress with those they support. One consumer reported that a “*peer worker’s own personal distress can be very unsettling*” (Consumer 2). Another carer was concerned about the impact that sharing her story would have on the carer peer worker and wanted to know that the carer peer worker was being supported. “*I am concerned that my sad story impacts on [the carer peer worker] even though I know she understands because she has been there*” (Carer 11).

(3) *Listening to the Personal Strategies and Resources Used by Carer Peer Workers Is Helpful to Family Members and Consumers.* Many participants described how carer peer workers provided practical help and education about BPD, including skills, strategies, and resources to help them communicate with and support consumers with BPD. “*Lots of resources to educate me on how to communicate and*

implement boundaries to understand BPD" (Carer 9). Some participants identified how carer peer workers and clinicians both provide valuable information and resources. However, the greater knowledge and lived experience of utilising the resources and services often differentiated the support from carer peer workers from the support provided by clinicians. "My peer support worker was also more aware of resources than my general practitioner or counsellor and this was invaluable" (Carer 8). One carer described how the carer peer worker had a greater understanding of how family members could be included in treatments for BPD, compared with clinicians. "[Carer peer workers have] more understanding of the treatments and skills that work. For example, that family members of the person experiencing BPD need to be included in therapy and also be consulted and informed so that they can best assist the person experiencing BPD" (Carer 3). Carer peer workers were also described as supporting family members with "practical help with navigating the hospital system" (Carer 9). Skills and strategies provided by carer peer workers were differentiated from skills provided by clinicians because carer peer workers share how skills and strategies have been used in personal situations. "I recall the feeling of validation when hearing the peer worker discuss how she approaches and manages stressful situations" (Consumer 2).

(4) *Family Members and Consumers Desired an Increased Availability, Accessibility, and Organisation of Carer Peer Support.* Many family members desired greater availability and accessibility of peer support services, including during crisis situations. "More accessible in the community, that it didn't take for an emergency to happen before family members can access them" (Carer 10). Increased funding for carer peer support was recommended to increase accessibility. "More funding to peer support services so that they can implement more programs to support family members and subsequently persons experiencing BPD" (Carer 3). Several family members desired more frequent interactions with their carer peer worker, particularly when carer peer workers worked part-time. "Monthly meetings . . . are not enough. Weekly would be better" (Carer 6). Participants also described the importance of clinicians connecting family members to carer peer workers. "Clinicians need to be aware that the family members need support just as much as their loved ones, and they need to be able to tell them where it is available" (Carer Peer Worker 2). Consumers and family members also commented that some carer peer workers require consideration about group processes, including improving time management in group meetings by "ensuring all participants have the opportunity to speak" (Carer 1).

3.1.2. *Carer Peer Worker and Clinician Perspectives.* This section describes the six themes from the views of carer peer workers and clinicians.

(1) *Carer Peer Workers Feel Supported by Clinicians When Their Role Is Recognised, Valued, and Incorporated.* Carer peer workers described how they felt supported when their

role was embedded into mental health services. "Peer support is integral to service delivery and leads to better outcomes for consumers and family members and is not a threat or contraindication to clinical work" (Carer Peer Worker 3). Clinicians viewing carer peer workers as equals with valuable skills was important for carer peer workers. "Support in a clinical setting to me has looked like equality, recognition of skills and co-contribution" (Carer Peer Worker 4). Carer peer workers employed within outpatient services described challenges when their role is excluded from specific mental health services or when peer support is added to services as an afterthought. "Carer peer workers (are) still an afterthought in a lot of service delivery planning or kept on the outer of clinical work" (Carer Peer Worker 3). Exclusion from mental health teams and having their skills unrecognised were also difficult for carer peer workers. Experiences of being undervalued and misunderstood by clinicians left carer peer workers feeling unsupported, such as clinicians not understanding that providing peer support can be difficult. "If you look like you are doing well that it's easy for [professionals] to forget that the work can be tough" (Carer Peer Worker 5).

