The Nature and Impact of Informal Mental Health Support in an LGBTQ Context: Exploring Peer Roles and Their Challenges

Shane Worrell¹ · Andrea Waling¹ · Joel Anderson¹ · Anthony Lyons¹ · Christopher A. Pepping² · Adam Bourne¹

Accepted: 20 December 2021 / Published online: 4 January 2022

© The Author(s), under exclusive licence to Springer Science+Business Media, LLC, part of Springer Nature 2022

Abstract

Background Research shows that LGBTQ communities experience high levels of suicidality and mental ill health. They also face significant barriers to accessing adequate mental health treatment in service settings. In response to these factors, it is likely that LGBTQ community members turn to their peers for informal mental health-related support. Such support, however, is largely undefined, the extent of it poorly understood and its impacts on those who perform it underexplored.

Methods We explored the nature and impact of informal mental health-related support provided by peers in LGBTQ communities in Melbourne, Australia. Drawing on semi-structured in-depth interviews with 25 LGBTQ adults in 2020, we explored how and why peers provided mental health support to friends, partners, housemates and even strangers and the impact this had on them.

Results We found that participants performed support roles as extensions of their existing relationships. We demonstrate that the support roles of the safe friend, housemate and partner, among others, represent everyday relationships stretched—even to breaking point—to incorporate informal mental health support. Each of these support roles is distinct, but they can all potentially result in similar impacts on those performing them. One of the more significant of these is burnout.

Conclusions LGBTQ community members face a diverse range of challenges when they support peers with their mental health. Informal peer-support roles are a significant responsibility for those performing them. LGBTQ community members stepping up to support others should be better supported to help manage their roles and the impacts of performing them.

Policy Implications Findings can contribute to policy that not only addresses high levels of mental ill health in LGBTQ communities, but also seeks to help peers in support roles to prevent them from being negatively impacted.

Keywords LGBTQ · Mental health · Suicide prevention · Peer support · Burnout · Boundaries

Introduction

Peers often provide significant informal support to people who are facing mental health challenges. Informal support is that which is offered in a non-professional context to help solve problems (Woodward et al., 2008). Although such support can be beneficial—even lifesaving—to those who receive it, those providing it can experience negative impacts. In this paper, we demonstrate the ways in which everyday relationships, like that of a friend, partner, or housemate, can develop into informal support roles (what

might be called the “nature” of informal mental health support). We demonstrate that these roles represent an extra dimension to a relationship that, if not managed effectively, can strain it, or even jeopardise its longevity.

This paper considers the nature of informal mental support provided by peers and its impacts on those providing it in the context of lesbian, gay, bisexual, transgender, or queer (LGBTQ) communities, which often experience exceptionally high levels of suicidality and mental distress (Hill et al., 2021; Skerrett et al., 2015; Swannell et al., 2016). Specifically, we focus on LGBTQ communities in Melbourne, Australia. North Western Melbourne Primary Health Network funded this research through the Australian government's National Suicide Prevention Trial. Inspired in part by the composite narratives method, we explore the added demands that informal mental health support roles place on the persons providing them, including through the experience of burnout (what might be considered a potential

✉ Shane Worrell
s.worrell@latrobe.edu.au

¹ Australian Research Centre in Sex, Health and Society, La Trobe University, Melbourne, Australia

² School of Psychology and Public Health, La Trobe University, Melbourne, Australia

“impact” of providing informal mental health support). Burnout is a “prolonged response to chronic emotional and interpersonal stressors”, characterised by inefficacy, exhaustion and cynicism (Maslach et al., 2001, p. 397).

Mental Ill Health in LGBTQ Communities

There is a critical need to help improve the mental health outcomes of communities who identify as LGBTQ. Research from Australia and other countries demonstrates that LGBTQ people are at considerably higher risk of poor mental health, and suicidal ideation and behaviour than non-LGBTQ people (Hill et al., 2021; King et al., 2008). Mental health inequalities are even more pronounced within some LGBTQ subcommunities. People with trans histories, for example, experience exceptionally high levels of suicidality (Johnson & Rogers, 2020). The largest study to date of young trans and gender diverse people in Australia (those aged between 14 and 25) found that almost half of the 859 participants had made attempts at taking their own life (Strauss et al., 2020). It is difficult, however, to know how many LGBTQ people die from suicide in Australia because sexual identity or diversity in gender beyond the male–female binary is rarely recorded alongside cause of death (Skerrett et al., 2014).

Even with evidence of elevated rates of mental distress among LGBTQ populations, many queer community members in high-income countries find it difficult to access adequate mental health services (Higgins et al., 2021; Lim et al., 2021a, b). LGB individuals in Australia report minority-related stress, finances and time constraints as barriers to accessing help (Cronin et al., 2021). Even if formal health services are accessed, many LGBTQ people in Australia experience negative and/or discriminatory experiences when dealing with practitioners across a wide range of social and mental health support services (Bonvicini, 2017).

Not all professionals in mainstream mental health and health settings have been adequately trained to support the needs of LGBTQ people (Klein, 2017). Many lack cultural competency (Higgins et al., 2021). LGBTQ people from diverse intersectional backgrounds face additional challenges in health settings. Difficulties accessing adequate mental health treatment are likely amplified if a person is from an immigrant or refugee background (Wohler & Dantas, 2017), while Indigenous Australians (Aboriginal and Torres Strait Islanders) have “a suicide rate 1.5 times higher than other Australians” (Hatcher et al., 2017, p. 21).

Previous research has shown that LGBTQ people sometimes avoid seeking help as a strategy to resist further experiences of stigmatization, discrimination and other discomforts (Karakaya & Kutlu, 2021). This becomes a potential barrier to accessing professional help during crisis

situations, even when relevant services exist. For example, suicide prevention programs for LGBTQ communities, though rare, are often reliant upon community members actively seeking help (Ferlatte et al., 2020). Cognisant of both the prevalence of mental health challenges, and the difficulties accessing culturally safe professional mental health services, this article is concerned with informal peer mental health support—that is, support provided to LGBTQ people outside clinical or health service settings.

