HHS Public Access

Author manuscript

Community Ment Health J. Author manuscript; available in PMC 2023 January 01.

Published in final edited form as:

Community Ment Health J. 2022 January ; 58(1): 111–120. doi:10.1007/s10597-021-00800-1.

Understanding Users' Perspectives of Psychosocial Mechanisms Underpinning Peer Support Work in Chile

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Author contributions: All authors contributed to the analysis included in the article. All authors read and approved the final manuscript.

Ethics Approval:
Informed consent was obtained from all individual participants included in the study. The authors affirm that human research participants provided informed consent for research publications.

Conflict of Interest: The authors declare that they have not conflict of interest.

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Abstract

This study explores the beliefs and attitudes about the psychosocial mechanisms of peer support work among users who participated in Critical Time Intervention-Task Shifting (CTI-TS), which tested the acceptability and feasibility of a peer support work model to improve community-based mental health care for individuals with psychosis in Latin America. We conducted a secondary analysis of 15 in-depth interviews with CTI-TS participants in Chile, using the framework method and defined the framework domains based on five major mechanisms of peer support work identified by a recent literature review. The analysis revealed that users' perceptions of peer support work mechanisms were strongly shaped by personal motivations, beliefs about professional hierarchies, familial support, and the Chilean mental health system's incipient recovery orientation. The findings underscore the importance of adopting culturally tailored strategies to promote peer support work, such as involving mental health professionals and fostering equal-powered relationships between PSWs and users.

Keywords

community mental health; peer support work; service users; psychosocial mechanisms; framework method; Latin America

Introduction

Peer support work in mental health services is a strategy of formally employing experienced service users as peer support workers (PSW) to provide instrumental and socio-emotional support to other users who are starting their recovery process, which has been defined as a transformation journey towards a meaningful life in community where individuals can

strive for their full potential (Davidson, Bellamy, Guy, & Miller, 2012; SAMHSA, 2010; Woodhouse & Vincent, 2006). Peer support work can be part of a task shifting strategy in which work typically done by highly trained professionals is distributed to those with less specialized or advanced qualifications (Hoeft, Fortney, Patel, Unützer, 2018). Although a few studies have presented inconclusive findings (Bellamy et al. 2017; Pitt et al., 2013), there is strong evidence to suggest that peer support work can improve clinical as well as psychosocial outcomes in both the novice users and the PSWs (Cabassa, Camacho, Vélez-Grau, & Stefancic, 2017; Coniglio, Hancock, & Ellis, 2012; Fuhr et al., 2014; Gillard, Edwards, Gibson, Owen, & Wright, 2013), including in low-resource settings such as South Asia (Fuhr, Weobong et al., 2019; Rahman, Malik, Sikander, Roberts, & Creed, 2008; Sikander, Ahmad et al, 2019; Singla et al, 2014).

A key to understanding whether and how the PSW role works is to understand the underlying psychosocial mechanisms (Chinman, 2017; Lloyd-Evans et al., 2014; Rogers 2017). Researchers have suggested several theories and concepts that undergird peer support work, including social learning theory (Bandura, 1969), helper-therapy principle (Riessman, 1965), experiential knowledge (Borkman, 1990), and intentional peer support (Mead, 2005). In an influential review of peer support work among persons with lived experience of mental distress, Davidson and colleagues (2012) identified three unique components of PSW roles: provision of hope through positive self-disclosure, ability to role model recovery and coping, and quality of the relationship between PSWs and recipients. Building on these works, and those of other mental health scholars, Watson (2017) conducted a scoping review of the mental health literature on peer support work and summarized five essential mechanisms underpinning peer support relationships. First, *provision of strengths-based social and practical support*, is based on the users' needs, interests, and strengths. This includes support with daily life and social activities such as accompanying users to appointments or social and community outings. Second, *use of lived experience* is how PSWs draw from their own experiences of recovery to connect with users and provide hope. Third, *love labor* refers to the "emotionally-engaged work" required to ensure the emotional safety and wellbeing of both the PSW and the user. Fourth, the *helper role* mechanism signifies the PSWs assuming the responsibility of helping others, which could facilitate their own recovery. Fifth, the PSW's *liminal position*, being both within society as a mental health service user and within mental health services as a worker, allows PSWs to serve as role models of recovery to other users and mental health professionals.