(2) *Supporting Others Provides Positive Emotions and Purpose and Helps Carer Peer Workers in Their Caring Role.* Providing peer support to others was described as a way for carer peer workers to find purpose and meaning in their difficult experiences. "I feel useful and what I have been through can be used to help others, so maybe there was a reason I experienced all that trauma" (Carer Peer Worker 2). Positive emotions and personal growth as a result of sharing their experiences and supporting others were also reported by carer peer workers. "Disclosing my carer lived experience as (a) direct part of my working role. . . this in itself has been the biggest influence, learning and growth in my own personal recovery" (Carer Peer Worker 4). One carer peer worker described how her experience as a carer peer worker has positively influenced her caring role and her relationship with the consumer she supports. "[I have] a different perspective of how to best support the consumer" (Carer Peer Worker 3). Another carer peer worker described how her experience as a carer peer worker has helped her interact with clinicians who support her daughter. "[Being a carer peer worker] also makes me realise that staying up to date with the latest research can give me more influence with my daughter's mental health professionals" (Carer Peer Worker 2).

(3) *Carer Peer Workers May Have Difficulty Maintaining Their Own Wellness and Supporting Others with Similar Experiences.* Carer peer workers described how it can be difficult to maintain their wellbeing when supporting others. Carer peer workers described difficulties hearing the experiences of other family members, including challenges accessing mental health services and traumatic incidents. "Hearing lots of very graphic stories many times over can bring me down and cause me sleepless nights, I worry about my daughter doing what they are experiencing" (Carer Peer Worker 2). Accepting people where they are at, particularly

when they are *“still stuck after a long period of time”* (Carer Peer Worker 5), was also difficult for carer peer workers. One carer peer worker described being self-critical and experienced feelings of inadequacy compared to clinicians. *“A big challenge for me was seeing myself as ‘equal’ to professionals”* (Carer Peer Worker 1).

(4) Increased Systemic Support, Training, and Opportunities Were Recommended to Support Carer Peer Workers. Greater systemic support for carer peer workers was requested, including having more resources that they can connect family members to and increased funding for supervision. *“There really needs to be greater funding and support for peer workers, they are a smaller workforce who often don’t have access to supervision”* (Clinician 1). One carer peer worker reported how carer peer workers require more consistent training. *“I would like to see uniform training and processes for peers in my organisation”* (Carer Peer Worker 5). Another recommended increased opportunities for carer peer workers to study and work. *“There should be more of [peer support]. More opportunities are needed for people in recovery to work and study in peer work”* (Carer Peer Worker 1).

(5) Carer Peer Workers Help Clinicians and Organisations Understand BPD and the Carer Role and Hold Hope for Recovery. Clinicians described how working alongside carer peer workers helped increase their hope for the consumers they support, changing their practice to be more recovery-oriented. *“They assist me to hold hope for the consumers we work with”* (Clinician 1). Interacting with carer peer workers also helped clinicians understand *“the role family members play and impact on them”* (Clinician 2). Receiving advice and having their views of BPD challenged by carer peer workers was appreciated by clinicians. *“Good at calling the team out on transference issues and advocating for the consumers to hold us all accountable in our treatment plans”* (Clinician 1). One carer peer worker noticed a shift within her organisation *“in acknowledging that peer work is now being invested in, that it holds value, and will be highly regarded into the future”* (Carer Peer Worker 4).

(6) Challenges Arise When Clinicians and Carer Peer Workers Have Differences in Opinion. Clinicians reported that challenges can arise when clinicians and carer peer workers have different perspectives regarding treatment. *“Working from different viewpoints can cause differences of opinion in treatment”* (Clinician 2). Furthermore, differences in language use were described as challenging and sometimes resulting in tension between and within mental health teams. *“Clinical language at times is different from peer workforce language and this can be a source of contention”* (Clinician 1). However, one clinician reported no challenges regarding their work alongside carer peer workers.

4. Discussion

This study illustrated the role, value, and some potential pitfalls of carer peer work and its impact on family members, consumers, and clinicians. Findings showed that the lived

experience of carer peer workers allows family members to feel understood in their unique experiences of caring for a consumer with BPD. In addition, carer peer workers were differentiated from clinicians due to their sharing of personal experiences, strategies, and resources. Benefits and challenges of being a carer peer worker were described, including finding meaning in difficult experiences. Following interactions with carer peer workers, clinicians described changing their practice to be more sensitive towards consumers and family members with lived experience of BPD.

