International Journal of Mental Health Promotion
DOI:10.32604/IJMHP.2020.013279
Article

Tech Science Press

Embracing and Growing as a Peer Support Provider: An Analysis of Participants' Experience in a Peer Support Program Based on the Recovery Model of Mental Illness

Su Yeon Kim[1], Kyung Mi Lim[2], Soo Jin Kim[3], Go-Un Kim[4] and Boyoung Kim[5,*]

[1]College of Nursing, Chonnam National University, Gwangju, 61469, South Korea
[2]John Village, Gwangju, 61469, South Korea
[3]College of Nursing, Chonnam National University, Gwangju, 61469, South Korea
[4]College of Nursing, Yonsei University, Seoul, 03722, South Korea
[5]College of Nursing, Institute of Health Sciences, Gyeongsang National University, Gyeongnam, 52727, South Korea
*Corresponding Author: Boyoung Kim. Email: bkimjhu@gmail.com
Received: 31 July 2020; Accepted: 28 September 2020

Abstract: Peer support is an important factor in the recovery of persons with mental illness. Most studies have focused on the effects of peer support programs on participants rather than on the process of mental health recovery. This study was a qualitative analysis of the experience of participants in a peer support provider program based on the recovery model of mental illness in Korean communities. The participants were recruited through flyers, and interested candidates were screened to determine whether they met the eligibility criteria. The total number of participants in individual interviews was 10, comprising 5 males and 5 females. The participants' age range was 20 years to 50 years, and schizophrenia was the most common diagnosis. By applying the six-step content analysis method by Braun and Clarke, this study extracted 140 meaningful statements, from which 20 sub-themes, 7 subcategories, and 3 categories were derived. The core theme of participants' experience was embracing and growing as a peer support provider as part of recovery progress by aspiring a peer support provider, positively accepting illness, and engaging in a meaningful role in the community. The participants expressed their emotions by sharing their experiences; they recognized the possibility of recovery from powerlessness and despair and learned to play a vital role as a member of the community.

Keywords: Mental health; peer; recovery; models; qualitative research

1 Introduction

Peer support activity involves participation of people with mental illness in the role of providing services for other individuals with mental illness [1]. Different terms such as self-help group, support group, or mentoring [2] are used to describe peer support initiatives. In general, peer support activities can be divided into self-help groups, internet support groups, peer services, peer management services, peer partnerships, and party employees [3]. Support groups created as part of community mental health development have proven to be an instrumental support system for persons with severe mental disorders.

This work is licensed under a Creative Commons Attribution 4.0 International License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original work is properly cited.

Community support systems have facilitated peer support and peer service provision as well as the development and expansion of official and unofficial resource systems [4].

In particular, with the introduction of the recovery model paradigm in the mental health care field, there has been an emphasis on the process of leading a self-satisfied life despite the illness and the severity of its symptoms [5]. Recovery is a process through which mental health symptoms improve and functioning becomes restored, thus improving life [6]. The recovery model for people with mental illness explains that the process of gaining empowerment is the key to recovery through factors such as social support, bonds, and skills [7]. Peer support services are important because they do not focus on the severity of the mental illness or the number of functions [8]. Peers sharing their experiences of recovering from severe emotional pain and facing stigma, and thereby becoming role models is an important factor for raising hope and empowerment among members of the peer support group [9]. These activities not only affect recovery from the disease, but emphasize recovery as a process, which seems to have a positive effect on people experiencing and suffering from mental illness [10]. In other words, a peer support service based on the recovery model of mental illness aims to overcome disabilities and create a meaningful life by adjusting attitudes, emotions, perceptions, beliefs, roles, and goals to achieve one's purpose in life despite the persistent symptoms and challenges [11].