This current understanding of the psychosocial mechanisms underlying peer support work, although comprehensive, is primarily based on models developed and implemented in English-speaking, high-income countries, notably in the U.S., U.K., Canada, Australia, and New Zealand (Gillard, 2019). Little is known about how this framework applies to peer support work in non-English-speaking mental health systems, where social and cultural ideologies and beliefs can be considerably different. As raised by an international charter of peer leaders in mental health, it is "unclear [if there are] culturally specific versus more universal aspects of peer support [work]" (Stratford et al., 2019). Few researchers have sought to explore this question, and fewer have done so from the perspectives of Latin American service users.

In Latin America, despite having a strong cultural emphasis on solidarity and social support (Sanabria, 2007), models in which peers are formally employed in the mental health system remain a novel and poorly understood concept (Agrest & Stastny, 2013; Mascayano et al., 2019; Stastny, 2012). In Chile, there exists a long tradition in community mental health services (Minoletti, 2012), and the 2017 update of the Mental Health and Psychiatry Plan opened the door for the incorporation of PSW roles and promotion of a more recovery-oriented approach to mental health treatment (Ministerio de Salud de Chile, 2017). However, the biomedical model still prevails (Minoletti, Galea, & Susser, 2012) and non-hierarchical relationships between users and health professionals remain uncommon (Mascayano & Montenegro, 2017). As these progressive mental health policies and strategies are further developed, a better understanding of how peer support work models are perceived by users is needed. On the one hand, the strong emphasis on family bonds and Catholicism, along with widespread social class divisions, authoritarianism and lack of social cohesion (Larraín, 2001; Tironi, 1990), and, on the other hand, the mental health services' structure and functioning with scarce territorial work and no mental health law, may have important implications for the appropriateness, acceptability, and necessity of the implementation of peer support work models in Chile and other Latin American contexts.

This article explores how peer support work is perceived by a sample of Chilean mental health service users who participated in Critical Time Intervention-Task Shifting (CTI-TS), a community-based psychosocial program to promote the recovery and community integration for people with severe mental distress (or, as defined in the research protocol, individuals with affective or non-affective psychosis). CTI-TS is the first known published model of incorporating PSWs into the mental health service delivery system in Chile and the first pilot randomized control trial (RCT) of a recovery-oriented intervention in Latin America (Agrest et al., 2019; Mascayano et al., 2019).

The pilot RCT of CTI-TS was conceived as a crucial step geared towards a broader objective of encouraging regional efforts to address limitations in community-based mental health. The intervention consisted of three consecutive phases, each lasting three months, and incorporated a PSW and community mental health worker (CMHW) within a task-shifting approach who worked collaboratively towards improving patients' health-related quality of life and meeting their needs, but with distinct roles (See Table 1). PSWs provided the users with individualized support and mentorship, and strived to engage the users, their families, and other community members in the user's recovery process, while CMHWs focused on building the users' formal support networks in health centers, social services, and the community (Conover & Restrepo-Toro, 2013). PSWs were recruited from local mental health centers and selected based on their user experience with mental health services and interest in helping other service users. PSWs received 54 hours of manualized training on topics such as the peer support movement, recovery orientation, active listening skills, creating a trusting relationship with users based on mutual respect, problem solving, and developing plans for crisis management and post-intervention monitoring. They also attended weekly supervision meetings with mental health professionals throughout the intervention. Specific diagnosis or having social support were not required to be invited to the project. However, during training other emerging criteria were considered before the final selection (i.e., empathy skills, disposition and ability to work as a team with the

community mental health worker, own progress in the recovery process, etc.). Further details on enrollment and training can be found in the project's protocol paper (Mascayano et al., 2019).

In this study we examine the applicability of the mechanisms underpinning peer support work as proposed by Watson (2017), informed by sociocultural factors that might impact the relevance and success of the outlined mechanisms in the given context to support the development of peer support work in Chile and other Latin American countries with similar mental health system and sociocultural characteristics.