Figure 1 outlines the differences and similarities between the carer peer worker and clinician role. While both roles provide emotional support, carer peer workers provide support from a place of shared understanding, and clinicians provide support using theory and empathy. Carer peer workers can provide shared understanding because they have had similar experiences to family members, such as supporting a consumer through a crisis. It is important to note that all clinicians participating in this study were psychologists.

In the current study, family members described being more honest about their experiences and emotions due to the shared experiences of carer peer workers, which is consistent with previous research on consumer peer workers [46]. This may be particularly important for family members with lived experience of BPD due to stigma towards BPD [47]. When interacting with other people, family members may think that they need to hide their experiences due to potential negative reactions [10]. Carer peer workers may be able to understand and normalise family members’ experiences which may reduce internal and external stigma [48]. Indeed, family members have experienced a nonjudgmental approach from carer peer workers, compared with others who may question their responses to consumers [8]. Compared with clinicians, all participant groups described how carer peer workers have more reciprocal interaction with family members and are perceived by family members as having more time for them, in line with previous findings [10, 49]. While several participants described clinicians as empathic and supportive, some family members did not experience clinicians as supportive. Family members can experience clinicians as not being sensitive to their needs [18, 50]. It may be important for clinicians and carer peer workers to work together to support family members, such as sharing ideas of how best to interact with family members and clinicians referring family members to carer peer workers [51]. Challenges of carer peer work were also identified, including family members’ concerns that sharing their experiences may emotionally impact carer peer workers. To ease these concerns, it may be helpful for carer peer workers to inform family members and consumers that they receive support and supervision.

Findings also contribute to gaps in previous research by differentiating the support provided by carer peer workers compared with clinicians. While both carer peer workers and clinicians provide skills and resources, a unique contribution was provided through a carer peer worker’s personal use and greater awareness of skills and resources [30]. In this way, carer peer workers may have a unique role in

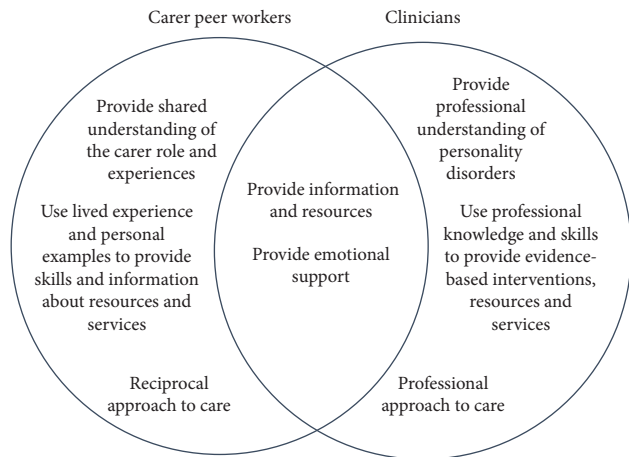


FIGURE 1: A comparison of the carer peer worker and clinician role.

connecting family members and consumers to specific mental health resources and services [7]. Importantly, by utilising their own lived experiences, carer peer workers can also help family members understand effective ways to support consumers with BPD [8]. The unique contributions of carer peer workers may also be important for family members supporting consumers with other mental health difficulties, such as psychosis [52, 53].

Participants described a need for increased availability and accessibility of support provided by carer peer workers, including more frequent contact and more public awareness of peer support services. Early connection between family members and carer peer workers may help family members navigate mental health crises and the mental health system and could be an important contribution to early intervention for BPD [7, 54]. In addition, greater funding and sustainable employment for carer peer worker roles may help facilitate increased meetings between family members and carer peer workers [55].