With the launch of a support project by Korea's Seoul Chamber of Commerce in 2008, rehabilitation facilities began to actively provide peer support services [12]. Further, the Mental Health Promotion Center, together with the Korea Disabled Employment Service, conducted a project to promote the employment of people with mental disabilities by developing work opportunities. For this purpose, people with mental disorders, who wished to support their colleagues were recruited, and they have been working in a mental health institute since September 2013 [13].

In the United States, there are centers where people with mental disorders work as counselors. The government supports most expenses for fellow counseling education, and several peer counseling projects for the differently abled are underway. In addition, the issuance of certificates related to peer counseling education has been rapidly increasing, and peer counseling has grown widely [14]. Japan considers people with disabilities who start with the Human Care Association and are currently working as fellow counselors [15]. Peer support counseling in the United States focuses on mental health and self-reliance aspects, while in Japan the focus is on human rights and self-reliance aspects. The United States has strong laws, and the level of welfare and support for the differently abled is relatively high, but this is not true in Korea [16]. The US has implemented powerful laws and welfare systems to provide support to the disabled. Therefore, there is a need to consider the legal system and cultural context to implement such a system in Korea. The recovery model emphasized in Korea can be said to be in the initial stage of service interdependence and mutual support of the parties concerned [17]. Previous studies have analyzed the quantitative aspects of peer support programs, which is possibly limited to explaining the qualitative progress of the recovery experience through peer support activities. Qualitative research on the application of peer support programs in the Korean situation and related experiences are yet to be conducted. Therefore, a qualitative study on the recovery process is needed to examine what they experience during their peer support program participation. The results of this study provided a qualitative analysis that can directly assess the participants' experiences, which can further help to expand and develop the peer support program based on the recovery model.

2 Methods

2.1 Study Design, Setting, and Sample

This qualitative study was conducted to explore the experience of participants in a peer support program based on the recovery model of mental illness.

Participants were recruited through flyers, and interested candidates were screened to determine whether they met the eligibility criteria. The inclusion criteria included regular visits to the psychiatric outpatient clinic, the ability to self-administer prescribed medicines, Global Assessment Function (GAF) scores of 71 or higher, those who have no social or occupational difficulties, and those with basic computer skills, self-management skills, and communication with others as peer supporters. Based on a study by Fugard et al. [18], the sample size of this study was set to 10 participants (5 males and 5 females) who agreed to attend individual interviews (Tab. 1).

Table 1: General characteristics of the participants

Characteristic	Value
Age (y)	
Mean ± SD	40.20 ± 10.05
Unmarried n(%)	10(100)
Education n(%)	
Middle school	1(10)
High school	3(30)
University	6(60)
Diagnosis n(%)	
Schizophrenia	5(50)
Schizoaffective	1(10)
Bipolar	2(20)
Depression	2(20)
Length of time in disease (y)	10.19 ± 7.16

The recovery model involves peers sharing their experiences of recovering from severe emotional pain and becoming role models [7]. The recovery model-based peer support program in this study is based on these goals. The program comprised education, practice, and peer supporter activities. In accordance with the programs developed by the Mental Health Promotion Center [19] and Korea Disabled Employment Service [20], the program in this study was revised and supplemented based on the recovery theory. The program consisted of nine sessions of three hours each, divided into theoretical education and practice. Theoretical education sessions were delivered by mental health experts as well as the present researchers on job-related contents, including the meaning and role of peer supporters, training on peer counseling skills, and crisis intervention skills. In practice sessions, the participants were divided into counselors and clients for simulation training on home visit, work visit, and independent housing resident counseling. After the end of the program, the participants worked as peer supporters three times. The content validity of this program was reviewed by three experts (two nursing professors and one mental health nurse) in terms of goals, contents, composition, duration, and appropriateness of educational methods and evaluation tools. As a result of calculating the content validity coefficient for each item, the range for each item was 0.80~1.00.

They were asked the following questions (Tab. 2). The interviews were conducted inside a personal counseling room using semi-structured and open questions. Each participant was interviewed two to three times, with each session lasting 60 minutes to 90 minutes. The first interview focused on building

rapport, the second consisted of semi-structured and open questions, and more interviews were conducted when answers to additional questions were needed. In the process of collecting and analyzing the data, the interview ended when new categories did not appear, and theoretical saturation was deemed to have occurred.