Methods

Data Collection, Participants, and Context

Data for this study included in-depth interviews with n=15 users who participated in CTI-TS in Santiago, Chile. Participants were randomly selected from a total of 30 users who received the intervention. Interviewed participants included ten males and five females, with ages ranging from 21 to 65. Seven participants (45%) were diagnosed with non-affective psychosis and eight (55%) with affective psychosis (see Table 2). Sociodemographic characteristics did not differ between users who were interviewed and those who were not. Data were collected as part of a larger qualitative study conducted in 2015–2016 evaluating the barriers and facilitators to the implementation of the pilot RCT of CTI-TS (Agrest et al., 2019; Mascayano et al., 2019). The interview guide included questions and probes that specifically evaluated users' experiences with the PSWs including how users perceived the services they received from someone with a history of mental illness (independently and in comparison to mental health professionals), the practical support they received from PSWs, and the logistical, social and emotional barriers to engaging with the PSWs (see Supplementary File 1 for list of relevant questions included in the guide). Interviews took place in the users' homes, lasted between 45 and 60 minutes, were audio-recorded and transcribed verbatim in Spanish by Chilean Spanish speakers, and were then translated to English by bilingual speakers. Any "Chileanisms" or idiomatic expressions were checked with native Chilean research team-members. The study was approved by the local ethics committee of the University of Chile and the Institutional Review Board of Columbia University. All interviewed participants provided consent for their data to be used in the research.

Analysis

We employed framework analysis (Gale, Heath, Cameron, Rashid, & Redwood, 2013; Ritchie & Spencer, 1994; Srivastava & Thomson, 2009), with Watson's (2017) five mechanisms of peer support serving as the basis of the thematic framework. A small team, independent from the data collection team, which included graduate-level clinical psychology trainees, professional clinical psychologists, and global mental health researchers, worked on analyzing the data. We first gained familiarity with the data by reading and coding the first few transcripts. We initially focused on user's responses about their perceptions of the PSWs, but also included user perspectives when they discussed the collaborative team of PSWs and CMHWs together. We met virtually each week to compare

notes and agreed on the codebook for the remaining transcripts, and then independently coded each assigned transcript, noting illustrative quotes for each mechanism. Subsequently, these quotes were arranged in a grid where the rows represented cases and columns represented codes. This facilitated comparison and analysis of coded data within cases (i.e., transcript), as well as across cases to identify common and distinctive perspectives and experiences. Throughout the analysis, we wrote memos to note any culture-specific issues that may have enhanced the interpretation of findings (Birks, Chapman, & Francis, 2008).

We also strived to engage in a reflexive process, considering how the researcher's background and subjectivity influences interpretation of data (Primeau, 2003). For example, at the stage when we were independently coding interview transcripts, weekly meetings provided a platform for the analysis team to engage in dialogue around interpretation of the data. Our similar academic backgrounds ensured reliability of the analysis process while the different cultural orientations of the team members helped us in identifying and contesting biases and assumptions. Not all team members belonged to the Chilean culture which helped clarify assumptions and facilitated rich discussions on the sociocultural factors that were observed. Further, we periodically sought insights from the Chilean and other Latin American members of the implementation team to confirm the meanings we constructed from the data around the relevance of the mechanisms and cultural influences. We the authors declare no conflicts of interest and certify our responsibility for the conduct of the study, the analysis and interpretation of the data, and the writing and submission of the manuscript. All tables included in this manuscript have not been nor will be submitted elsewhere before appearing in the Journal.

Results

Results are presented according to Watson's (2017) mechanisms, including highlights of both the positive and negative perceptions among this sample of Chilean mental health service users. Table 3 provides a summary of the results for each of the five mechanisms.

Provision of strengths-focused social and practical support

Overwhelmingly, the users noted that the CTI workers' general disposition in terms of their availability and openness was extremely helpful. Participant 1 (P1) described: "*They supported me in the most difficult moments that I went through, they were with me, they even came the same day I had a crisis*." She later described this support in terms of its importance, "*to have someone who wasn't from the family who was worried about me and was with me*."

Additionally, many users highlighted the benefits of the practical, strengths-focused approach, such as accompanying them on their appointments or for social activities. One user described: "*The most useful piece was the outing, specifically. When they took me to join the tango club, that helped me a lot*" (P3). Another user explained how practical support combined with the social support helped her get through treatment:

> "What happens is that during the psychiatric treatment process…you tend to 'abandon ship' in every moment…to let it go. So, what helped me with the trained

> peer was that they were there and reminded me that we were in a process and that we have to move on."
>
> (P7)

This type of support was often perceived as complementary to the support provided by mental health professionals. Some users also highlighted the difference in the approaches between the doctors and the worker pair. For example, a user stated that doctors were more likely to ask, "*How are you? Did you sleep?*," centering on potential clinical problems, whereas the worker pair would ask, "*How are you living your life?*" (P5)

The use of lived experience

PSWs' use of their experiences living with severe mental distress resonated strongly with many users. A user's reflection illustrated how PSWs' sharing of their lived experiences promoted hope and empowered some of the users: "*There are diseases that stay forever… So, the idea is to understand that it may remain the same, but you can have a normal life. That's the interesting thing about knowing the peer support worker*." (P7)