Carer peer workers described how providing peer support may also contribute to their wellbeing and recovery, including improvements in their relationships with consumers with BPD. Furthermore, challenges experienced by carer peer workers were identified, including listening to the similar experiences of others. Therefore, carer peer workers and consumer peer workers may experience similar benefits and challenges in their role [26, 27, 56]. Findings also highlighted the importance of clinicians and organisations valuing and including carer peer workers in the planning and delivery of BPD services. Recommendations to increase systemic support of carer peer workers included providing supervision and training, which may help support carer peer workers when they experience personal challenges or challenges in the workplace [29]. Clinicians identified how they may have different language use and treatment preferences compared with carer peer workers, possibly contributing to carer peer workers feeling misunderstood or undervalued. Therefore, it may be important for organisations to provide ways for clinicians and carer peer workers to work in a complementary way where both clinical and lived experience perspectives are valued and considered. For

example, organisations could facilitate open conversations between clinicians and carer peer workers regarding their perspectives of language and treatment to help them come to a mutual understanding of one another. Additionally, findings revealed how carer peer workers may influence clinicians to be more aware of recovery in BPD and the role of family members, in line with previous research [10, 57].

Recommendations for the carer peer worker role in BPD services are outlined in Table 2. Emotional support and education may be provided to family members by carer peer workers in one-on-one or group settings and in various contexts, such as outpatient or acute settings. It may be important for this support to be provided early. For example, a carer peer worker might listen to and provide information to a family member in the emergency department when the consumer they support presents for the first time. Carer peer workers and clinicians communicating with one another may further support family members, such as clinicians being more aware of nonclinical and peer support services to refer family members to. Qualitative research studies such as the current study do not aim for generalisability, and further research is required to support the recommendations outlined.

5. Limitations

There are several limitations with this study. All family member, consumer, and carer peer worker participants were female, potentially highlighting a need for gender diversity in the carer peer workforce. Furthermore, the purposive sampling technique used to recruit carer peer workers may have led to biased results [58]. For instance, only carer peer workers that were known to the authors via the consumer and carer networks were approached, and carer peer workers in other sites may have had alternative perspectives. Additionally, only three clinicians participated and they were all psychologists, making it unclear whether their perspectives were representative of other clinicians [59]. The small number of consumer participants and carer peer workers is another limitation, hindering thorough understanding of their perspectives. The low participant numbers may be explained by the study taking place during the COVID-19 pandemic or the fact that the carer peer workforce is relatively new. Both reasons may have contributed to difficulties finding carer peer workers and clinicians who can comment on their work. In addition, it might be rare that consumers receive support from carer peer workers as consumers may prefer to work with a consumer peer worker. While the research collected perspectives of diverse voices, the heterogeneity of the participant types and service settings may have limited the qualitative analysis [60]. Researchers were also unable to seek elaboration on participant responses. A few participants from each case were contacted for member checking of the analysis; however, no feedback was received from the participants [61]. Future research is required to evaluate services provided by carer peer workers to family members supporting consumers with BPD and to evaluate how clinicians and carer peer workers can best work together to support family members.

TABLE 2: Recommendations for establishing and progressing carer peer worker roles within mental health services for consumers with BPD.

-
- (1) Carer peer workers may have a role in providing emotional support, education and skills related to BPD, and information about services and resources for BPD
 - (2) Open communication between carer peer workers and clinicians may help increase understanding of lived experience and clinical roles and may help family members access the support they need through referrals
 - (3) Greater systemic support of carer peer workers is required, including funding for greater availability and accessibility of peer support services and increased training and supervision for carer peer workers
 - (4) Early connection between family members and carer peer workers may be an important way to support family members and consumers
-

6. Conclusion

This study examined the role of carer peer workers in services for BPD from the perspectives of consumers, family members, carer peer workers, and clinicians. Findings identified how carer peer workers enable family members to feel understood in their unique experiences of BPD. A carer peer worker's reciprocal approach and sharing of personal strategies and resources differentiated them from clinicians. Carer peer workers experienced benefits and challenges regarding their role, and clinicians described how their practices became more recovery-oriented through interactions with carer peer workers. Findings from this study contribute to gaps in previous research by focusing specifically on the carer peer worker role in BPD services and adding knowledge regarding benefits and challenges of the carer peer worker role and how clinician practices are altered by interacting with carer peer workers. This study highlights a need for greater systemic support of carer peer workers, including more training and supervision opportunities for carer peer workers. Future research may investigate how combining clinical intervention and carer peer support for family members with lived experience of BPD can enhance family member wellbeing.

