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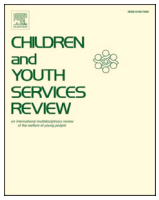

A theory of change for one-on-one peer support for older adolescents and young adults

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A B S T R A C T

Peer support has become increasingly available as a formal mental health service. However, high quality research and implementation of peer support has been hampered over the years by the lack of theory that clarifies peer support roles and explains exactly how these roles foster positive outcomes for peer support users. Observers have noted that theory is particularly sparse in regard to peer support for older adolescents and young adults, and they have called for theory that not only clarifies roles and mechanisms of impact, but also identifies how peer support for young people might differ from peer support for older adults This qualitative study brought young people with experience providing and using peer support together in small group discussions focused on understanding the activities and outcomes of peer support. This information was used to develop a theory of change that outlines key activities that constitute a one-on-one peer support role for young people, and describes how and why carrying out these activities should lead to positive outcomes. The theory highlights the characteristics of a successful "peerness-based relationship," and proposes that the development of this kind of relationship mediates other positive outcomes from peer support. The article concludes with a discussion of how this theory can usefully inform the development and specification of peer support roles, training and supervision, and other organizational supports.

1. Introduction

Peer support has become increasingly available as a formal mental health service in conjunction with other mental health services in the United States (Adams, 2020; Gillard, 2019; Klee et al., 2019; Wolf, 2018) and internationally (Puschner et al., 2019). This trend has also been observed with respect to peer support for adolescents and young adults specifically (Gopalan et al., 2017; Hawke et al., 2019; Simmons et al., 2020; WESTAT, 2019b). Peer support is based on the general idea that a person that has lived through a particular type of adversity is uniquely positioned to promote positive outcomes for people experiencing similar challenges.

Reports from researchers, practitioners and government entities in the United States have called for making peer support even more widely available (Farkas & Boevink, 2018; Myrick & del Vecchio, 2016; Puschner et al., 2019), based in part on steadily accumulating evidence of the potential positive impacts of one-on-one peer support within mental health services (Bellamy et al., 2017; Gillard, 2019; Klee et al., 2019). However, these and other reports also caution that more and better-quality research is urgently needed to ensure that peer support users (PSUs) experience positive outcomes. High quality research and implementation of peer support has been hampered over the years by the lack of connection to theory that clarifies peer support roles and explains exactly how these roles foster positive outcomes for PSUs (Cronise et al., 2016; Lloyd-Evans et al., 2014). In the area of adult mental health services, there have been multiple efforts over the last ten years to build theory that clarifies the mechanisms responsible for the impacts of peer support (Watson, 2019), with the work of Gillard (2015) being one particularly well-recognized example. However, as noted by a number of researchers—including the authors of studies focused on theory building—these efforts are still in their early stages (e.g., Bellamy et al., 2017; Chinman et al., 2017; Farkas & Boevink, 2018; Gillard et al., 2015; King & Simmons, 2018; Watson, 2019).

Observers have noted that theory is particularly sparse for youth and young adult peer support specifically, and they have called for theory that not only clarifies roles and mechanisms of impact, but also identifies how peer support for young adults might differ from peer support for older adults (Gopalan et al., 2017; Jivanjee et al., 2020; Simmons et al., 2020; Walker et al., 2022). Recent studies by Hiller-Venegas et al. (2022) and Halsall et al. (2021) have taken steps toward filling this gap. Hiller-Venegas et al. used qualitative methods to identify key aspects of peer support roles from the perspectives of PSUs aged 16–25, while

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Halsall et al. used qualitative interviews with peer support specialists (PSSs, i.e., those providing peer support) and other staff to identify hypotheses about why peer support services should contribute to outcomes for young people, and under what circumstances.

Further clarification of roles and theory is important not only for ensuring positive impacts for PSUs, but also for ensuring good working conditions for peer support specialists. Research has documented that a lack of clarity around peer support roles and responsibilities can lead to stress and confusion among PSSs (Crane & Lepicki, 2016; Cronise et al., 2016; Simmons et al., 2020; Wallker & Bryant, 2013). Additionally, the under-specification of roles and theory can also contribute to the lack of understanding or respect for peer work that has been documented among non-peer co-workers (Adams, 2020; Byrne et al., 2022; Cronise et al., 2016; Firmin et al., 2019; Shepardson et al., 2019). This issue may be particularly pronounced for young adult PSSs, and can lead to job stress, including burnout, emotional distress and exhaustion, and low job satisfaction (Delman & Klodnick, 2017; Simmons et al., 2020; Watson, 2019).