Table 2: Interview questionnaire

	Question contents
Introduction	What motivated you to join the peer support provider program?
Main question	What did you experience after serving as a provider? What new experiences did you get from the peer support provider program?
Final question	How did this experience affect your life? How was your interview?

2.2 Data Analysis

The general characteristics of the sample were analyzed using descriptive statistics, including frequency, percentage, and mean values. In the qualitative analysis, the categories were inductively derived through a series of coding processes for conceptual abstraction, and analyzed according to the 6-step thematic analysis method of Braun et al. [21]. In Step 1, two coders highlighted words or sentences that indicated the key statements and metaphorical expressions used by the participants. In addition, the two coders independently developed a primary coding book for meaningful words, sentences, and paragraphs through line-by-line analysis. In Step 2, open coding was performed while comparing and reviewing the consistency of the coding vocabulary, and the similarities and differences of expression. The two coders extracted 140 codes for each content. In Step 3, the researchers searched for themes by grouping each code into similar concepts and examining if they matched the themes, followed by comparing how the themes were conceptualized and interconnected. To measure the reliability of this study, the coefficient of agreement was derived and verified to measure the degree of consistency coded by the two coders, including the researcher. The coefficient of agreement between the two coders was about 92.8%, thus enhancing the consistency and reliability of this study, and a review was performed until meaning saturation was reached. A total of 20 sub-themes were derived through this process, and the saturation point of data was confirmed by going over the interview contents with the participants. The themes and sub-themes were reviewed by other team members for similarities and differences. Step 4 involved reviewing the themes. After extracting 140 meaningful statements, 3 categories and 7 subcategories were derived from 20 provisional themes according to common attributes. Step 5 involved clarifying and naming the themes; the researchers identified themes that were clearly distinct from others while comparing the derived themes. Two participants reviewed the final analysis results to check for any misunderstandings or misinterpretations. As a result of calculating the content analysis coefficient on a 4-point scale for the analysis by the two participants, the range for each item was 0.75~1.00. Clear definitions for any misinterpretations were made by reflecting the participants' feedback in order to name and describe the results of each theme. Step 6 was the report writing stage, in which the topics that made meaningful contributions were determined.

2.3 Ethical Consideration

This study was initiated after receiving approval (IRB No. 079-01) through the Bioethics Committee of St. John of God Hospital in order to protect the identity and privacy of the subjects. The researchers received

written consent from the participants. In addition, we explained the participants' right to confidentiality, the recording for data analysis, the confidentiality and utilization of interview results, and the possibility of withdrawal from the study.

3 Results

Tab. 1 shows the general characteristics of the participants. All participants were single, and most were middle-aged (mean [SD] = 40.20 [10.05]). More than 90% of the participants had completed high school education or higher, and had been diagnosed with a mental illness an average of 10 years previously. Six participants were diagnosed with schizophrenia, two with bipolar disorder, one with depression, and one with schizoaffective disorder. Each of the themes and sub-themes is explained in detail below (Tab. 3).

Table 3: Themes and subcategories from qualitative data analysis

Theme	Categories	Subcategories
Embracing and growing as a peer support provider	Aspiring a peer support provider	Self-reflection Experiencing positive effects through sharing Meeting a role model
	Positive acceptance of illness	Empathy treatment providers Becoming sensitive toward family's members
	Engaging in meaningful roles in the community	Hoping to helping Peers Concern about social issues

3.1 Aspiring Peer Support Provider

3.1.1 Self-Reflection

Participants saw their own vulnerabilities and shortcomings in the people they met during the program. At first, they were not willing to acknowledge their weaknesses, but eventually they did self-reflection. They confirmed that they were gradually changing as the program continued and felt they were headed in a good direction.