Data Availability

Data from the current study will not be made available, as participants did not consent for their transcripts to be publicly released. Extracts of participant responses have been made available within the article.

Additional Points

What Is Known about This Topic. (i) Carer peer workers can provide emotional and informational support to family members supporting consumers with mental health problems. (ii) Group programs facilitated by carer peer workers may improve stress and relationships for family members supporting consumers with borderline personality disorder (BPD). *What the Paper Adds to Existing Knowledge.* (i) By interacting with carer peer workers, family members felt understood in their unique experiences of caring for a consumer with BPD. (ii) Clinicians who worked alongside carer peer workers altered their practice to be more sensitive towards consumers with BPD and their family members.

Disclosure

This study was completed as part of Karlen Barr's PhD thesis.

Conflicts of Interest

The authors declare that they have no conflicts of interest.

Acknowledgments

The authors would like to acknowledge the people with lived experience who participated in this study. KRB was supported by the Australian Government Research Training Program Scholarship. BFSG receives funding from NSW Ministry of Health for the Project Air Strategy for Personality Disorders. Open-access publishing was facilitated by University of Wollongong, as part of the Wiley-University of Wollongong agreement via the Council of Australian University Librarians.

References

- [1] L. Davidson, M. Chinman, D. Sells, and M. Rowe, "Peer support among adults with serious mental illness: a report from the field," *Schizophrenia Bulletin*, vol. 32, no. 3, pp. 443–450, 2005.
- [2] A. C. Stratford, M. Halpin, K. Phillips et al., "The growth of peer support: an international charter," *Journal of Mental Health*, vol. 28, pp. 627–632, 2017.
- [3] Peer Work Hub, "What is peer work?" 2019, <http://peerworkhub.com.au/what-is-peer-work/>.
- [4] S. Gillard, R. Foster, S. Gibson, L. Goldsmith, J. Marks, and S. White, "Describing a principles-based approach to developing and evaluating peer worker roles as peer support moves into mainstream mental health services," *Mental Health and Social Inclusion*, vol. 21, no. 3, pp. 133–143, 2017.
- [5] M. Slade, M. Amering, M. Farkas et al., "Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems," *World Psychiatry*, vol. 13, no. 1, pp. 12–20, 2014.
- [6] N. Jacobson, L. Trojanowski, and C. S. Dewa, "What do peer support workers do? A job description," *BMC Health Services Research*, vol. 12, pp. 205–211, 2012.
- [7] B. Visa and C. Harvey, "Mental health carers' experiences of an Australian Carer Peer Support program: tailoring supports to carers' needs," *Health and Social Care in the Community*, vol. 27, no. 3, pp. 729–739, 2018.
- [8] K. R. Barr, M. Jewell, M. L. Townsend, and B. F. S. Grenyer, "Living with personality disorder and seeking mental health treatment: patients and family members reflect on their experiences," *Borderline Personality Disorder and Emotion Dysregulation*, vol. 7, no. 1, pp. 21–11, 2020.
- [9] B. K. Brightman, "Peer support and education in the comprehensive care of patients with borderline personality disorder," *Psychiatric Hospital*, vol. 23, no. 2, pp. 55–59, 1992.
- [10] K. R. Barr, M. L. Townsend, and B. F. S. Grenyer, "Using peer workers with lived experience to support the treatment of