This study aimed to contribute to the theory and role clarification for one-on-one peer support for older adolescents and young adults that have been diagnosed with serious mental health conditions. Young people with experience providing and using peer support in conjunction with clinical mental health services participated in discussion groups to answer questions focused on two areas: What do young adult PSSs do when they are working effectively one-on-one with PSUs? And what is different for PSUs as a result? This information was used to develop a theory of change that links PSS activities and PSU outcomes, and describes mechanisms of change.

2. Method

The Portland State University Institutional Review Board (IRB) reviewed the study proposal, determined the study to be exempt, and confirmed the adequacy of procedures and materials for protecting participants' welfare. Young adults with experience providing peer support and supervising PSSs were paid staff of the organizations conducting the research and full members of the study team, participating in conceptualization of the project, data gathering and analysis.

2.1. Participants

The study recruited young adults who had provided and/or participated in peer support as a part of formal services provided in community-based outpatient programs focused on serving young people diagnosed with serious mental health conditions in the United States. Recruitment targeted young adults connected to first episode of psychosis (FEP) programs, as well as programs serving transition-aged young people determined to have serious mental health conditions, regardless of specific diagnosis (i.e., non-diagnosis-specific programs or NDS programs). Peer support specialists (PSSs) and peer support users (PSUs) were recruited by circulating an electronic flyer to formal and informal email listservs that reached PSSs across the nation directly, and/or reached other staff in programs employing PSSs, who then forwarded the flyer to PSSs and PSUs. The flyers provided urls and QR codes linking to further study information as well as an online form that potential participants used to indicate interest in the study, and to provide background and contact information.

A total of 52 young adults participated in small group discussions for the study, including 17 PSUs (6 from FEP programs; 11 from NDS programs) and 35 PSSs who had paid employment experience providing one-on-one peer support (16 from FEP programs; 19 from NDS programs). Both types of programs served adolescents and young adults: a recent national study found a mean age of 20.6 years for participants in FEP programs (WESTAT, 2019a), and the NDS programs contacted for the study served young people up to age 24, typically offering peer support to those over 14 years old. The young adult PSSs that participated in discussion groups were aged 18–28. Of the total sample of 52 young adults, 7 identified themselves as Black, 6 as Latino/a, 2 as Asian and 37 as White/Caucasian. Regarding their gender, 18 identified as male, 27 as female and 7 as non-binary.

2.2. Data collection and analysis

A total of 24 discussion groups were held, 7 for PSSs and 3 for PSUs in FEP programs, and 10 for PSSs and 4 for PSUs in NDS programs. Discussion groups were held in three "rounds," allowing the project team to work on analyzing the data and formulating new questions between rounds. Modal group size was 3, though groups ranged from 1 to 5 participants. (There were two "groups" with only one participant due to no-shows. The same questions and probes were used for these sessions.) PSSs were invited to participate in up to 3 discussion group rounds over time, with modal participation being 2 groups. PSU groups occurred after the PSS groups were complete, and each PSU participated in a single discussion group only. Most groups had two facilitators, one of whom was a young adult with experience providing peer support; however, four groups had only one facilitator. Participants were paid $25 per hour via Venmo or gift card for participation.

The small group discussions were held online and recorded via Zoom. The first round of PSS groups began with an introduction to the purpose of the study and a discussion of two questions: *"What do PSSs do when they are working effectively?"* and *"What kind of impact does this have on PSUs?"* After a general discussion of these questions, facilitators guided participants to unpack terminology they had used and to provide concrete examples. Questions for subsequent rounds were based on preliminary analyses, and asked participants to provide further clarification of key terms as needed. Other questions in later rounds focused on additional topics that had come up repeatedly in the early rounds due to their impact on PSS activities and/or outcomes, including training, organizational support and co-worker relationships, what makes a peer a peer, and the how a PSS's practice might be individualized or change over time in their work with a given young person.

To analyze the data, four members of the study team—including two young adults with lived experience—worked with transcripts from the discussion groups, using reflexive thematic analysis (Braun & Clarke, 2019, 2023), an approach to qualitative data analysis in which existing theory and constructs (in this case, those related to peer support practice and theory) are held in mind as potentially relevant during the development of coding themes as emergent themes are identified in the data using a specified inductive process (Braun & Clarke, 2023). For this study, each team member separately reviewed the transcripts from a completed round of discussion groups, identifying codes and exemplar excerpts, creating and editing code and theme descriptions, and attaching "memos" to particular excerpts for later group discussion. As analysis proceeded, the team worked collaboratively and iteratively to identify additional exemplar excerpts for existing codes and themes and/or recategorize exemplars into new codes, to group/re-group codes within themes and themes within larger themes, and to review and revise theme definitions in light of revised sets of exemplars. The team also developed questions for the next round of discussion groups, to encourage participants to reflect on key constructs, codes and themes where the team had uncertainties. Reflexive thematic analysis was particularly appropriate for this study because the PSSs themselves came into the discussions with quite a bit of exposure to terms and constructs that appear in the existing theoretical and practice literature on peer support, and our approach encouraged them to use their own words to unpack the meaning of these terms. Additionally, since the rounds of data collection were interspersed with rounds of analysis, the research team was able to use later discussion groups to have participants reflect directly on the themes that had been identified and their definitions and exemplars, as well as the relationships between the themes.