Mental Health Peer Support

Connectedness with peers and affiliation with a broader LGBTQ community has been identified as beneficial to those trying to cope with minority stressors (Hinton et al., 2021). Mental health support in this context, however, is typically delivered by peers who have not necessarily earned qualifications or received training in how to respond to a mental health crisis. It is important to differentiate this kind of informal peer support from that which occurs within health and mental health services and community-run organisations.

Peer support has a long history in formal mental health services, dating back to at least the 1920s in the USA (Hardy et al., 2019). Peer-support programs often involve people who have experienced and recovered from mental health disorders supporting others (Hardy et al., 2019). This might be considered “intentional peer support” (Faulkner & Basset, 2012, p. 42). Such formal support uses a combination of peer training and a person’s own experience of recovery to assist someone else (Chapman et al., 2018). The employment of peer-support workers in countries like Australia, New Zealand and the USA increased considerably in the first decade of this century (Faulkner & Basset, 2012).

Mental health peer support also has a long history in more informal service settings, such as in LGBTQ community-run organisations. In such settings, peer support also complements more formal care (Mahlke et al., 2014). One example of this kind of support is peer advocacy, which has been identified as a positive, community-centred approach to helping LGBTQ people who experience mental ill health. It is contingent upon advocates having adequate training in terms of safety, boundaries and cultural sensitivity (Willging et al., 2016, p. 233).

Peer Support Outside Health Settings

Peer support that is unattached to health services or community organisations also plays an important role in the mental health of LGBTQ people. However, much less is known about it due to its informal nature, being performed in private, and with little or no interaction with health services (Asad & Chreim, 2016). This article attempts to address a knowledge gap, focusing on the nature and impact

of informal mental health support provided by LGBTQ community members who may not have experienced mental health crises themselves or have been trained in how to respond to them.

Many sexual and gender minority individuals report that they would be willing to help a peer experiencing suicidality and develop their peer-support skills through training (Ferlatte et al., 2020). However, broader support mechanisms for LGBTQ community members who care for others are often lacking. For example, LGBTQ peers providing care to friends, particularly older people, struggle to access support systems designed specifically for spouses or biological family members and encounter service providers who are not queer-friendly (Shiu et al., 2016). This suggests a lack of recognition for LGBTQ carers, which presents barriers to accessing support and potentially leaves them in vulnerable situations. Thus, this article aims to examine and build new knowledge relating to the nature and impact of informal care—such as mental health-related peer support—on those LGBTQ people who provide it.

Methodology and Methods

This article is part of the Lean on Me study, which focuses on informal mental health support provided by peers in LGBTQ communities in Melbourne, Australia. The research centred on Melbourne to reflect the sphere of influence of the North Western Melbourne Primary Health Network, which provided funding for the Lean on Me study through the Australian government's National Suicide Prevention Trial.

The composite narratives method informs in part the conceptual framework of this paper. Composite narratives draw “data from several individual interviews to tell a single story” (Willis, 2019, p. 471). A composite narrative is a depiction of a phenomenon that multiple people have experienced; it is something interpreted and combined into a “story that readers can imagine in a personal way” (Wertz et al., 2011, p. 2). The composite narratives approach allows researchers to present complex individual accounts, provide sufficient anonymity without omitting important data and produce accessible research (Willis, 2019). Todres' (2007) work developed composite pictures of research informants through first-person reflective stories. This foregrounded the “personal pronoun ‘I’ to indicate ... someone who typifies the general experiences within a living and situated context” (Todres, 2007, p. 50).

More recently, Willis' (2019) use of composite narratives was a response to the need to convey the richness of interviews with politicians while providing them anonymity; as public figures, case studies would have rendered them easily recognisable to readers (Willis, 2019). Willis developed her composite narratives by quoting from three to five

interviews, drawing other details from a single interview and avoiding “imposing any judgement on the interviewees' experiences and opinions” (Willis, 2019, p. 475). This resulted in a narrative in the form of a hypothetical “individual” to whom a name was assigned.

We draw on some of the features of composite narratives to present thematic understandings of informal peer-support roles. We diverge from composite narratives by presenting composite stories through the prism of support roles. The composite “individuals” we present are not given names, nor are their stories presented wholly in the first person. Instead, they are identified in terms of their support role rather than their personality. We refer to them as the safe friend, the housemate, the partner, and so forth. The composites we present are profiled more in terms of the themes associated with these roles rather than a narrative experience. Thus, it is the “composite” part of the composite narratives method that is useful to our analysis. We use it to represent collective experiences of phenomenon—that being how LGBTQ people provide informal mental health support to peers. This approach allows us to do three things: first, present informal mental health support roles as extensions of existing peer relationships; second, synthesise shared experiences across the sample group that reflect such relationships and roles; and third, avoid associating individual support roles with specific gender and sexual identities and, thus, avoid stereotyping LGBTQ subgroups.

Data Collection

We drew on in-depth interviews with 25 people, aged 23 to 79, living in metropolitan Melbourne, Australia, and identifying as LGBTQ (and/or using other terms synonymous with non-heterosexual or cisgender identities). The research was granted ethics approval by La Trobe University's Human Research Ethics Committee (Reference: HEC20369) and received community research endorsement (Reference: THH/CREP 20–015) from Thorne Harbour Health, a leading community-run health organisation for LGBTI communities in the state of Victoria.

The 25 interviewees included six cisgender women, seven cisgender men and 12 people who were trans or gender diverse. Ten participants used multiple terms to describe their sexual identity, five identified as queer, four as gay, three as bisexual, one as lesbian, one as bisexual and one preferred not to specify. Most participants—20 out of 25—were aged below 40. Four of the participants were born outside Australia, while a further six were from culturally diverse and/or migrant backgrounds. None identified as Aboriginal or Torres Strait Islander (the Indigenous peoples of Australia). All participants spoke English as their first language. The interviews were the qualitative part of a broader mixed-methods research study (see Worrell et al., 2021) into

mental health-related peer support provided in LGBTQ communities in Melbourne. To be interviewed, respondents were required to be aged 18 or over, to identify as LGBTQ, to live in metropolitan Melbourne and to have provided mental health support to peers in the previous 12 months.

Interviews explored the experiences of those who provided support to peers. This was a way of demonstrating the complex nature and impact of care roles and to challenge notions of care as unquestionably “good” and unproblematic. It was also the intention of the study to focus on people providing informal support rather than professional support; however, some participants’ experiences included both.