- borderline personality disorder: a qualitative study of consumer, carer and clinician perspectives,” *Borderline Personality Disorder and Emotion Dysregulation*, vol. 7, no. 1, pp. 20–14, 2020.
- [11] A. J. King and M. B. Simmons, “A systematic review of the attributes and outcomes of peer work and guidelines for reporting studies of peer interventions,” *Psychiatric Services*, vol. 69, no. 9, pp. 961–977, 2018.
 - [12] B. Lloyd-Evans, E. Mayo-Wilson, B. Harrison et al., “A systematic review and meta-analysis of randomised controlled trials of peer support for people with severe mental illness,” *BMC Psychiatry*, vol. 14, no. 1, pp. 39–12, 2014.
 - [13] C. Winsper, A. Bilgin, A. Thompson et al., “The prevalence of personality disorders in the community: a global systematic review and meta-analysis,” *The British Journal of Psychiatry*, vol. 216, no. 2, pp. 69–78, 2019.
 - [14] B. F. S. Grenyer, “Improved prognosis for borderline personality disorder,” *Medical Journal of Australia*, vol. 198, no. 9, pp. 464–465, 2013.
 - [15] M. I. Korzekwa, P. F. Dell, P. S. Links, L. Thabane, and S. P. Webb, “Estimating the prevalence of borderline personality disorder in psychiatric outpatients using a two-phase procedure,” *Comprehensive Psychiatry*, vol. 49, no. 4, pp. 380–386, 2008.
 - [16] R. C. Bailey and B. F. S. Grenyer, “Supporting a person with personality disorder: a study of carer burden and well-being,” *Journal of Personality Disorders*, vol. 28, no. 6, pp. 796–809, 2014.
 - [17] E. Dunne and B. Rogers, “It’s us that have to deal with it seven days a week”: carers and borderline personality disorder,” *Community Mental Health Journal*, vol. 49, no. 6, pp. 643–648, 2013.
 - [18] E. Lamont and G. L. Dickens, “Mental health services, care provision, and professional support for people diagnosed with borderline personality disorder: systematic review of service-user, family, and carer perspectives,” *Journal of Mental Health*, vol. 30, no. 5, pp. 619–633, 2019.
 - [19] A. Javed and H. Herrman, “Involving patients, carers and families: an international perspective on emerging priorities,” *BJPsych International*, vol. 14, no. 1, pp. 1–4, 2017.
 - [20] E. Kuipers, J. Onwumere, and P. Bebbington, “Cognitive model of caregiving in psychosis,” *British Journal of Psychiatry*, vol. 196, no. 4, pp. 259–265, 2010.
 - [21] L. Wonders, A. Honey, and N. Hancock, “Family inclusion in mental health service planning and delivery: consumers’ perspectives,” *Community Mental Health Journal*, vol. 55, no. 2, pp. 318–330, 2019.
 - [22] D. Flynn, M. Kells, M. Joyce et al., “Family Connections versus optimised treatment-as-usual for family members of individuals with borderline personality disorder: non-randomised controlled study,” *Borderline Personality Disorder and Emotion Dysregulation*, vol. 4, no. 1, pp. 18–19, 2017.
 - [23] B. F. S. Grenyer, R. C. Bailey, K. L. Lewis, M. Matthias, T. Garretty, and A. Bickerton, “A randomized controlled trial of group psychoeducation for carers of persons with borderline personality disorder,” *Journal of Personality Disorders*, vol. 32, pp. 1–15, 2018.
 - [24] R. Sutherland, J. Baker, and S. Prince, “Support, interventions and outcomes for families/carers of people with borderline personality disorder: a systematic review,” *Personality and Mental Health*, vol. 14, no. 2, pp. 199–214, 2020.
 - [25] J. R. Stephens, J. Farhall, S. Farnan, and K. M. Ratcliff, “An evaluation of Well Ways, a family education programme for carers of people with a mental illness,” *Australian and New Zealand Journal of Psychiatry*, vol. 45, no. 1, pp. 45–53, 2011.