All of the PSS study participants were invited to review key study findings and to provide feedback on these—including the specific

wording that would be used to label and define the key categories of findings—via internet surveys. Thirty-one of the PSSs completed surveys. Additionally, four PSSs read a draft of this article and provided written feedback. This feedback was incorporated into the submitted version of this article.

3. Results

Thematic analysis resulted in the development of a peer support theory of change detailing how and why peer support positively impacts young people with serious mental health diagnoses (see Fig. 1). Note that participants were not asked directly to name the theoretical mechanisms causing change (shown in italics in Fig. 1). These mechanisms of change were generated by project staff to fill in plausible, well-recognized theoretical rationales for causal connections described by the study participants.

3.1. Developing a peerness-based relationship (PBR)

A *peerness-based relationship* (PBR) was identified as the key driver of peer support outcomes in this study. A PBR is characterized by a PSU's perception that, compared to other people in their lives, their PSS is uniquely able to understand and relate to them, and has a uniquely helpful perspective to offer. Factors contributing to the development of a PBR included not only experiences or facets of identity that a PSS might have in common with a PSU, but also a manner of self-presentation and interaction that is seen as unique to PSSs, particularly as compared to other mental health professionals that a PSU might interact with.

3.1.1. Experience as a basis for unique understanding. Study participants described how a PSS's personal experiences related to having a serious mental health condition and receiving mental health treatment provided the foundation for a PBR built around the PSS's unique ability to understand a PSU.

> *I have found that like clients can say things that are hard to understand, but I know exactly what they're talking about like, for example, the other week a client told me that psychosis made them feel like they weren't human. (PSS-FEP)*

> *… just sharing a little bit about my experience, so they immediately know we have some similarities, that I'm a safe person, that I do understand some of what they've been through. So that's, you know, clinicians don't do that. (PSS-NDS)*

Study participants spoke frequently of how being close in age also contributes to a unique type of understanding that PSSs draw on in their work. Some of these shared experiences were based on being part of a specific generation, and ranged from popular culture, social media and technology to political upheaval, economic stressors (e.g., housing costs, educational debt, lack of access to jobs paying a living wage) and climate change. Participants also stressed the importance of current or recent experience, versus the more remote memories that professionals might have of their own early adulthood.

> *Professionals can think so [that they remember what it's like to be a young adult], but every time you recall those memories they changed a little bit every time, and that's like not just a feeling, but it's actually, we actually know every time you access a memory it'll change. (PSS-NDS)*
> *I think we had some important things in common, like he was around the same age as me, um, he was also kind of you know grinding to get an honest first job and, like, I was in like similar life circumstances. (PSU-FEP)*

Participants cited a variety of other kinds of shared personal characteristics, aspects of identity and types of experience that had contributed to building a PBR in specific PSS-PSU relationships, including: having the same gender identity, being a survivor of sexual assault, being a person of color or having a history of substance use disorder or involvement in foster care or the justice system.

> *As a young person of color we go through a lot of very culturally specific kinds of traumas, for example, last summer [PSUs] would reach out to me and say, "Hey I'm having a really hard time dealing with what happened George Floyd." (PSS-NDS)*

As much as having shared experiences were emphasized as critical for the emergence of a PBR, both PSSs and PSUs gave examples of how *not* sharing key experiences or identities might not necessarily hamper PBR development:

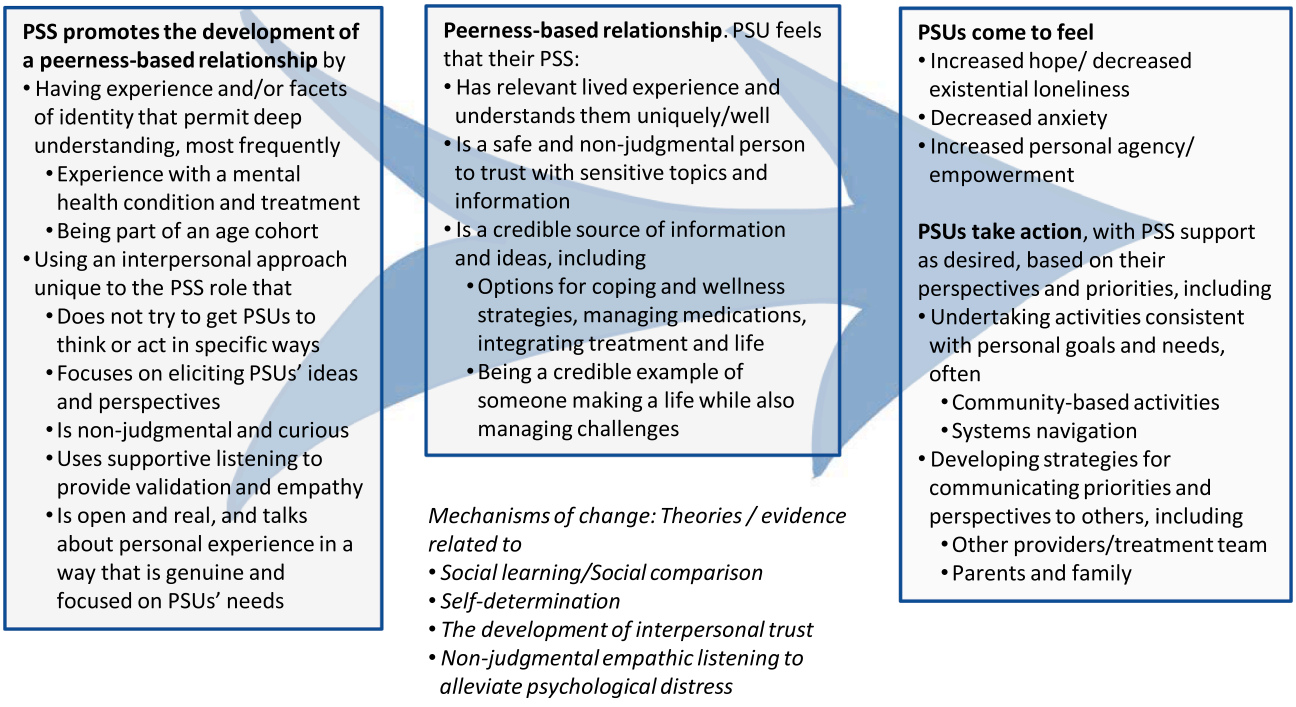

Fig. 1. Outline of a theory of change for one-on-one peer support for young adults.

We're not going to understand everything, you know, so I think yeah being curious and sort of just being really honest about like what we can relate to and can't relate to, and just treating people's experiences as real, because they are real, whether or not we might agree or be experiencing the same thing. (PSS-FEP)

However, in other examples, not sharing certain key experiences or aspects of identity *was* seen as potentially detracting from developing the type of understanding that characterizes a peerness-based relationship:

An African American youth, or you have like a trans youth, who has maybe a white or a cis-gendered youth peer support. They won't exactly understand why specific things are really important and might not know exactly what to look for in terms of how a young person might need to be supported, or how to start those conversations. (PSS-NDS)

3.1.2 Interpersonal approach. PSSs and PSUs made the case that having key shared experiences or identities was important but certainly not sufficient for building a PBR. It was equally important for PSSs to interact with PSUs in ways that were specific and unique to the role. First, it was important for PSSs to use a non-directive interpersonal approach that did not use suggestion or persuasion to try to get PSUs to think or do specific things. Rather, PSSs were concerned about helping PSUs to explore their own perspectives and ideas about their experiences, their lives and their treatment.

It's not my job to be like, "Oh, you should do this, and this is how you should communicate, you know, it's not my job to tell you how to live your life." (PSS-FEP)

This mode of interaction was seen as unique to the PSS role, in fact, frequent comparisons were made between how PSSs and other professionals interacted with PSUs. Unlike PSSs, other mental health professionals were seen as using the power of their roles to encourage service users to think or act in certain ways, or to undercut their experience of what is real for them.

I have one [PSU], she has a spirit husband and she has celestial children, you know and, like our prescriber's like "Oh, we have to break her delusions," and I'm like, I think for a peer , or at least for me, I'm just making sure that I'm being supportive, like I don't want to break her down, you know. (PSS-FEP)

PSSs acknowledged that they had some degree of power over PSUs, but described this power differential as very limited compared to the power of other mental health professionals.

But there is different power. We, we have power over the clients as well and stuff but, like our level of power, isn't nearly as high like as it is for other roles. (PSS-NDS)

Further, PSSs described how important it was for them to be cautious about using their interpersonal power when offering ideas or anecdotes from personal experience, so that a recipient would not be swayed to the PSS's perspective.

But that's just me, I am not going to tell you what to do, what you should do, and I even then like hesitate on like saying what I would do in that situation, because I feel like they would be like, sometimes they sort of look at you in a way that's like "Okay, then that's what I should do," and I'm like, "No, no, no." Um it's really just giving them tools to make their own decision at the end of the day, so I give them plenty of options. (PSS-NDS)

Similarly, PSSs described the importance of maintaining a curious and non-judgmental posture toward the ideas, perspectives or interpretations that recipients might offer. PSSs described themselves as using supportive listening techniques such as open-ended questions and reflections to provide empathy and validation of a PSU's experiences and perspectives.