"I felt like I was looking at myself in the mirror. I was repulsed at first, but I became comfortable by acknowledging my weaknesses." (Participant 3)

"I did self-reflection on my way home from time to time. I realized it was time to acknowledge my shortcomings and accept myself as I am." (Participant 7)

"I was shy and complained about the smallest things. Through the program, I started to open up and tried to reach out to other people first. Over time, I felt stronger than before, and I realized I had to change myself first in order to work with my colleagues." (Participant 4)

3.1.2 Experiencing Positive Effects Through Sharing

Participants perceived their experience of suffering from mental illness negatively, but they felt healed after sharing their experiences with patients from other institutions. In addition, they were also able to learn and care for each other through peer relationships and achieved their goals with a sense of belonging. These results showed that psychological change occurred within the individual after sharing his/her experiences.

"Before this program, I was only a mentally handicapped person who was stigmatized in society. After visiting a different institution and sharing my experiences, I felt a special connection." (Participant 1)

"I talked to other patients about the difficulties of suffering from a mental illness and told them how I overcame hardship. They asked me for advice, and I got a sense of satisfaction by answering them." (Participant 2)

3.1.3 Meeting a Role Model

Before joining the program, the participants regarded mental illness education as a formality, but after attending the lectures of other colleagues and observing the activities, they felt inspired and wanted to be mentored by their role model.

"*I have had training from therapists, but this was the first time I trained with people with mental disabilities. When I heard his story, I was motivated, and I wanted to change. He became my mentor." (Participant 3)*

"I was envious when I watched them acting as peer supporters in another community service. I wanted to experience the same recovery." (Participant 9)

3.2 Positive Acceptance of Illness

3.2.1 Empathy with Treatment Providers

Close relationship with specialists was necessary for the management of their own symptoms, acceptance of illness, maintenance of daily functions, and maintenance and self-management of diseases. Participants expressed gratitude toward their therapists and reflected on how they had focused on their own difficulties, before joining the program. The change in the attitude of the participants toward treatment providers, who offered psychological and emotional comfort, may have helped to counter the negative perception of their illness.

"I learned about the challenges faced by my therapists. As I tried listening to others and encouraging them, I realized how much I had been helped." (Participant 7)

"I was able to look at psychiatric illnesses more objectively while making a home visit and adopting the view of a therapist. After that I could understand the encouragement and advice given by my counselors." (Participant 2)

3.2.2 Becoming Sensitive Toward Family's Members

Families interact most closely with participants and have a significant impact on the whole process of treatment and recovery. The family of a person suffering from mental illness not only protects and cares, but also provides the much needed emotional and economic support. However, before the program began, the participants were resentful of their parents and blamed them for their illness. After attending the program, they felt sorry for their past behavior and tried to be more empathetic toward their family members during any conflict.

"I blamed my parents for my mental illness. I had a better understanding and became less resentful after the program." (Participant 6)

"I felt sorry for my parents. My parents have supported me all along, and I realized how fortunate I was to have them by my side." (Participant 8)

3.3 Engaging in Meaningful Roles in the Community

3.3.1 Hoping to Helping Peers

Participants said that they had dreamed of escaping from the pain of illness, planning their future, and becoming a part of the community. Despite the limitations due to the disease, they were able to strengthen their abilities to lead fulfilling lives and actively participated as members of the community. Therefore, hope

is an essential element in recognizing the possibilities of recovery from the sense of powerlessness and despair that comes from the stigma and prejudices associated with mental illnesses.

"*I want to share the pain of mental illness with others. I want to give back what I have received so far so that I can take the next step forward. I wanted to gain professional knowledge in counseling and practice it." (Participant 4)*

"I was thinking about what role to play in society while participating in the program. I would like to get a driver's license and participate in home visits." (Participant 8)

3.3.2 Concern About Social Issues

Participants focused on their own difficulties before joining the program and did not show any enthusiasm toward any of the services. However, after the program, they began to worry about the overall system of national support, such as human rights, work life, and home visiting services. They said that they were not excluded from society and were able to recognize themselves as integral members. Participants were able to perform appropriate social functions and played a meaningful role in daily life.