Due to COVID-19-related stay-at-home orders enforced by the Victorian government during the fieldwork stage of this research, interviews took place over Zoom, a video-conferencing application. Interviews centred on the nature of the peer support that participants offered, their experience of providing this support and what support they felt might help them better identify mental ill health and refer someone onto professional support services.

Interviews also focused on whether, and to what extent, participants had received formal training to respond to acute mental health crises, through their employment, studies or affiliations with community organisations. Participants were asked about the impact that providing informal mental health support had on them but were not specifically asked about their own mental health history. Some participants volunteered details about their own experiences of suicidality, depression and anxiety. We developed a support protocol for instances in which participants appeared distressed, including information on accessing professional support services. Audio of the interviews was captured digitally and transcribed.

Analysis

NVivo, a qualitative data-analysis software package, was used to code data. We worked with themes in the data using thematic analysis, following the six phases outlined by Braun and Clarke (2006). This involved becoming familiar with the data through working closely with the transcripts (phase one); drawing from the themes of the interviews to generate codes (phase two); sorting data further based on new themes that emerged during analysis, especially in terms of the support roles that informed the composite stories (phase three); and reviewing these themes as we began to build the framework for this article (phases four and five). We then produced this article (phase six), exploring the nature of informal mental health support (in terms of support roles) and its impact (in terms of burnout and other effects).

Findings

Participants had supported a peer or peers with their mental health in a range of situations. They had been there for friends, partners, housemates, colleagues, strangers (often through community support groups) and friendship circles. Participants supported people who were at immediate risk of suicide or following a suicide attempt, and when they were experiencing issues such as depression, anxiety, post-traumatic stress disorder (PTSD), discrimination, homelessness, imprisonment, work-related stress, family rejection and challenges with substance use.

Support was provided through various means, including in-person; remotely using communicative technology such as smartphones; and in the context of community support groups. Participants provided support to others as a one-off event, or multiple times over a period of weeks, months or years. Thus, informal support was highly variable in terms of longevity, frequency and the volume of people helped. Impacts on those who provided support were in some ways similar despite the varying roles performed. We now discuss results by exploring these two main themes: first, the nature of the support provided, and second, the impact of the support on those providing it.

The Nature of Mental Health Support: Informal Roles and Their Challenges

No two participants’ experiences of supporting peers were the same. There were, however, notable similarities between participants, which were based on their relationships to the person or persons being helped. To highlight these similarities, we present the findings as thematic understandings of six different support roles. Each story combines the experiences of multiple participants, presenting it in terms of an unnamed “individual” performing a support role. These six individuals are characterised by their relationship to the person they are helping. Thus, they are described as the safe friend, the peer leader, the partner, the housemate, the help worker, and the friendship circle member. These composites are thematic understandings of each role and help emphasise the similar situations and challenges that LGBTQ people providing support can experience, despite diversity in their sexual and gender identities, age, employment and family background.

The Safe Friend

The safe friend was a “go-to” person during a mental health crisis. They stood out to their peers as trustworthy,

empathetic and non-judgmental. The safe friend made themselves available—anytime, anywhere—especially if the situation was severe. They saw themselves as not just caring, but a natural carer:

It comes naturally to me. I mean there's people that I know who, when they try to support other people, they don't know what to say or they're uncomfortable and you can see that. It's not from lack of care – they definitely care. But they just don't know what to say.

Even though they considered themselves as naturally suited to caring, the safe friend reported sometimes feeling unprepared for the complexity and intensity of a support role. They said:

I've just always been that person. I probably didn't do a very good job of supporting people when I was younger ... now I just know the right language, know to listen rather than talk as much as I might have. You know, know the supports to offer.

Challenges for the safe friend included significant investment of their time and energy in ways that impacted upon their relationships (both with those they were helping and others), employment and studies. They had, at times, remained in a support role when providing such support was detrimental to their own wellbeing. They explained:

It gets a bit harder every year – you know, like, it keeps happening. So, there's a lot of background stress ... I've never lost anyone [to suicide], but the fear is real – when it goes on for months, years ... it can be a little bit stressful.

The Peer Leader

The peer leader was visible to their friendship and community groups as someone who was there to help LGBTQ peers whether they shared a close bond or not. Whereas the safe friend was more like a trusted confidante, the peer leader had a much more public profile as the person to go to during times of crisis or exacerbated need. Their own experiences—as a leader but also an individual who had experienced their own challenges—were known to others, having been voiced in a support group setting. This dynamic was conducive to their providing wise counsel.

The peer leader had helped multiple people, from those close to them, to complete strangers at community events. The support provided was at times brief and performed as one-off advice to someone in urgent need. Other peer support continued over longer periods. The peer leader was not always aware of just how vital the help they provided was, especially when offered to strangers. They said:

I've had people come up to me years after the fact and during coffee turn around and say, 'Do you realise that I'm only alive today because of what you did at so-and-so event?' and I'm like, 'What are you talking about?' and they're like, 'That week, I was literally debating committing suicide. I was getting my affairs in order and everything like that and then I went to one of the events and you actually sat down and spoke to me like a human being and I wasn't used to that. I wasn't expecting that.' I'm like, 'Well, that's just being human.'

Challenges for the peer leader included burnout due to the frequency of requests for help and difficulties in finding space and time to have their own support needs met. As they recounted noticing at one point:

I didn't feel I had anyone to call, or there wasn't someone for me to call in the friendship circle when, let's say, I was at my lowest point ... and I just needed someone to talk to on the phone.

The Partner

The partner demonstrates how informal peer support is provided in the context of a loving, intimate relationship. The partner was emotionally—and often proximately—well placed to provide support. Whether co-habiting or living apart, the partner had unique emotional access to a partner or partners experiencing distress. This contributed to them being able to be leant on during a mental health crisis. Being there for a significant other, however, was sometimes difficult, especially if support was prolonged and provided in the context of competing responsibilities. One of the partner's experiences of helping their significant other while trying to maintain their own mental health demonstrates this. They said:

At the time, my partner had some serious mental health issues. My mental health wasn't good as a result of trying to support them every day ... I just felt completely emotionally drained for a month afterwards.