I try to always show that I'm coming from a place of like curiosity and not judging and also like doing my best to not use clinical language to talk about them. Which is, does differ from the other people on my team. (PSS-FEP)

PSSs' non-directive approach was also focused on eliciting PSUs' own ideas about their services and the steps they might take that would contribute to wellness, quality of life and progress on goals they had for themselves.

With the little crumbs that they leave I can, you know, follow and ask more about and expand upon it. And using open-ended questions, so that they can build trust that what they want is something that would be good for them. Making sure that they're confident in themselves is usually my main goal. Because a lot of them aren't very confident and [don't] trust themselves. (PSS-FEP)

In addition to being scrupulous about not trying to get PSUs to do or think certain things, PSSs also described their mode of interaction as unique in terms of the extent to which they strove to be real and open with recipients. Conversely, not being this way was seen as detracting from the development of a peerness-based relationship.

So just being real with people that like this is a continual process like the recovery process isn't linear. In that there's no like end date to it. Right, this is just a continual process um and so being vulnerable with people but also just like showing people that you can recover– what that looks like and not giving up (PSS-NDS)

PSSs and PSUs described how, when PSSs were real and open, they were making themselves vulnerable, which was identified as a key and unique feature of the relationship.

But being vulnerable, I remember when I first got into this and I thought, like, "Oh I can't tell anybody about, I can't you know, I need to look good to my clients," and the best thing was like my clients calling me on my shit you know and then me just being like, "Yup you're right." (PSS-NDS)

Finally, study participants pointed out that PSSs needed to be able to share information about their own experiences in a way that maintained a focus on what was useful for recipients, versus serving PSSs' own needs through venting, "propping up their self-image," or "working through their own baggage."

Study participants were clear about the ways that PSSs' interpersonal approach was different from other provides'. However, they were equally clear about how the interpersonal approach of the PSS role was different from that of a friend:

Young people don't want to burden their friends… I'm not your friend. You don't have to worry about me in the same way that I worry about you. You don't need to, if you don't ask about my life I don't view that as a personal slight. (PSS-NDS)

3.2. Characteristics of a PBR

Study participants clearly described how PSSs' experience, identity and interpersonal approach facilitated the emergence of a peerness-based relationship (PBR)—a unique type of relationship that in turn served as the foundation for other positive outcomes. A PBR could be recognized through PSUs' perceptions about the nature of the relationship. First and foremost were PSUs' feelings of being understood and validated in a unique way.

[My PSS] had been in my shoes a lot, and even if they hadn't [experienced exactly the same thing] it felt like they were listening to me from my point of view, versus from the outside. (FEP-PSU)
I mean the best part about having a peer mentor is that they had lived experience as well, and just being able to hear parts of her story relate to mine really help build a connection of some sort, like with a therapist or psychiatrist it just wasn't there. She really, she understood. (PSU-NDS)

Peerness-based relationships also were characterized by PSUs' sense of trust in their PSS. One form that this trust takes is PSUs' perceptions that a PSS is a "safe" and non-judgmental person to trust with sensitive topics.

> *They trust me more so they will be like, "I don't want to share something with my therapist or psychiatrist," but tell me. (PSS-FEP)*
> *And also, like, just being honest, because I feel like sometimes we have the thing that we want to say but we're not saying it. And I think with a good connection [with a PSS] you don't even really like censor. But yeah, you don't like, you don't filter yourself to be palatable for someone else. You just kind of talk and you're received. And it doesn't feel like you're disclosing something that you're not comfortable with. (PSU-NDS)*

Participants described another form of trust within PBRs, namely PSUs' perception that their PSS was a credible source of ideas, options and information for them to consider as they evolved their own perspectives on their mental health, wellness, coping strategies, treatment and future. Importantly, this included seeing PSSs as a credible example of a person making a life while also continuing to manage challenges related to mental health and wellness.

> *Having been in a hopeless place, you know, myself at times, having [a peer as] an example, something to hold on to is really important, I think. (PSS-FEP)*
> *Say I have an episode. I go on medical leave and then I come back to work. And I'm still a role model for doing that because my life is not disrupted or abandoned, whereas the feeling of many of our clients is that's what an episode does. (PSS-FEP)*

3.3. Peer support outcomes

Participants described several positive outcomes for PSUs resulting from the successful development of a PBR. Participants believed that when PBRs developed, recipients gravitated to new, more hopeful ways of understanding their current circumstances and possibilities for the future. In particular, PBRs helped alleviate hopelessness, existential loneliness and feelings of being "not normal" or even "not human."