 - [26] K. R. Barr, M. L. Townsend, and B. F. S. Grenyer, “Peer support for consumers with borderline personality disorder: a qualitative study,” *Advances in Mental Health*, vol. 20, no. 1, pp. 74–85, 2021.
 - [27] G. S. Moran, Z. Russinova, V. Gidugu, J. Y. Yim, and C. Sprague, “Benefits and mechanisms of recovery among peer providers with psychiatric illnesses,” *Qualitative Health Research*, vol. 22, no. 3, pp. 304–319, 2012.
 - [28] L. Byrne, C. Roper, B. Happell, and K. Reid-Searl, “The stigma of identifying as having a lived experience runs before me: challenges for lived experience roles,” *Journal of Mental Health*, vol. 28, no. 3, pp. 260–266, 2019.
 - [29] I. Otte, A. Werning, A. Nossek, J. Vollmann, G. Juckel, and J. Gather, “Challenges faced by peer support workers during the integration into hospital-based mental health-care teams: results from a qualitative interview study,” *International Journal of Social Psychiatry*, vol. 66, no. 3, pp. 263–269, 2020.
 - [30] L. Byrne, H. Roennfeldt, P. O’Shea, and F. Macdonald, “Taking a gamble for high rewards? Management perspectives on the value of mental health peer workers,” *International Journal of Environmental Research and Public Health*, vol. 15, no. 4, pp. 746–812, 2018.
 - [31] J. Hurley, A. Cashin, J. Mills, M. Hutchinson, D. Kozlowski, and I. Graham, “Qualitative study of peer workers within the ‘Partners in Recovery’ programme in regional Australia,” *International Journal of Mental Health Nursing*, vol. 27, no. 1, pp. 187–195, 2018.
 - [32] M. C. Zanarini, A. A. Vujanovic, E. A. Parachini, J. L. Boulanger, F. R. Frankenburg, and J. Hennen, “A screening measure for BPD: the McLean screening instrument for borderline personality disorder (MSI-BPD),” *Journal of Personality Disorders*, vol. 17, no. 6, pp. 568–573, 2003.
 - [33] S. Gillard, “Peer support in mental health services: where is the research taking us, and do we want to go there?” *Journal of Mental Health*, vol. 28, no. 4, pp. 341–344, 2019.
 - [34] L. Bixo, J. L. Cunningham, L. Ekselius, C. Öster, and M. Ramklint, “‘Sick and tired’: patients reported reasons for not participating in clinical psychiatric research,” *Health Expectations*, vol. 24, no. 1, pp. 20–29, 2021.
 - [35] M. Oates, K. Crichton, L. Cranor et al., “Audio, video, chat, email, or survey: how much does online interview mode matter?” *PLoS One*, vol. 17, no. 2, Article ID e0263876, 2022.
 - [36] S. Gillard, “Introducing peer workers into mental health services: An organisational toolkit,” *Comparative Study*, vol. 42, pp. 1–25, 2015.
 - [37] H. Reidy and M. Webber, *Evaluation of the Peer Support Scheme in Southwark*, King’s College London/University of York, London, UK, 2013.
 - [38] P. Leavy, *The Oxford Handbook of Qualitative Research*, Oxford University Press, Oxford, UK, 2014, <http://ezproxy.uow.edu.au/login?url=https://search.ebscohost.com/login.aspx?direct=true&db=catt03332a&AN=uow.b3038262&site=eds-live>.
 - [39] D. Galasiński, “No mental health research without qualitative research,” *The Lancet Psychiatry*, vol. 8, no. 4, pp. 266–267, 2021.
 - [40] D. Byrne, “A worked example of Braun and Clarke’s approach to reflexive thematic analysis,” *Quality and Quantity*, vol. 56, no. 3, pp. 1391–1412, 2022.
 - [41] J. W. Creswell and J. D. Creswell, *Research Design: Qualitative, Quantitative, and Mixed Methods Approaches*, SAGE Publications, Inc, Washington, DC, USA, 5th edition, 2018.