Challenges for the partner included not always having their own needs met, particularly when their care role began to overshadow other aspects of a relationship in which they expected more reciprocal support and a diversity of shared experiences.

The partner also tended to refer to the help they provided to non-partners when asked about informal mental health support, despite later telling quite compelling stories and noting challenges about helping a partner. This potentially demonstrates that mental health peer support for a significant other carries the risk of being under-recognised and perhaps thought of as “just part of being in a relationship”.

The Housemate

The housemate emerged as similar to the partner in terms of their proximity to a peer experiencing suicidality or other mental health concerns. But they differed in the sense that the housemate did not necessarily share a close emotional connection (at least, at first) with peers they supported. This meant that the housemate sometimes found themselves providing informal mental health support beyond what they tacitly expected out of a particular friendship. The housemate's role was multi-faceted; it included the provision of peer support in emotional, physical, practical and financial ways. With such varied responsibilities in their own home, they often found it difficult to step back:

It's a lot harder to draw those boundaries because we're friends but we're also housemates but I'm also acting as your carer and I'm also loaning you a lot of money and I'm also driving you to appointments and keeping track of your meds and things like that. So, yeah, in practice a lot harder than knowing that, in theory, this is what I can help you with, but you need to try and do this by yourself. Yeah, so it's been really difficult finding that balance.

This example shows how informal support among LGBTQ peers can become all-encompassing for the housemate. It is worth considering, in a situation like this, what resources in terms of time and energy would be left beyond the care arrangement for the housemate and the person they are supporting to engage simply as friends.

The Help Worker

The aim of this research was to focus on people who had not received formal training in mental health support. However, in attempting to speak with people who provided peer support informally, we attracted participants who also provided professional mental health support in a formal capacity. The help worker performed a “double shift” in that they provided peer support both in professional settings and their personal life. They differed from other peers in having formal education and training in suicide prevention and mental health support. They were employed in roles that assisted LGBTQ people, either exclusively or as part of their wider work. The help worker had worked in dedicated mental health services and sectors such as housing and family violence.

Outside of work, the help worker was regarded as someone who was willing and able to help. This made them more likely to be approached not just by friends, but also by friends of friends. Their expertise significantly benefited those around them. Working this “double shift”, however, was not conducive to easily setting boundaries for themselves. They found it difficult to switch off from situations involving suicide and depression. This had led to burnout, as demonstrated here:

I was studying and working in mental health and then I was also supporting someone quite frequently. They were pretty unwell, and I got really burnt out. I'm still kind of recovering from that whole thing.

The Friendship Circle Member

The friendship circle member was part of a social network of peers who rallied around someone in need. This kind of group support occurred after a peer had made an attempt at their own life or was known by multiple people to be experiencing active suicidal ideation. The friendship circle member, like those around them, recognised that it would take more than just one person to help someone through a crisis. They said:

Sometimes we can't be everything we want to be to our friend. Sometimes people find the things they need in multiple people.

Participants in this study generally spoke of mental ill health being widespread in LGBTQ communities in Melbourne. Many also described an openness when it came to talking about mental health and a culture of supporting fellow community members. This seems conducive to the development of a dedicated peer network during a crisis. As the friendship circle member said:

In my experience, it's fairly common. I think, particularly, if someone posts on social media something that suggests they're at risk, you know – it could be a good-bye note or just something that seems a bit off and then someone will comment, reach out to people and naturally a mini-network or support group forms. Certainly, within my communities, that's really normal.

In the context of high rates of mental ill health, members of a friendship circle had found themselves, over time, supporting each other.

Most of the people I know who have major issues or ... really worrying breakdowns and so on would be turning to a group of friends. Not a large group of friends but a group of friends.

A friendship circle was made up primarily of people who had little or no mental health qualifications, professional experience or training, though some people who did were able to provide more specialised support to a person in need.

The Impact of Providing Peer Support

As described, six distinct informal support roles were evident in interviews with LGBTQ participants. We now focus on the impact of peer support on those performing these roles. Participants' accounts of being there to be

leant on demonstrated that informal mental health-related peer-support roles had both positive and negative impacts. This section demonstrates that, despite different support roles bringing their own situations and challenges, positive impacts (e.g., the satisfaction of helping someone) and negative impacts (e.g., burnout) transcended role types.

Three main types of impacts, which covered both positive and negative experiences, were visible in participants' discussions and can be described as psychological, social and practical. The first of these refers to how participants thought and felt about the peer support they provided. Many participants said they helped people who were suicidal. We can say, broadly, that peers provided vital support that has helped to save lives. One participant said that "helping a friend to stay alive feels like helping your entire community, because we know the knock-on effects of that grief". This support had a positive impact not only on those being supported (whose lives have been saved), but also on those providing support, due to their having helped loved ones, friends and fellow community members survive.

Some participants derived significant meaning from their roles, aligning their experiences with their caring nature. Many felt like their support, although challenging, made a significant difference. They were happy to help. Others felt more obliged to be there for others, considering themselves on call for people who were especially important to them. Several participants reported that providing peer support made them feel needed. Some experienced this as a positive, as the safe friend described:

I think some of the rewards are it feels meaningful ... [it's] kind of an honour if you're there with someone when they're at their worst or what they think is their worst. That's a big one and I think that's the core of life; it doesn't have to be all of what life is, but I think for those that we love, we show up.

Positive experiences were, however, co-terminus with a broad range of challenges that many participants perceived as negatively impacting their own wellbeing. Some questioned why feeling needed was something that they themselves "needed". Others described feeling ill-equipped for some peer-support situations. Some expressed how they felt unable to manage boundaries between being, for instance, a carer and a friend, despite knowing that doing so would likely benefit both themselves and the person they were helping.

Intense and/or prolonged situations of providing peer support could lead to feelings of burnout for participants (which we discuss in more detail later). Providing support was a struggle for some and could impact on other aspects of their lives. As the peer leader said:

I have assisted someone who was having suicidal thoughts at 2:30 in the morning, which was difficult

for me in that sleep is obviously important to someone with my own ongoing mental health issues.

Social impacts relate to stress placed on participants' relationships and friendships during periods of providing peer support. Due to the intensity, frequency and longevity of peer-support situations, participants sometimes noticed relationships or friendships being impacted. The safe friend said:

If I do have to spend an ample amount of time with a struggling friend ... it impacts on my relationship and it's obviously eating away at the time I could be spending with my partner. There's that sort of tension every now and then.

