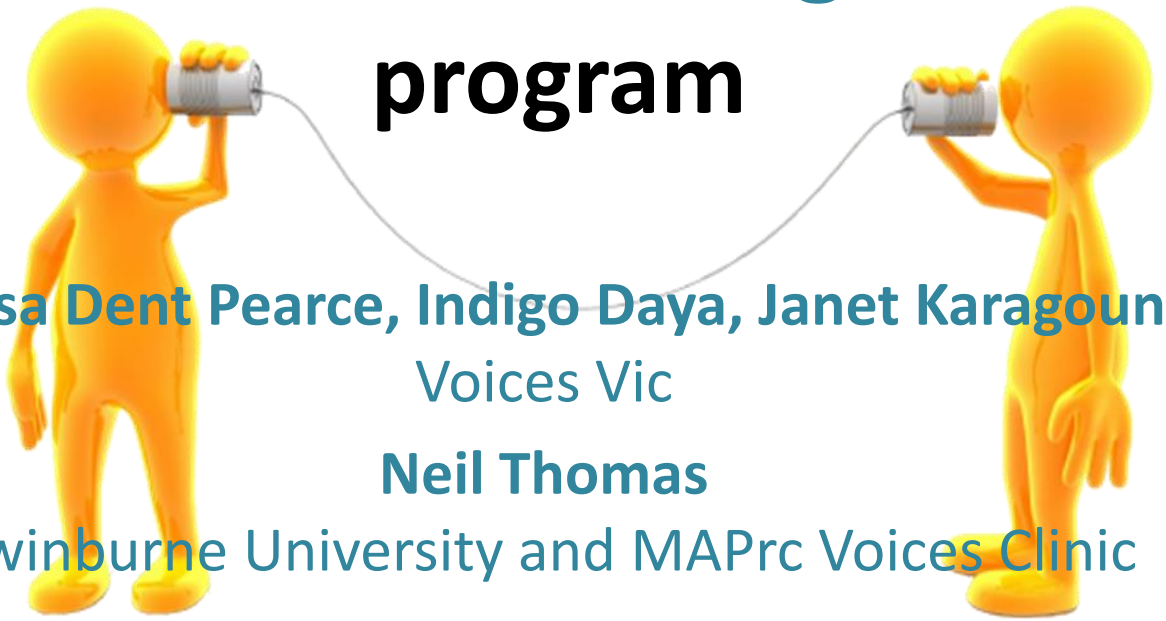
Integrating peer work with a specific therapeutic target: Experiences from the Voice Exchange program



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Background

- Contact with peers advocated within the Hearing Voices Movement as helpful in promote recovery in voice hearers (Corstens et al., 2014)
  - Mainly in form of hearing voices groups
  - One-to-one peer support has evolved in places where peer expertise is well developed
- However:
  - No clear framework for integrating one-to-one peer support with work on voices
  - Outcome research on one-to-one peer support has involved targeting recovery broadly, rather than with a specific focus such as hearing voices (Lloyd-Evans et al., 2014)

The Voice Exchange program

- Collaborative 2-year project between Voices Vic and local research expertise in psychosocial intervention trialing and hearing voices

- Intervention framework
  - 12 x 1 hour weekly sessions with one of two peer workers
  - Peer workers had lived experience of hearing voices
  - Manualised, regular group supervision with both peer worker and clinical psychologist

- Conducted as a pilot randomised controlled trial:
  - Independent assessments of subjective experience of voices and personal recovery pre- and post-intervention
  - Random allocation: 50% peer work / 50% waiting list
  - 25 participants received peer work