> *You know it's like just the existence of other people being open to each other in that way, can like inspire hope. (PSU-FEP)*
> *I opened up a little bit more after my positive peer support experience. Like before, I had kind of the doubt, like, I just kind of doubted that anybody could understand what I was going through, and everything felt like you just felt very alone in it. And then I think after that I was proven wrong. And I was like, "Oh, okay, so I'm not the only one." (PSU-NDS)*

In turn, when feelings of hopelessness and alone-ness lifted, PSUs could experience profound relief and a dissipation of anxiety.

> *Being understood in that way is like extremely important, and so validating and normalizing these experiences when they're going through a mental health crisis, I think, is really important to reducing anxiety and making you feel normal. (PSS-FEP)*
> *It's just big like, I don't know, it takes a weight off your back almost because you feel like you're not alone. (PSU-FEP)*

PBRs were also seen as facilitating PSUs' empowerment and agency.

> *And for these young adults like maybe having a peer is the first time they've been asked to take more charge in their personal wellness so really building those tools for them to take care of themselves. And that's, that can be a really empowering process to know that, you know, they're in charge of their own lives and their wellness. (PSS-NDS)*
> *[Working with a PSS] made me feel a lot more validated and certain in certain ways because I felt like when I was given any sort of advice, I was told that it would be okay if it didn't work out or if I had to go a different route. And I didn't feel pressure, so I just felt more validated in being myself and doing things my own way. (PSU-FEP)*

As PBRs develop, emerging information about PSUs' perspectives and goals leads to taking action. First, PSSs often work with PSUs on activities or goals PSUs have identified. Most typically these are community-based activities that run from having coffee or going for a walk or hike, to taking steps towards getting a job or a place to live. Often, this work includes supporting PSUs in navigating systems and accessing benefits and additional services.

Additionally, PSSs may work with PSUs on strategies to communicate PSUs' perspectives and goals to other key people in their lives, usually other providers and, less frequently, family members, employers or friends. PSSs in FEP programs spoke particularly about how they advocated for their PSUs' perspectives during treatment team meetings (which PSUs do not attend).

> *They [PSUs] have things that they just needed to share that they have not been comfortable to share with their therapist yet. Usually I'm the person they shared it with, so I guess like a small goal within that is like we talked about it and then talk about like, how can they share that with their therapist, can they get additional support for that? (PSS-NDS)*
> *Like planning how to talk to my family about some boundaries… (PSU-NDS)*

4. Discussion and conclusion

Much of the previous literature on peer support has focused on the construct of "peerness," or "…the qualities and/or experiences that make a peer a peer" (Nicholson & Valentine, 2018, p. 158) as a key active ingredient leading to outcomes from peer support (Muralidharan et al., 2017; Nicholson et al., 2022; Silver et al., 2016). Analyzing the data for this study led us to propose a somewhat different theoretical model, summarized in Fig. 1, for how peerness operates in producing outcomes. We propose that it is not the qualities and experiences per se that lead to positive outcomes, rather that outcomes are enabled when a specific type of relationship—a peerness-based relationship or PBR—develops between a PSS and a PSU. Furthermore, our model proposes that aspects of shared experience and/or identity are necessary, but not sufficient for the development of a PBR. It is equally necessary for PSSs to use an interpersonal approach that is unique to PSSs versus other providers in mental health treatment contexts. This approach is grounded in empathic listening, and focuses on drawing out and validating PSUs' priorities, perspectives and ideas. Additionally, the development of PBR depends on a PSS's skill in sharing from personal experience in a way that is open and genuine about past and current struggles and successes. Of course, as conveyed in the quotations provided previously, Fig. 1 is a simplification of a complex process in which feedback loops operate between and among aspects of PSS activities, the PBR relationship and PSU outcomes as they interact and build over time.

Study participants' descriptions of the connections between PSS activities and PSU outcomes are in line with several evidence-supported theories from social psychology, positive development and mental health, shown in italics in Fig. 1. Social Learning (Bandura, 1977) and Social Comparison (Festinger, 1955) theories provide a rationale for why, when recipients see key similarities between themselves and PSSs, they are likely to feel more "normal" and hopeful (Gillard et al., 2015). Self-determination theory and research (Deci & Ryan, 2008) back participants' contention that supporting PSUs in making choices and taking action steps based on their own priorities and perspectives can lead to increased motivation, feelings of agency/empowerment and positive affect. Interpersonal trust theories see reciprocal vulnerability, including the disclosure of sensitive information, as a foundation for strengthening trust and perceptions of credibility (Lewicki et al., 2006; Luhmann, 1988). Findings from meta-analyses examining the impact of common and specific factors on psychotherapy outcomes show expressed empathy as a crucial determinant of outcomes. In fact, the effect size for empathy is consistently larger than most other common factors and all specific factors that appear consistently in mainstream models of mental