"I think we need a national support system for people with mental disabilities. I feel it is necessary for the mentally handicapped to live independently and to be able to work after getting employed." (Participant 1)

"I think that education for mental illness is necessary for the general public because of the social prejudice against persons with mental disabilities. I thought about what we can do to make the world free from discriminations on the basis of mental disabilities." (Participant 8)

3.4 Theme: Embracing and Growing as Peer Support Providers

Participants seemed to feel guilty about mental illness before joining the program, but they gained confidence after completing each course successfully. The participants had received assistance from various volunteers, but for the first time they were helping others. They played the role of an assistant, helping and encouraging others. They were fully capable of becoming valued members of society. In other words, they discovered their potential and developed self-growth. This experience was in line with their subjective belief that they could recover.

"I was having a hard time preparing for the lecture. However, I did my best, and after I finished all the courses, I was filled with confidence." (Participant 3)

"Being ill is not a sin. I feel like I am a diamond in the rough, and I can succeed as long as I work hard." (Participant 5)

4 Discussion

This study aimed to describe the experiences of people with mental disorders in a Korean community, who had participated in a peer support provider program based on the mental health recovery model. The core theme of the participants' experience was "embracing and growing as a peer support provider." The three sub-themes were "aspiring a peer support provider," "positive acceptance of illness," and "engaging in meaningful roles in the community". In this study, the participants experienced various types of personal growth, developed a better understanding of their mental illness, and gained motivation to achieve their goals in life. The findings of this study have several implications in supporting the recovery of mental health patients in the Korean community.

It is important to share information on mental illnesses through peer support activities. Peer support activities were effective in helping people accept mental illness in a positive manner. The participants with mental disorder acted as professional counselors, which allowed them to experience the process of mental health recovery by expressing their emotions and talking about their experiences [22,23]. This was similar to the results reported in previous research on peer support program experiences. These activities

were essential for the participants to develop a positive view of the program. The relationship between mental illness and peer support activity was investigated by the mirror effect, and those with good interpersonal relations were able to report on their capacity, limit, and potential more objectively [23]. The discovery of new values and attaining growth with their colleagues in a new role could be seen as part of the recovery process.

The participants received positive support through close ties with their peers and experts, and this can be seen as a significant advantage of a peer support program. They were able to understand their treatment providers' and family members' perspective; they could witness their recovery by performing a new role upon embracing their mental illness. For most mental patients, their sufferings aggravate as the symptoms progress into chronic mental health conditions. The participants in this study experienced positive changes in their emotional and social state after working as a service provider [24]. Their renewed determination to play a role as a member of the community and increased awareness of policies showed that they were in the recovery process. This is consistent with the results of a previous study in which the recovery process helped the subjects to actively engage in the community [25]. In addition, they gained confidence in their roles in society with the support of colleagues and shared about their lifestyle changes with others. Above all, the participants were able to live independently in the community, work in harmony with other members, and pursue their own advocacy or interests. In other words, the participants could improve their competence and confidence by helping their colleagues, after the program. These results may imply that peer support activities are indeed useful for strengthening participants' social skills in the context of mental health illness. When developing a peer support program for mental health illness, we should consider the recovery patterns.

The participants' perspectives and values changed after completing the program. Although the "engaging in meaningful roles in the community" category indicated gaining confidence in social roles, it can be realized only when stable employment is guaranteed. Previous studies have shown that individuals with positive relationships with their peers demonstrate competence in their local communities [26,27]. However, these changes did not develop until the stage of politically demanding social transformation and peer support systems in the community. This is because peer supporters are currently hired either as volunteers or as contract workers who are paid low salaries in Korea [26]. Therefore, it is necessary to establish systems for people with mental illness to encourage stability among peer supporters in Korea. In this sense, the experiences of the peer supporters in this study provide basic data to successfully establish systems related to peer supporters.