Another user (P15) added, *"If I want to, then I should be able to do it, just like [the PSW], to get better,"* demonstrating increased confidence in recovery through the PSW' shared experience. Users also appreciated the authenticity and sincerity from the PSWs, especially because of their experience-based advice: "*They weren't talking because they wanted to talk, but rather because they had the experiences*." (P5)

Although most of the users developed emotional connections and trust with the PSWs because of their similar experiences, a few users noted that they wished the PSWs would share their personal experiences more openly. For example, one user (P4) stated that she "didn't know who [she] was with" and wanted the PSW to be more transparent about his own experience, "*Perhaps…say, 'Hey! Can I tell you something?'"* so that she would have felt more comfortable talking about her own problems.

Notably, a few participants commented that the PSW's shared experience did not immediately contribute to their recovery process. A user (P10), who expressed admiration for the PSW's commitment to recovery and journey reintegrating into the community, said: *"It isn't like 'oh, it improved my life'.. No, it's like I see it didn't help me much."* Similarly, another user (P8) also commented: *"[I felt] bad, because I have pity for people who get sick…I don't find any reason that gives me satisfaction [in hearing the PSWs story]."*

Love labor

Due to the intervention structure—i.e., the PSWs and CMHWs working as a team, participants' remarks about love labor often referred to both CTI workers. Users generally appreciated the worker pair's emotional engagement and investments in the peer relationships. A user's response (P9) captured this common sentiment: "*[The relationship] was very affectionate. They called me to know how I was, and this is uncommon to me… They were concerned about me*."

In some cases, the worker pair became an important part of users' lives. A user (P7) described: "*They knew a lot of me, and I know a lot of their lives as well*," demonstrating that some peer relationships became deeply personal and that some users also reciprocated the love labor. A few participants even mentioned that the PSW had become like "family." For instance, a user said: "*You see, we don't have friends. We got our family and our family does not come*" (P7). This user also added that he and his wife were able to easily talk to the PSW about "*almost everything that was happening to us*."

Although the love labor shown by the worker pair was well-received by most participants, some users did not develop deep relationships with the PSWs and CMHWs. Four of the users either did not make statements reflecting strong emotional bonds with the PSWs, or explicitly acknowledged that they did not have these types of relationships. Participant 15 stated that the relationship with his PSW was "*more like a 'hello and goodbye.'*" In the same vein, Participant 3 mentioned that their relationship was "*good, but not as deep*."

The helper role

While PSWs' adoption of the helper role is a fundamentally important aspect of their job and is intrinsically beneficial to them, it may not be apparent to users. However, a few users did recognize the manifestations of this mechanism. A participant provided particularly insightful comments about this mechanism and reflected the mutuality of the peer relationships:

> "It's good because it gives [the PSW] an opportunity to help others…He told me: 'I also don't want to wake up in the morning, but I have to go to work because I do nothing in my house'…He would help me with his visit and I would help him to do his work."
>
> (P15)

Another important aspect of the helper role mechanism that emerged was the users' perceptions that the PSWs' adoption of the helper role may in fact harm the PSW's recovery. Drawing on her own experiences of hiding her suffering from others, Participant 4 suggested that the PSW may have been doing the same thing:

> "[My suffering] remains inside…many pains, many sorrows…if [my family members confide in me] I don't tell them: 'you know, I'm also doing badly,' I keep that for myself and I swallow my tears."

Additionally, because this participant had relapsed herself, she was concerned that the PSW may be adversely affected by listening to her problems and suicidal thoughts, making him vulnerable to relapse. Thus, she adopted the helper role herself: *"If in that moment I had told [the PSW…about the sadness that I have…Wouldn't that have affected him? He is a human being just like me."* (P4)

A 'liminal' position within mental health services

As illustrated earlier, many participants perceived the roles of PSWs positively. A few users, however, viewed PSWs' partial identity as mental health service users as an aspect that

made them inferior, to both the mental health professionals and to some users. One user's statement illustrates the complexity of users' perceptions of the PSWs' liminal role:

> "I saw [in the PSW] a person who is worse than me and copes in a similar way or even better way. It's like there is a person who is running and another in a wheelchair. The person who is running [the user] thinks he is very bad and suddenly he sees the other person in a wheelchair [the PSW]…I saw [the PSW] as a patient, I saw him as a peer. And I see the professional as [somebody who] will help me."
>
> (P10)