health intervention (Wampold, 2015). Finally, theory and evidence for various psychotherapies and other forms of emotional support that are based in non-directive, non-judgmental, active and empathic listening and reflecting show that this general approach can be very helpful in alleviating distress (Murphy & Joseph, 2016). Interestingly, in a randomized study of young people at "ultrahigh" risk for psychosis, non-directive reflective listening—included in the study as a control condition—provided greater reduction in distress than Cognitive Behavioral Therapy (Stain et al., 2016). Similarly, a large study comparing three bipolar disorder treatments for young people aged 15–25 found that psychosocial outcomes under the control condition, "befriending," were no different from those under the specialized bipolar disorder treatment models (Chanen et al., 2022).

The findings from the current study include both similarities and differences to previous descriptions of PSS roles and mechanisms of change. With regard to studies focusing on older youth and young adults specifically, there are similarities between the model and the key themes identified in Hiller-Venegas et al.'s (2022) study of PSS roles from the perspective of PSUs, particularly the importance of building trust-based relationships and supporting empowerment, and of having PSSs acting as examples of recovery. Similarly, several of the proposed mechanisms of change listed in Halsall et al. (2021) have parallels in the current study. Specifically, mechanisms suggested by Halsall et al. connect PSSs' lived experience—including experience-based practical knowledge regarding strategies for coping and maintaining wellness—to PSU outcomes including empowerment, decreased loneliness and well-being. Parallels also exist between the current study and prior work focused on peer support for adults. For example, like the current study, the model proposed by Gillard et al. (2015) identifies building trusting relationships based on shared lived experience as the key mechanism underpinning peer support interventions. Trusting relationships encourage PSUs to identify with PSSs as successful recovery role models, thereby building hope and empowerment. The Gillard et al. model also highlights the role of peer support in promoting engagement in the community. Recently, Watson (2019) reviewed 13 studies of peer support for older adults and identified general mechanisms through which PSSs promote outcomes, including using lived experience to build trust and credibility; engaging in an emotionally genuine manner; enacting a role that combines aspects of a service provider and a service user; and providing strengths-focused social and practical support.

In sum, the model from the current study resonates in many ways with previous studies, in which similar types of role and theory elements recur, albeit in varying constellations and with differences in definition. Nevertheless, the current study also contributes new perspectives. Partly, this is a result of choices regarding method, which reflect the key priority for future work identified in the discussion in Watson's review, i.e., to "clarify how these mechanisms contribute to peer support in different contexts" (p. 677). Specifically, the population for the current study was young adults and included both PSSs and PSUs; the focus was limited to one-on-one peer support provided as part of multi-component programs including other clinical services; and PSSs were engaged in multiple rounds of discussion to inform iterations of the model. This is in contrast to previous studies, of which the large majority focused on a general/older adult population, included either PSSs *or* PSUs, included participants from across a broad range of program types and contexts, and did not involve participants over time in specifying elements of role or theory. While bearing similarities to findings from other studies as noted above, the current model contributes new information and propositions in terms of its specific definitions of a set of role and theory elements (as presented through description and quotations in the body of the text) and the manner in which these elements are arranged to propose causal connections. The model highlights the key importance of the PBR as a potential mediator of other outcomes, and defines the PBR as one in which the PSU has a specific set of perceptions about the relationship, including perceptions that their PSS has relevant experience, understands them well, is a safe person and serves as a credible source of information. Further, the findings—including descriptions and quotations from the text—highlight how a skilled young adult PSS works to create the conditions that facilitate the development of a PBR.

The relational approach to peer work collectively described by participants in the current study represents a coherent and plausible theory of change for one-on-one peer work with older adolescents and young adults. Furthermore, participants' descriptions and examples of PSS interactions and activities form a helpful framework for clarifying the role. In turn, role clarification provides a basis for creating training and ongoing professional development that can help PSSs become more confident and competent in their role, and ensure that other colleagues, supervisors and managers are better able to understand and support the PSS role. As numerous studies and reports have pointed out, improved training and understanding should contribute to decreases in the high levels of work-related stress, burnout and microagressions that PSSs often report (e.g., Cronise et al., 2016; Delman & Klodnick, 2017; Firmin et al., 2019; Walker et al., 2022; Watson, 2019).