The limitations of this study are as follows. First, the samples of this study are from one area only. In future studies, potential sampling bias can be minimized by recruiting subjects who participated in peer support training programs at various institutions or regions throughout Korea. Second, this study is limited to people with mental illnesses in Korea, and thus, more such studies should be conducted in other countries to compare the findings. Third, there is a limit to diagnosing the mental illnesses of those who participate in peer support training programs. Therefore, the results of this study cannot represent all psychiatric diagnoses. Fourth, this study did not verify the therapeutic effects of the two subjects in the peer support training program. Therefore, it is necessary to expand qualitative research on the recovery experiences of people who have received these services.

Nevertheless, this study has some strengths. First, the use of triangulation strategies and participant validation ensured the reliability of the survey results. Second, this study is significant for being the first qualitative study conducted in Korea to examine the recovery process experience after participating in a peer support service training program for people with mental illness. Third, the results of this study provide insights for ways to understand peer support service providers, and how they can provide support in community mental health services during the recovery process.

5 Conclusions

This study aimed to explore the experiences of people with mental illness in a peer support program based on the community recovery model for mental health patients in Korea, using qualitative research methods. The analysis of participants' experiences revealed three categories of the recovery process. Aspiring a peer support provider, positive acceptance of illness, and engaging in meaningful role in the community. They formed the core theme of "embracing and growing as a peer support provider." In this study, the participants became aware of the possibilities of recovery from helplessness and despair caused Equations in display format are separated from the paragraphs of the text. Equations should be flushed to the left of the column.

Funding Statement: This research was supported by Basic Science Research Program through the National Research Foundation of Korea (NRF) funded by the Ministry of Education (2019R1F1A1A0057735). This work was supported by the fund of St. John of God Hospital.

Conflicts of Interest: The authors declare that they have no conflicts of interest to report regarding the present study.

References

1. Song, G. Y. (2010). The exploratory research of reducing effect on self-stigma by the peer-visiting service: A case study of Hanwool community mental health center's Dong-Haeng. *International Conference of the Korea Academy of Mental Health Social Work, 5,* 103–119.
2. Ryan, G. K., Kamuhiirwa, M., Mugisha, J., Baillie, D., Hall, C. et al. (2019). Peer support for frequent users of inpatient mental health care in Uganda: Protocol of a quasi-experimental study. *BMC Psychiatry, 19(1),* 374–386. DOI 10.1186/s12888-019-2360-8.
3. Spaniol, L., Gagne, C., Koehler, M. (1997). Recovery from serious mental illness: What it is and how to assist people in their recovery. *Continuum, 4(4),* 3–15.
4. Krogh, J., Speyer, H., Nørgaard, H. C. B., Moltke, A., Nordentoft, M. (2014). Can exercise increase fitness and reduce weight in patients with schizophrenia and depression? *Frontiers in Psychiatry, 5(10),* 89–95. DOI 10.3389/fpsyt.2014.00089.
5. Repper, J., Perkins, R. (2003). *Social inclusion and recovery: A model for mental practice*. London: Elsevier Health Sciences.
6. Ha, K. H. (2012). A study on the peer support experience of people with psychiatric disabilities. *Mental Health & Social Work, 40(3),* 175–201.
7. Woo, S. H. (2020). Empowerment experience of mentally ill persons providing peer support. *Perspectives in Nursing Science, 17(1),* 40–48. DOI 10.16952/pns.2020.17.1.40.
8. Corrigan, P., Ralph, R. (2005). *Recovery in mental illness: Broadening our understanding of wellness*. Washington, DC: American Psychological Association.
9. Jacob, K. S. (2015). Recovery model of mental illness: A complementary approach to psychiatric care. *Indian Journal of Psychological Medicine, 37(2),* 117–119. DOI 10.4103/0253-7176.155605.
10. Kim, M. Y. (2010). *A structural model of recovery among people with mental illness (Dissertation)*. Ehwa Women's University, Seoul.
11. Staples, L. H. (1990). Powerful ideas about empowerment. *Administration in Social Work, 14(2),* 29–42. DOI 10.1300/J147v14n02_03.
12. Ha, K. H. (2012). A study on the peer support experience of people with psychiatric disabilities. *Mental Health Social Work, 40(3),* 175–201.
13. Deegan, P. E. (1998). Recovery: The lived experience of rehabilitation. *Psychosocial Rehabilitation Journal, 11 (4),* 11–19. DOI 10.1037/h0099565.