In some situations, the only way for a participant to withdraw from a support situation was to end the relationship or friendship with the person they were helping. This was more the experience of younger participants, those in their 20s (or older participants describing peer support they had provided at that age). Some participants looked back at such situations with regret.

In terms of practical impacts, some participants found that their care responsibilities impacted on their work. They spoke of missing work or leaving casual shifts early, taking time off and underperforming in their role. For others, missing university classes, writing assignments at the last minute or even withdrawing from their studies were linked to the stress of supporting someone with mental health concerns.

Burnout and Boundaries: Recognising and Responding to Peer-Support Challenges

Burnout was a recurring theme in the interviews—and seemed relevant to all the impact types outlined above. Burnout is a "prolonged response to chronic emotional and interpersonal stressors", characterised by inefficacy, exhaustion and cynicism (Maslach et al., 2001, p. 397). Its conceptual genesis can be traced back to the 1970s when it was explored in relation to heightened negative feelings associated with employment (Freudenberger, 1974).

Participants sometimes used "burnout" or synonymous terms to describe their experiences of providing informal support. Recognition of burnout, however, did not always mean a participant felt themselves to be effective at managing or preventing it. Some acknowledged this themselves. Participants spoke about burnout in terms of the impacts above and about the difficulties of providing peer support in acute situations and/or over longer periods of time. Some said burnout was inevitable, making peer support unsustainable in the long term. The peer leader recounted:

It does force me to reassess the support I offer people, because there's only so much of me, and I am a finite

resource ... If something like that has happened, I'll tell the other people I care for in my life ... 'You will have to go elsewhere, because I'm depleted.'

Signs of burnout that participants reported included feeling exhausted, stressed, anxious and cynical about their ability to help, and resentment at the extent to which it impacted them. When describing a situation in which a significant other, who had been abusive, was threatening suicide, the partner said:

Oh absolutely, it was bloody awful ... yeah, it was extremely draining ... It was draining, and ultimately, I adopted the attitude, 'Well, you know, stuff it. If that's what you want to do, do it.'

An awareness of mental health issues seemed to contribute to participants' ability to recognise signs of burnout in themselves. Not everyone, however, was able to make changes in their lives that enabled them to better manage the care situations in which they found themselves.

As demonstrated through the social impacts of providing peer support, wisdom was often acquired through difficult situations, though sometimes, this happened only after the loss of a friendship or relationship with someone for whom a participant had been helping. The friendship circle member reflected that:

As I got kind of older and wiser, I was better able to identify ... when a friend was in crisis...I think I have learnt to pace myself a little bit. But there's a grey area between pacing your involvement and kind of developing that crusty burnt-out outer shell.

Retreating was sometimes a response to a situation that someone considered unmanageable. Some participants took COVID-19-related enforced lockdowns in Melbourne during 2020 as an opportunity to step back. Others, however, felt they had a lot of support from people around them. Finally, some participants were not especially impacted in a negative way by their peer-support experience. Being able to effectively set boundaries was one factor that contributed to this.

Boundaries were another recurring theme in the interviews that also traversed the three impact types. Participants talked about the importance of setting boundaries between their peer-support situations and other aspects of their lives. The housemate said:

It's not best practice to insert yourself fully into someone's life and give them all the support. You know, what happens if you can't do it anymore? What happens if that's not sustainable basically because you'll burn out? And I know that – but in practice it's just really, really difficult sometimes to draw those boundaries.

The extent to which boundaries were effectively managed varied between participants. Some were in situations in which boundaries were clearly defined. Others wanted to feel needed, so they resisted stepping back. Others feared what might happen if they did retreat. As the help worker expressed, contemplating such action came with concerns for another person's welfare. They said of a friend:

I feel like to withdraw would further derail her, so I feel like I don't know. I'm not confident in managing that boundary.

Some participants were dependent on the person they supported, so they stepped back at the risk of not having someone to "lean on" themselves. Many had thrown themselves emotionally into a peer-support role as a young adult. Only through experience, much later, had some realised the right they had to their own space and self-care, as the peer leader said:

When I was younger, I was a bit more idealistic, and I'd be willing to give more of my time and my effort and my energy to basically anyone, whereas now there are certain boundaries.

Discussion

Participants in this study provided informal mental health-related support to their LGBTQ peers. These participants played essential—and varied—roles when supporting people around them during times of mental health crisis. Support was provided in the context of everyday relationships, such as that of a safe friend, partner or housemate or a more formal role such as that of a help worker or peer leader. In many instances, informal mental health support provided an extra element to these relationships, even straining them. At their most extreme, participants' relationships with the person they had helped did not survive.

Being leant on might be considered a typical part of a relationship or friendship. A high demand for mental health-related peer support, however, increases instances in which a person is leant on. Cumulatively, this may stretch the boundaries of a relational role. In the case of participants from LGBTQ communities in this study, this has resulted in the role of a "friend" or "housemate", to use two examples, becoming more complex and demanding as peers have attempted to balance their increased care duties with myriad other responsibilities in their broader lives.

Understanding that LGBTQ people provide different types of support and are faced with different situations and challenges based on their relationship to the person they are

helping is important. It can better inform the development of targeted services and interventions that can help both the person being supported and the person providing support. The housemate, for example, might benefit from a type of support different from that which best suits a peer leader or a partner. Foregrounding these roles through the composite stories provided, therefore, is an important step towards better outcomes.

It is also important, however, to understand that the impacts of providing support are similar across the participant group and, in a sense, traverse the various roles outlined. Impacts that are psychological, social or practical are evident in all the roles. Boundaries can be difficult to draw and maintain, and one of the more serious consequences of being there to support someone is burnout. Thus, while it is useful to distinguish between the types of relationships that can develop a peer support element to them, it is equally important to note that the impacts of providing support can be similar no matter what the role.

All this should be considered in the context of the broader responsibilities and support networks those performing informal mental health support roles have. Participants in this study supported others while fulfilling responsibilities such as working, studying, managing a disability, maintaining relationships, raising children and managing their own mental health issues. They did so with varying levels of financial, social and emotional support. Efforts to help people providing informal peer support should be multifaceted in their approach, focusing on the support roles they perform, the impacts of those roles and where they sit in the context of people's broader responsibilities and support systems.