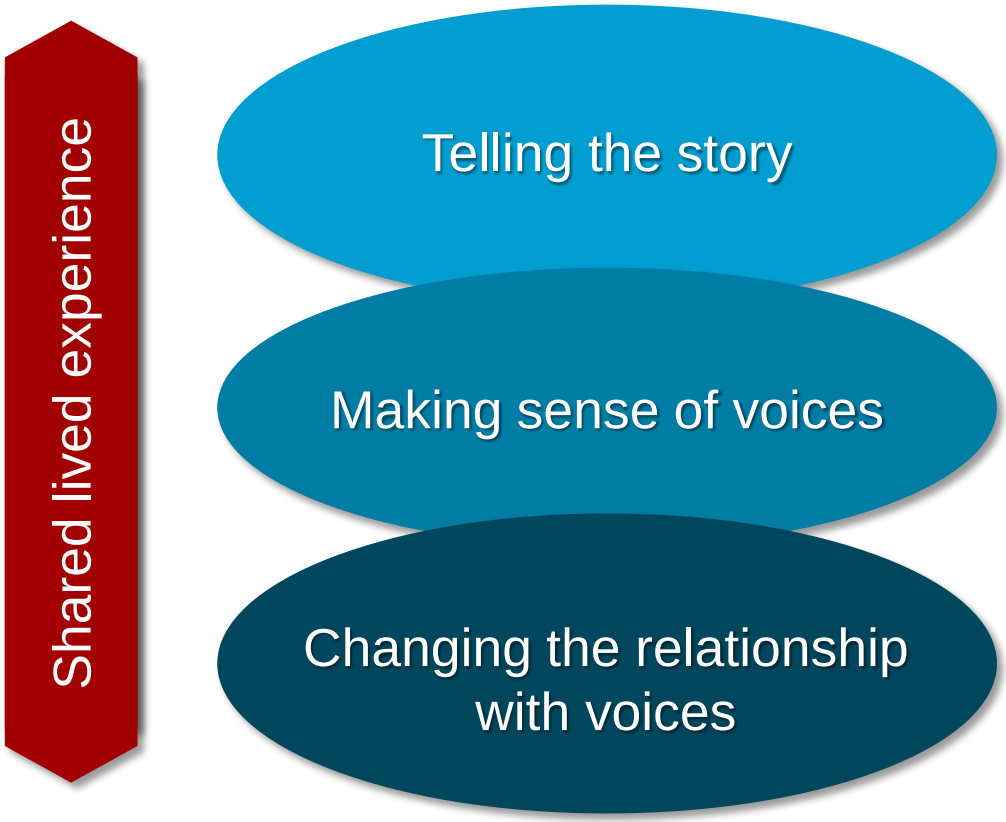
Starting point: the Hearing Voices Movement

Some key principles of the Hearing Voices Movement

- Hearing voices can be understood as a natural part of human experience
- Diverse explanations are accepted for the origins of voices
- Voice-hearers are encouraged to take ownership of their experiences and define it for themselves
- Voice-hearing can be interpreted and understood in the context of life events and interpersonal narratives
- A process of understanding and accepting one's voices may be more helpful for recovery than continual suppression and avoidance
- Peer support and collaboration is empowering and beneficial for recovery

Corstens, Longden, McCarthy-Jones, Waddingham & Thomas (2014).
Schizophrenia Bulletin, *40* (suppl.4), S285-294