Findings from the study have several important implications for training, implementation and research on the PSS role. First, as noted previously, it's quite clear from participants' comments that having certain kinds of personal experience is probably necessary, but certainly not sufficient for forming a PBR. A majority of the PSUs described relationships with PSSs that did not work out (though in almost all cases, they were contrasting these unsuccessful relationships to other PSS relationships that were more helpful), and PSSs also described circumstances under which PBRs did not emerge. In some cases, this was traced to PSSs not feeling comfortable or not having skill in talking about their personal experiences, to PSSs having difficulty expressing empathy in a way that came across as genuine, or to PSSs interacting with recipients in a way that was not empowering. Fortunately, these types of interpersonal skills are malleable and can be enhanced with targeted training and professional development (Walker et al., 2022).

However, personal experiences and key aspects of identity are inherent rather than malleable. Participants clearly held the opinion that, in certain instances, experiences or identities that were *not* connected to mental health conditions or treatment—for example, being queer, having experienced a substance use disorder, experience in foster care, being a survivor of sexual assault, being Black or Latino/a—were more important for allowing a particular PBR to emerge. Other studies and commentaries on peer support have come to similar conclusions (Corrigan et al., 2017; Nicholson & Valentine, 2018; Silver et al., 2016; Simmons et al., 2020). This challenges the field to understand more about when and why PSUs perceive their relationships with PSSs as based in peerness, and to come up with strategies to respond when a PBR is not emerging. Furthermore, if the emergence of a PBR is necessary in order for peer support to "work," then it is essential for this to be assessed as a potential mediator in studies examining the effectiveness of peer support interventions.

Study findings also imply the need for a more nuanced understanding of what is meant by mutuality in the context of peer support for youth and young adults. Mutuality is often described as a cornerstone of peer support (e.g., Myrick & del Vecchio, 2016; Nicholson & Valentine, 2019; Silver et al., 2016). Study participants did describe aspects of PBRs that were mutual, particularly mutual vulnerability in the sharing of sensitive information. However, they were also firm about aspects of the relationship that were not mutual, for example, that PSSs had more interpersonal power within relationships, as well as many more responsibilities, including responsibilities to guide meetings, to be a mandatory reporter, and to adhere to the PSS role expectations. As noted previously, participants distinguished their role from that of a friend, and explicitly challenged the idea of peer relationships characterized by mutuality:

> *If you ask people what peer support is you're going to hear the word mutuality. The [specific training] that is the training for most peers in our state really stresses mutuality… I think that word is hard, because it*

sounds like friendship or like an even exchange, but it's not an equal exchange. Even if you don't ever do anything for me, I am here for you. (PSS-NDS)

Finally, it's concerning how frequently study participants described other treatment providers—in contrast to PSSs—as being unable or unwilling to consider PSUs' perspectives. Participants offered numerous examples of providers using their interpersonal and institutional power to ignore or override PSUs' ideas, goals and interpretations of their mental health-related experiences, leaving PSUs—at least at times—feeling disempowered, misunderstood and talked down to. While other treatment providers may typically take an approach that is more directive than that used by PSSs, it is worth considering when and how directiveness should be moderated in service of improving therapeutic alliance and promoting PSUs' feelings of agency in their own lives.

Study findings should be considered in light of limitations. The study used a sample of convenience. While participants represented a range of sociodemographic backgrounds, our sample was mostly White, cisgender and well educated. The sample also likely overrepresents young adults who were "successful" in mental health programs: PSUs that stayed in treatment, and PSSs who not only stayed in treatment but also were seen by their employers as having achieved an appropriate level of recovery. Our participants were also connected to various networks that we used for recruitment. It is thus possible that participants were disproportionately likely to have experienced services in well-established programs and/or to be connected to mental health advocacy networks. As a result, it's difficult to know the extent to which participants' views and experiences reflect those of PSSs and PSUs more generally. Additionally, the PSSs were all employed in programs that served young people with serious mental health conditions, and that simultaneously provided other mental health services. The findings thus may not reflect the work that PSSs do in other kinds of programs.

Despite these limitations, the study represents a contribution to building theory and defining key aspects of a PSS role for one-on-one peer support for older adolescents and young adults. Importantly, the theory of change was developed based on the lived experience of young adults with experience providing and receiving peer support. Young adults provided these perspectives not only as research participants, but also as members of the research team, collaborating on study design, data gathering, analysis and reporting. Information and implications from the theory can be of immediate use in creating trainings and enhancing supervision and other organizational supports to promote positive experiences for both PSSs and PSUs.

CRediT authorship contribution statement

Janet S. Walker: Conceptualization, Writing – original draft, Supervision, Funding acquisition. **Vanessa V. Klodnick:** Conceptualization, Writing – original draft, Supervision. **Brianne LaPelusa:** Validation, Writing – review & editing. **Shannon M. Blajeski:** Validation, Writing – review & editing. **Alex R. Freedman:** Validation, Writing – review & editing. **Shannon Marble:** Writing – review & editing.

Declaration of competing interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data availability

The data that has been used is confidential.

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