Making Peer Support in LGBTQ Communities More Sustainable

Some participants in this study were carrying a load that was unmanageable. They were providing support to LGBTQ peers whose communities experience exceptionally high levels of mental ill health and suicidality and often face barriers to adequate professional support services. Participants' experiences suggest that the support they provided was crucial to their peers. They also highlight the ways in which peer support in LGBTQ communities can have positive effects on those who provide it. This resembles more formal mental health settings where peer-support workers perform roles that contribute to increased self-esteem and confidence (Repper & Carter, 2011).

Participants in this study, however, were providing support outside health services—a factor likely influenced by the barriers their communities face in accessing professional help. This contrasts significantly with peer-support roles that are connected to, or at least better acknowledged by, health

services, community organisations and educational institutions. Peer-support workers in these settings have access to training and support. An example of this can be drawn from a study of peer educators who worked to prevent suicide among college students in the USA. The study found that many of the peer educators described themselves as “natural” helpers. They were taught not only about suicide and helping others, but also “about the hazards of taking on something too big” (Catanzarite & Robinson, 2013, p. 48).

Such support has not been available to many participants in this study. Many, in fact, received little or no mental health education or training before being leant on. Thus, participants were often not qualified to provide support for people experiencing acute or chronic mental ill health. However, barriers preventing people access mental health services (such as funding and capacity issues and providers not being LGBTQ friendly) meant participants were often left with no choice but to be the ones to help.

People in helping professions are “more susceptible to burnout because of the emotional work and level of emotional exhaustion experienced on a consistent basis” (Viehl et al., 2018, p. 52). But even with training and professional oversight, peer-support workers in formal settings are also prone to burnout (Rebeiro Gruhl et al., 2016). Burnout is now considered something that occurs in situations in which other forms of emotional labour are performed. This includes support roles in queer spaces (Vaccaro & Mena, 2011).

Through performing roles in an informal peer-support context, participants in our study took on caring roles—with the associated risk of burnout, but often without the support systems available to formal peer support workers and mental health professionals. Being frequently “leant on”, especially over long periods of times, had negative impacts on many of the participants in this study, particularly in relation to burnout. Several expressed the characteristics of burnout described by Maslach et al. (2001), including exhaustion, cynicism and inefficacy.

With peer support adding an extra dimension to some participants' friendships or relationships, roles were stretched and strained. Providing support, in these instances, extended what the role of a partner, housemate or friend was. Such extension represents additional work and responsibilities. People formally employed as peer-support workers have emphasised the importance of setting clear boundaries, especially in terms of this helping them sustain their role (Faulkner & Basset, 2012). Participants in our study found drawing boundaries difficult and lacked support from mental health or community services to do so.

Although the peer-support roles outlined are meaningful to those performing them, our findings suggest that LGBTQ peers being leant on should be better supported. This could be approached in at least two ways. Better supporting

LGBTQ people with their mental health, including through addressing contributors to mental ill health, discrimination and stigma, is one. Another is providing better access to LGBTQ-friendly mental health and health services, which would offer more formal, focused options for people experiencing suicidality and other mental health-related distress. One way to do this would be to increase and improve training of mental health practitioners to ensure they were LGBTQ-friendly. Such training has been shown to be beneficial for therapists and LGBT clients (Pepping et al., 2018).

These reforms would help LGBTQ people experiencing distress. In turn, it would reduce their need to lean on peers in their communities for acute and chronic mental health care. This could change the nature of peer support, allowing the safe friend, housemate, help worker or others to be less defined by experiences of crisis. They would still be defined somewhat by peer support but could perform their roles in more sustainable ways. This study has demonstrated that informal peer support, although vital, can be unsustainable. Participants in this study were “leant on” whether they had the training, time and capacity to help. Many had no straightforward way of “opting out” if they were overwhelmed or burnt out and had little or no help from others.

Gidugu et al. (2015, p. 445) argue that more formal peer support is something that “complements rather than supplants needed traditional mental health services”. Considering informal support in LGBTQ communities in a similar way might ease the pressure on people in situations like ones that participants in this study faced. This, of course, means more investment in ensuring that formal mental services meet the needs of LGBTQ people. Cronin et al. (2021) have highlighted that systemic barriers, including the financial burden of seeking help, should be addressed, especially for the LGBTIQ+ community, due to its higher prevalence of mental ill health.

Even if crises were to become less frequent with better mental health outcomes and improved service options, situations in which an LGBTQ person helps a peer with their mental health concerns would likely still emerge. It is, therefore, crucial to devise ways of better supporting peers who provide such support. Rebeiro Gruhl et al. (2016) argue that training focusing on boundary setting and self-care strategies should be a priority for peer-support workers. We argue that such an approach should also form part of a response to helping those who provide peer support informally. This seems particularly relevant to LGBTQ communities, due to the prevalence of mental health issues and barriers to treatment and support. This would help ensure peers were supplementing the work of formal services rather than filling gaps where they should be operating.

There is a need to ensure peers have access to basic mental health response training, have knowledge of how to define their roles and draw boundaries, are capable of

recognising suicide risks, and know how to refer the person they are helping to a mental professional. Importantly, they would also benefit from knowing how to manage the impacts of peer support, including burnout, on themselves. Addressing these needs is central to supporting LGBTQ community members who will continue to provide informal support—even if rates of mental ill health decline and professional services become more inclusive.

This paper is among the first studies to provide a detailed account of different roles and their impacts on peer supporters in LGBTQ communities. It offers a useful knowledge base and a typology to assist researchers in examining the experiences of LGBTQ people beyond the communities studied here. A limitation is that this sample was drawn from a single city. People living in regional or rural settings—or other metropolitan centres—may have different experiences of providing informal mental health support.

Conclusion

LGBTQ peers who provide informal mental health-related support to peers are largely unacknowledged for their challenging yet vital work. Participants in this study demonstrated the extent to which they help those around them through the provision of support outside clinical and health service settings. This support in LGBTQ communities in Melbourne can begin to be understood in relation to key roles that are extensions of everyday relationships. Through performing these roles in an informal peer-support context, participants have taken on care roles—with the associated risk of burnout but often without the support systems available to formal peer support workers or mental health professionals. These roles and their associated impacts provide insight into the heavy load that LGBTQ community members carry when it comes to their peers’ mental health. Findings in this article can contribute to policy that not only addresses exceptionally high levels of mental ill health in LGBTQ communities, but also seeks to better support peers who are there to be leant on.