Another user elaborated on the inferior status assigned to PSWs due to their identity as mental health users:

> "What happens to me is that when [I am with] the psychologist…I feel that I am with someone superior…With [the PSW] we were like peers, both equal. I don't want to look down at [the PSW], but we couldn't get into deep matters, regardless that he also had suffered from a disease."
>
> (P3)

Comments from another user reflected many Chilean users' attitudes regarding the status of peers with respect to the social hierarchy of mental health professionals:

> "[The PSW]…was only a patient…[The CMHW] was my monitor…and [the PSW] was her assistant…[The PSW] knew less than the other people that were in charge…And the psychologist had the leading voice…It was a matter of rank…Who prescribes the medications knows more…Doctors are competent…[The doctor] knows more and so I get along better with the doctor."
>
> (P15)

This user also added, *"mostly when they are cheerful or charming, with blue eyes,"* alluding to Chilean mental health service users' preferences for doctors who have European physical features and who typically occupy a higher socioeconomic status.

Discussion

This is the first study dedicated to understanding the suitability of an international peer support worker framework to a Chilean sample of mental health service users. We found that users appreciated the PSWs' use of their lived experience to provide strengths-focused support, and the PSWs' emotional commitment to working for users' recovery and their positive attitude towards developing a helper role. However, some users had ambivalent or negative sentiments with respect to the *'liminal' position* mechanism. These findings are similar to other studies that have examined perceptions of peer support work relationships and roles in mental health services (Davidson, Bellamy, Guy, & Miller, 2012; Ochocka, Nelson, Janzen, & Trainor, 2006). As peer support work is a model still novel in the Chilean mental health system, we will focus the discussion on how these perceptions reflect sociocultural dynamics within the Chilean context, to inform future efforts to incorporate

PSWs into community-based mental health care in Chile and similar contexts in Latin America.

Perhaps the most salient undercurrent that propelled users' perceptions about the peer support relationships was the set of beliefs and attitudes about professional—and other social—hierarchies. Users clearly differentiated between the roles of the mental health professionals (i.e., psychologists and psychiatrists) and the CTI workers (i.e., CMHWs and PSWs). Some participants explicitly indicated that they valued psychiatrists over psychologists, who in turn were considered more skilled than the CMHWs and then the PSWs. This deference to mental health professionals is congruent with the widespread acceptance of social hierarchies in Chile. While social hierarchies exist in virtually all societies, it is important to examine their distinctive characteristics in Chile. Social interactions in Chile have been dominated by a "soft authoritarianism" culture, a byproduct of colonial rule (Gomez & Rodriguez, 2006). Indeed, many Chileans form a class-based society in which everyday citizens often aspire to resemble and be accepted by those of higher social standing, who are typically of European descent (Bochniak-Piasecka, 2013). Users appreciated the support from the PSWs and admired the PSWs' ability to share their lived experiences and become emotionally invested to help others, but some were not fully comfortable with the PSWs' paraprofessional roles. Some users perceived the PSWs to be of the same social background, and hence, could not provide much help in improving their social standing. Furthermore, some users compared themselves with the PSW and ultimately considered themselves 'superior' to the PSW (e.g., with greater cognitive capacities or in a generally better shape). Despite reports from other studies of PSWs role modeling for users and contributing to decrease in users' self-stigma (Dahl, Mitkiewicz de Souza, Lovisi, & Tavares-Cavalcanti, 2015; Pyle, Pilling, Machin, Allende-Cullen, & Morrison, 2018), stigmatizing attitudes towards PSWs have also been described from different sources, particularly from mental health professionals (Clossey, Gillen, Frankel, & Hernandez, 2015). To a lesser extent, conflicts around "competence and agency" (Bracke, Christiaens, & Verhaeghe, 2008, p.454) have been described in the dynamics between users and PSWs, potentially affecting users' appreciation for the PSW. In particular, users may reject the idea of being recipient of aid from somebody not hierarchically superior (Brown & Lucksted, 2010; Fisher, Nadel & Whitcher-Alagna, 1982; Verhaeghe, Bracke, & Bruynooghe, 2008) or as an attempt to distinguish themselves from others who are similarly "marked" for having a mental illness (Goffman, 1963). In this sample of Chilean participants, some users' devaluation of the PSW may be expressing similar social dynamics in combination with the aforementioned cultural aspects of the Chilean people.