- [42] T. A. Schwandt, "Three epistemological stances for qualitative inquiry: interpretivism, hermeneutics, and social constructivism," in *Handbook of Qualitative Research*, N. K. Denzin and Y. S. Lincoln, Eds., Sage Publications, Washington, DC, USA, 2nd edition, 2000.
- [43] V. Braun, V. Clarke, N. Hayfield, and G. Terry, "Thematic analysis," in *Handbook of Research Methods in Health Social Sciences*, P. Liamputtong, Ed., Springer Singapore, Singapore, 2019.
- [44] QSR International Pty Ltd, "NVivo 12," 2020, <https://www.qsrinternational.com/nvivo/nvivo-products/nvivo-12-plus>.
- [45] R. K. Yin and D. T. Campbell, *Case Study Research and Applications: Design and Methods*, SAGE Publications, Inc, Washington, DC, USA, 6th edition, 2018.
- [46] L. Pallaveshi, K. Balachandra, P. Subramanian, and A. Rudnick, "Peer-led and professional-led group interventions for people with co-occurring disorders: a qualitative study," *Community Mental Health Journal*, vol. 50, no. 4, pp. 388–394, 2014.
- [47] D. Ring and S. Lawn, "Stigma perpetuation at the interface of mental health care: a review to compare patient and clinician perspectives of stigma and borderline personality disorder," *Journal of Mental Health*, vol. 12, pp. 1–21, 2019.
- [48] J. Sun, X. Yin, C. Li, W. Liu, and H. Sun, "Stigma and peer-led interventions: a systematic review and meta-analysis," *Frontiers in Psychiatry*, vol. 13, Article ID 915617, 2022.
- [49] N. A. L. Myers, Y. Alolayan, K. Smith et al., "A potential role for family members in mental health care delivery: the family community navigation specialist," *Psychiatric Services*, vol. 66, no. 6, pp. 653–655, 2015.
- [50] I. Skärsäter, B. Keogh, L. Doyle et al., "Advancing the knowledge, skills and attitudes of mental health nurses working with families and caregivers: a critical review of the literature," *Nurse Education in Practice*, vol. 32, pp. 138–146, 2018.
- [51] J. K. Davis and S. I. Pilgrim, "Maximizing utilization of peer specialists in community mental health: the next step in implementation," *Journal of Psychosocial Rehabilitation and Mental Health*, vol. 2, no. 1, pp. 67–74, 2015.
- [52] M. A. Levasseur, M. Ferrari, S. McIlwaine, and S. N. Iyer, "Peer-driven family support services in the context of first-episode psychosis: participant perceptions from a Canadian early intervention programme," *Early Intervention in Psychiatry*, vol. 13, no. 2, pp. 335–341, 2019.
- [53] J. Schiffman, G. M. Reeves, E. Kline et al., "Outcomes of a family peer education program for families of youth and adults with mental illness," *International Journal of Mental Health*, vol. 44, no. 4, pp. 303–315, 2015.
- [54] A. M. Chanen and K. Nicol, "Five failures and five challenges for prevention and early intervention for personality disorder," *Current Opinion in Psychology*, vol. 37, pp. 134–138, 2021.
- [55] J. Vandewalle, B. Debyser, D. Beeckman, T. Vandecasteele, A. Van Hecke, and S. Verhaeghe, "Peer workers' perceptions and experiences of barriers to implementation of peer worker roles in mental health services: a literature review," *International Journal of Nursing Studies*, vol. 60, pp. 234–250, 2016.
- [56] G. S. Moran, Z. Russinova, V. Gidugu, and C. Gagne, "Challenges experienced by paid peer providers in mental health recovery: a qualitative study," *Community Mental Health Journal*, vol. 49, no. 3, pp. 281–291, 2013.
- [57] J. Chisholm and M. Petrakis, "Peer worker perspectives on their potential role in the success of implementing recovery-oriented practice in a clinical mental health setting," *Journal of Evidence-Based Social Work*, vol. 17, no. 3, pp. 300–316, 2020.
- [58] A. Geddes, C. Parker, and S. Scott, "When the snowball fails to roll and the use of 'horizontal' networking in qualitative social research," *International Journal of Social Research Methodology*, vol. 21, no. 3, pp. 347–358, 2018.
- [59] E. Bodner, S. Cohen-Fridel, and I. Iancu, "Staff attitudes toward patients with borderline personality disorder," *Comprehensive Psychiatry*, vol. 52, no. 5, pp. 548–555, 2011.
- [60] J. Omona, "Sampling in qualitative research: improving the quality of research outcomes in higher education," *Makerere Journal of Higher Education*, vol. 4, no. 2, pp. 169–185, 2013.
- [61] L. Busetto, W. Wick, and C. Gumbinger, "How to use and assess qualitative research methods," *Neurological Research and Practice*, vol. 2, no. 1, p. 14, 2020.