Acknowledgements Thanks to the North Western Melbourne Primary Health Network and the members of this project’s community advisory board, who helped provide valuable feedback on this research: Rei Alphonso (Flat Out), Amelia Arnold (Thorne Harbour Health), Anne-lise Ah-fat (Undercurrent Victoria), Anna Bernasochi (Switchboard Victoria), Daniel Bryen (Thorne Harbour Health), Eliza Hovey (Beyond Blue), Ray Jackson (Beyond Blue), Jo Read (North Western Melbourne Primary Health Network), Sara Strachan (Zoe Belle Gender Collective) and Kian Hall.

Funding This research received funding from the North Western Melbourne Primary Health Network, through the Australian government’s National Suicide Prevention Trial.

Declarations

Conflict of Interest The authors declare no competing interests.

References

- Asad, S., & Chreim, S. (2016). Peer support providers' role experiences on interprofessional mental health care teams: A qualitative study. *Community Mental Health Journal*, 52(7), 767–774. <https://doi.org/10.1007/s10597-015-9970-5>
- Bonvicini, K. (2017). LGBT healthcare disparities: What progress have we made? *Patient Education and Counselling*, 100, 2357–2361. <https://doi.org/10.1016/j.pec.2017.06.003>
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101. <https://doi.org/10.1191/1478088706qp063oa>
- Catanzarite, J. A., & Robinson, M. D. (2013). Peer education in campus suicide prevention. *New Directions for Student Services*, 2013(141), 43–53. <https://doi.org/10.1002/ss.20039>
- Chapman, S. A., Blash, L. K., Mayer, K., & Spetz, J. (2018). Emerging roles for peer providers in mental health and substance use disorders. *American Journal of Preventive Medicine*, 54(6), S267–S274. <https://doi.org/10.1016/j.amepre.2018.02.019>
- Cronin, T. J., Pepping, C. A., Halford, W. K., & Lyons, A. (2021). Mental health help-seeking and barriers to service access among lesbian, gay, and bisexual Australians. *Australian Psychologist*, 56(1), 46–60. <https://doi.org/10.1080/00050067.2021.1890981>
- Faulkner, A., & Basset, T. (2012). A helping hand: Taking peer support into the 21st century. *Mental Health and Social Inclusion*, 16(1), 41–47. <https://doi.org/10.1108/20428301211205892>
- Ferlatte, O., Salway, T., Olliffe, J. L., Kia, H., Rice, S., Morgan, J., Lowik, A. J., & Knight, R. (2020). Sexual and gender minorities' readiness and interest in supporting peers experiencing suicide-related behaviors. *Crisis*, 41(4), 273–279. <https://doi.org/10.1027/0227-5910/a000632>
- Freudenberger, H. (1974). Staff burn-out. *Journal of Social Issues*, 30(1), 159–165. <https://doi.org/10.1111/j.1540-4560.1974.tb00706.x>
- Gidugu, V., Rogers, E. S., Harrington, S., Maru, M., Johnson, G., Cohee, J., & Hinkel, J. (2015). Individual peer support: A qualitative study of mechanisms of its effectiveness. *Community Mental Health Journal*, 51(4), 445–452. <https://doi.org/10.1007/s10597-014-9801-0>
- Hardy, S., Hallett, N., & Chaplin, E. (2019). Evaluating a peer support model of community wellbeing for mental health: A coproduction approach to evaluation. *Mental Health & Prevention*, 13, 149–158. <https://doi.org/10.1016/j.mhp.2019.01.007>
- Hatcher, S., Crawford, A., & Coupe, N. (2017). Preventing suicide in indigenous communities. *Current Opinion in Psychiatry*, 30(1), 21–25. <https://doi.org/10.1097/YCO.0000000000000295>
- Higgins, A., Downes, C., Murphy, R., Sharek, D., Begley, T., McCann, E., Sheerin, F., Smyth, S., Vries, J. D., & Doyle, L. (2021). LGBT + young people's perceptions of barriers to accessing mental health services in Ireland. *Journal of Nursing Management*, 29(1), 58–67. <https://doi.org/10.1111/jonm.13186>
- Hill, A. O., Distefano, A., Gilmour, S., Bavinton, B. R., Hidaka, Y., Bourne, A., & Armstrong, G. (2021). Social correlates of recent suicidal ideation among men who have sex with men in greater Tokyo. *Sexuality Research and Social Policy*, 18(2), 467–478. <https://doi.org/10.1007/s13178-020-00472-8>
- Hinton, J. D., De la Piedad Garcia, X., Kaufmann, L. M., Koc, Y., & Anderson, J. R. (2021). A systematic and meta-analytic review of identity centrality among LGBTQ groups: An assessment of psychosocial correlates. *The Journal Sex Research*, 1–19. <https://doi.org/10.1080/00224499.2021.1967849>
- Johnson, A. H., & Rogers, B. A. (2020). “We’re the normal ones here”: Community involvement, peer support, and transgender mental health. *Sociological Inquiry*, 90(2), 271–292. <https://doi.org/10.1111/soin.12347>
- Karakaya, S., & Kutlu, F. Y. (2021). LGBT individuals' opinions about their health care experiences: A qualitative research study. *Journal of Nursing Management*, 29(1), 24–31. <https://doi.org/10.1111/jonm.13199>
- King, M., Semlyen, J., Tai, S. S., Killaspy, H., Osborn, D., Popelyuk, D., & Nazareth, I. (2008). A systematic review of mental disorder, suicide, and deliberate self harm in lesbian, gay and bisexual people. *BMC Psychiatry*, 8(1), 70. <https://doi.org/10.1186/1471-244X-8-70>
- Klein, E. (2017). Using social support for LGBTQ clients with mental illness to be out of the closet, in treatment, and in the community. *Journal of Gay & Lesbian Social Services*, 29(3), 221–232. <https://doi.org/10.1080/10538720.2017.1332534>
- Lim, G., Waling, A., Lyons, A., Pepping, C. A., Brooks, A., & Bourne, A. (2021a). Trans and gender-diverse peoples' experiences of crisis helpline services. *Health & Social Care in the Community*, 29(3), 672–684. <https://doi.org/10.1111/hsc.13333>
- Lim, G., Waling, A., Lyons, A., Pepping, C. A., Brooks, A., & Bourne, A. (2021b). The experiences of lesbian, gay and bisexual people accessing mental health crisis support helplines in Australia. *Psychology & Sexuality*, 1–18. <https://doi.org/10.1080/19419899.2021.1904274>
- Mahlke, C. I., Krämer, U. M., Becker, T., & Bock, T. (2014). Peer support in mental health services. *Current Opinion in Psychiatry*, 27(4), 276–281. <https://doi.org/10.1097/YCO.0000000000000074>
- Maslach, C., Schaufeli, W., & Leiter, M. (2001). Job burnout. *Annual Review of Psychology*, 52, 397–422. <https://doi.org/10.1146/annurev.psych.52.1.397>
- Pepping, C. A., Lyons, A., & Morris, E. M. (2018). Affirmative LGBT psychotherapy: Outcomes of a therapist training protocol. *Psychotherapy*, 55(1), 52–62. <https://doi.org/10.1037/pst0000149>
- Rebeiro Gruhl, K. L., LaCarte, S., & Calixte, S. (2016). Authentic peer support work: Challenges and opportunities for an evolving occupation. *Journal of Mental Health*, 25(1), 78–86. <https://doi.org/10.3109/09638237.2015.1057322>
- Repper, J., & Carter, T. (2011). A review of the literature on peer support in mental health services. *Journal of Mental Health*, 20(4), 392–411. <https://doi.org/10.3109/09638237.2011.583947>
- Shiu, C., Muraco, A., & Fredriksen-Goldsen, K. (2016). Invisible care: Friend and partner care among older lesbian, gay, bisexual, and transgender (LGBT) adults. *Journal of the Society for Social Work and Research*, 7(3), 527–546. <https://doi.org/10.1086/2F687325>
- Skerrett, D. M., Kölves, K., & De Leo, D. (2014). Suicides among lesbian, gay, bisexual, and transgender populations in Australia: An analysis of the Queensland Suicide Register: LGBT suicide in Australia. *Asia-Pacific Psychiatry*, 6(4), 440–446. <https://doi.org/10.1111/appy.12128>
- Skerrett, D. M., Kölves, K., & De Leo, D. (2015). Are LGBT populations at a higher risk for suicidal behaviors in Australia? Research Findings and Implications. *Journal of Homosexuality*, 62(7), 883–901. <https://doi.org/10.1080/00918369.2014.1003009>
- Strauss, P., Cook, A., Winter, S., Watson, V., Wright Toussaint, D., & Lin, A. (2020). Associations between negative life experiences and the mental health of trans and gender diverse young people in Australia: Findings from trans pathways. *Psychological Medicine*, 50(5), 808–817. <https://doi.org/10.1017/S0033291719000643>
- Swannell, S., Martin, G., & Page, A. (2016). Suicidal ideation, suicide attempts and non-suicidal self-injury among lesbian, gay, bisexual and heterosexual adults: Findings from an Australian national