Development of a peer-work framework for voices

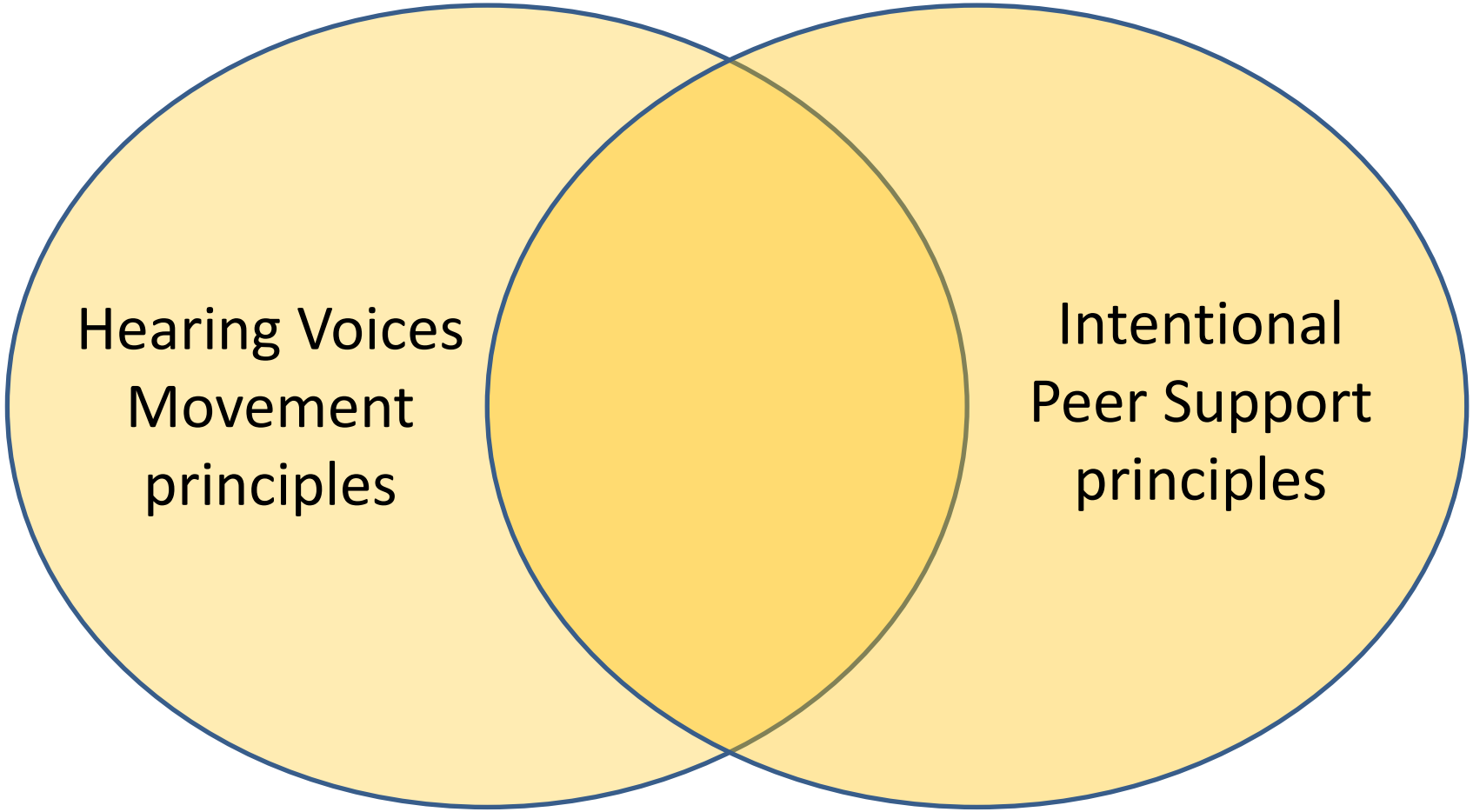


Discussing life history, establishing a context for emergence of voices

Development of a deeper understanding of voice characteristics, phenomenology, content, identities

Promote empowered and accepting relationship with voices

Integrating with the peer relationship



What is IPS?

- IPS was developed by peer support workers Shery Meade and Chris Hanson as a framework to describe their practice of working with peers.

- Intentional peer support is not a friendship, nor is a clinical therapeutic relationship; it falls somewhere between the two….

How is IPS different?

Clinical therapy	Intentional peer support
Therapist is an expert by qualifications	Both peers are expert by experience
Symptom-based and uses diagnoses	Experience-based and does not use diagnoses
One-sided disclosure	Intentional disclosure (talking honestly but with a purpose to learn)
Person has the problem, therapist doesn't	Both peers share and "own" their problems in the context of the relationship

How is IPS different?

Clinical therapy	Intentional peer support
Unbiased, neutral attitude towards person	Empathy based on lived experience for peer
Contained and controlled (e.g. assessing safety and risk)	Partially controlled by both people (e.g. safety is negotiated between peers)
Often rigid boundaries defined by clinician (e.g. no touching or socialising)	Boundaries are negotiated to suit both people
Formal etiquette	Negotiated etiquette

Learning vs helping examples

- Client as “detective”, worker as “sidekick”
- Investigating together things that are of interest (e.g. quantum theory)
- Drawing mind-maps/time-lines together
- Jointly doing exercises (e.g. “Russian dolls” and “personality maps”)
- Peer worker shares their own insights and experiences along the way

Mutuality

Power Imbalance	a. Named power imbalance (1%) b. Co-wrote notes (60%) c. Reframed diagnosis/symptom as life experience (42%)
Reciprocity	a. Shared how I felt (14%) b. Allowed participant to help me / give back (16%) c. Co-engaged in session activities (50%) d. Disclosed my story(41%)
Mutual responsibility / collaboration	a. Negotiated safety issues (10%) b. Negotiated boundaries (3%) c. Owned my mistakes (4%) d. Encouraged client to do out-of-session work (62%) e. Encouraged client to contribute ideas (35%) f. Asked client to evaluate progress (30%)

Mutuality Examples

- Collaborative case notes
- Collaborative work
- Collaborative record-keeping
- Collaborative safety plan
- Peer worker disclosing own story and/or feelings

Opportunities and challenges

- Opportunities
  - Rapport and engagement
  - Increased empathy from shared lived experience
  - Modelling of recovery and acceptance of voices

- Challenges
  - Fitting collaborative agenda with a focused 12-session voice-focused framework
  - Maintaining boundaries
  - More in-depth work with a specific focus potentially more complex/demanding of peer worker skill and experience

Thank you

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