14. Wade, D., Crompton, D., Howard, A., Stevens, N., Metcalf, O. (2014). Skills for psychological recovery: Evaluation of a post-disaster mental health training program. *Disaster Health, 2(3–4),* 138–145. DOI 10.1080/21665044.2015.1085625.
15. Sullivan, G., Wells, K. B., Leake, B. (1992). Clinical factors associated with better quality of life in a seriously mentally ill population. *Psychiatric Service, 43(8),* 794–798. DOI 10.1176/ps.43.8.794.
16. Jung, G. H., Chin, Y. R. (2015). The effects of an integrated health care program on the physical, psychosocial, and spiritual health of people with mental disorder in community. *Journal of Korean Academy of Community Health Nursing, 26(2),* 69–78. DOI 10.12799/jkachn.2015.26.2.69.
17. Davison, L., Strauss, J. S. (1992). Sense of self in recovery from severe mental illness. *British Journal of Medical Psychology, 65(2),* 131–145. DOI 10.1111/j.2044-8341.1992.tb01693.x.
18. Fugard, A. J. B., Potts, H. W. W. (2015). Supporting thinking on sample sizes for thematic analysis: A quantitative tool. *International Journal of Social Research Methodology, 18(6),* 669–684. DOI 10.1080/13645579.2015.1005453.
19. Son, J. H. (2017). *Peer support provider guideline for people with mentally disabled*. 2nd ed. Seoul: Seoul Mental Health Welfare Center, 52.
20. Kim, H. B., Na, E. Y., Lee, S. Y., Sohn, J. H., Cho, J. H. (2018). A comparative study on peer support activities in the mental health service area-focused on deriving implications for the management of the peer support project in Seoul. *Mental Health, 8,* 40–52.
21. Braun, V., Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology, 3(2),* 77–101. DOI 10.1191/1478088706qp063oa.
22. Lee, G. H. (2014). A study of grounded theory on the recovery process of people with psychiatric disabilities in peer-support activities. *Mental Health, 5,* 17–32.
23. Ha, K. H., Sung, J. M. (2012). An exploratory study on the economic activities of people with psychiatric disabilities-comparisons between disability types. *Journal of Rehabilitation Research, 16(2),* 31–158.
24. Mora, A., Guillot, A., MacIntyre, T., Collet, C. (2012). Re-imagining mental imagery: Building bridges between cognitive neuroscience and sport psychology. *British Journal of Psychology, 103(2),* 224–247. DOI 10.1111/j.2044-8295.2011.02068.x.
25. Yanos, P. T., Primavera, L. H., Knight, E. L. (2001). Consumer-run service participation, recovery of social functioning and medicating role of psychological factors. *Psychiatric Service, 52(4),* 493–500. DOI 10.1176/appi.ps.52.4.493.
26. Shin, S. Y., Choi, H. S. (2020). A Systematic review on peer support services related to the mental health services utilization for people with severe mental illness. *Journal of Korean Academy Psychiatric and Mental Health Nursing, 29(1),* 51–63. DOI 10.12934/jkpmhn.2020.29.1.51.
27. Song, G. O. (2010). Validation of the Korean version of the mental health recovery measure. *Mental Health Social Work, 34(4),* 154–188.