- study. *Australian & New Zealand Journal of Psychiatry*, 50(2), 145–153. <https://doi.org/10.1177/0004867415615949>
- Todres, L. (2007). *Embodied enquiry: Phenomenological touchstones for research, psychotherapy and spirituality*. Palgrave Macmillan.
- Vaccaro, A., & Mena, J. A. (2011). It's not burnout, *It's more*: Queer college activists of color and mental health. *Journal of Gay & Lesbian Mental Health*, 15(4), 339–367. <https://doi.org/10.1080/19359705.2011.600656>
- Viehl, C., Dispenza, F., Smith, J., Varney, M., Guvensel, K., Suttles, M., McCullough, R., Chang, C., Brack, J., & Kaufmann, J. (2018). How do sexual minority men experience burnout in the mental health field: A grounded theory study. *Journal of Gay & Lesbian Mental Health*, 22(1), 52–70. <https://doi.org/10.1080/19359705.2017.1357663>
- Wertz, M. S., Nosek, M., McNiesh, S., & Marlow, E. (2011). The composite first-person narrative: Texture, structure, and meaning in writing phenomenological descriptions. *International Journal of Qualitative Studies on Health and Well-Being*, 6(5882), 1–10. <https://doi.org/10.3402/2Fqhw.v6i2.5882>
- Willging, C. E., Israel, T., Ley, D., Trott, E. M., DeMaria, C., Joplin, A., & Smiley, V. (2016). Coaching mental health peer advocates for rural LGBTQ people. *Journal of Gay & Lesbian Mental Health*, 20(3), 214–236. <https://doi.org/10.1080/19359705.2016.1166469>
- Willis, R. (2019). The use of composite narratives to present interview findings. *Qualitative Research*, 19(4), 471–480. <https://doi.org/10.1177/1468794118787711>
- Wohler, Y., & Dantas, J. A. (2017). Barriers accessing mental health services among culturally and linguistically diverse (CALD) immigrant Women in Australia: Policy implications. *Journal of Immigrant and Minority Health*, 19(3), 697–701. <https://doi.org/10.1007/s10903-016-0402-6>
- Woodward, A. T., Taylor, R. J., Bullard, K. M., Neighbors, H. W., Chatters, L. M., & Jackson, J. S. (2008). Use of professional and informal support by African Americans and Caribbean Black with mental disorders. *Psychiatric Services*, 59, 1292–1298. <https://psycnet.apa.org/https://doi.org/10.1176/appi.ps.59.11.1292>
- Worrell, S., Waling, A., Anderson, J., Fairchild, J., Lyons, A., Pepping, C., & Bourne, A. (2021). *Lean on me: exploring suicide prevention and mental health-related peer support in Melbourne's LGBTQ communities*. Melbourne: Australian Research Centre in Sex, Health and Society, La Trobe University. <https://doi.org/10.26181/60ac728cdb7ef>

Publisher's Note Springer Nature remains neutral with regard to jurisdictional claims in published maps and institutional affiliations.