Given this finding, a strategy that might be particularly suited for the Chilean context is to leverage the mental health professionals' existing status. Because mental health professionals are highly valued and respected by the users, their agreement and support of incorporating PSW roles will likely enhance users' acceptance of the PSWs. A study by McLean and McLean (2009) demonstrated that involvement of psychiatric and clinical service managers, along with senior management, through one-on-one meetings and awareness campaigns to clarify the role of PSWs and the expected challenges, was crucial in raising awareness and acceptance of the PSWs among users. Mental health professionals' own negative perceptions towards PSWs must also be directly targeted, as these stigmatizing

attitudes can be projected onto the users during clinical interactions (Mahlke, Krämer, Becker, & Bock, 2014; Sapag et al., 2019).

The analysis also revealed that although the participants generally showed appreciation for the love labor and strengths-focused social support from the PSWs, some users—particularly those whose families were actively engaged in their care—did not reciprocate the intensity of the CTI workers' emotional investment. A few participants who did not have supportive family members, however, expressed that they considered the CTI workers to be "like family." This sentiment is inextricably linked to *familism*, the cultivation and prioritization of supportive family relationships, which is the prevailing social ethos in many Latin American cultures (Campos, Ullman, Aguilera, Dunkel Scheter, 2014). Thus, familism likely attenuated the users' receptivity of and reciprocity to the PSWs' socio-emotional investment and support. That is, users who had family support may not have felt the need to emotionally invest in developing deep relationships with the CTI workers, but PSWs appeared to fill an important social void for users who did not have close family members. Accordingly, future efforts to incorporate peer support work models should consider users' family background in matching them with PSWs, perhaps prioritizing users who may not have family support. Although this might add complexity to the PSW's role, PSWs may be able to demonstrate their true and unique value to such users.

Chileans' general attitudes towards the recovery of individuals with severe mental distress also strongly influenced users' perceptions of the PSWs. To both successfully incorporate the PSW model in Chile and promote acceptance of this model among users, it would be prudent to focus on efforts that further promote recovery-oriented activities. This could be achieved by further developing the guiding vision of recovery at a policy level, such as developing different types of community-based services as alternatives to psychiatric hospitalization, and educating the general population as well as mental health professionals to promote positive, recovery-oriented perceptions of individuals with mental illness (Pincus et al., 2016; Stastny, 2012). Additionally, in settings such as Chile, where the recovery orientation is still being integrated and most mental health professionals have limited knowledge about the role of PSWs, it is imperative to ensure that the uniqueness of PSW roles and authority are preserved as the integration of their roles are being explored. For instance, PSWs should not be assigned responsibilities outside of their experiential knowledge, defined as "truth learned from personal experience with a phenomenon" (Borkman, 1976, p. 446). For example, PSWs should not be asked to deal with concerns and problems such as providing information about medications or to perform administrative duties, for these tasks are beyond PSW's experiential expertise (Ardila-Gomez, Agrest, Abadi, & Cáceres, 2013; Dixon, Krauss, & Lehman, 1994; Rebeiro Gruhl, LaCarte, & Calixte, 2016; Repper & Carter, 2011). Instead, equitable relationships should be fostered, whereby the focus is not on illness management but on normalizing shared experiences and strengthening wider connections to the community (Gidugu et al., 2015; Gillard, 2019; Stastny, 2012).

Limitations

Findings from the present study should be considered in the context of several limitations. First, this is a secondary analysis of data from a larger qualitative study, so the collected data sometimes did not directly relate to in-depth analyses of specific psychosocial mechanisms. Second, although specific questions were asked about the PSWs, some participants provided responses that combined their opinions of both CTI workers, making it challenging to discern users' direct attitudes and perceptions about the PSWs. Third, because few evidence-based psychosocial interventions have been introduced in Chile, it was difficult to distinguish participants' opinions about the PSWs from their opinions about the novelty of CTI-TS.

Conclusion

Based on the five underpinning mechanisms of peer support work categorized by Watson (2017), we explored the degree to which these mechanisms are reflected and clarified among users of CTI-TS in Chile. Although many users recognized and welcomed the PSWs' use of lived experience and provision of strengths-focused social support, some also demonstrated ambivalent appreciation for the unique value of PSWs and particularly regarding the PSWs' love labor and adoption of the helper role. The observed receptions from users are likely related to sociocultural norms and practices, such as perceptions about social class stratification, familism, and the nascent recovery orientation in Chile. Future efforts to implement, disseminate, and sustain the PSW model in the country should begin with addressing these sociocultural norms—e.g., engaging mental health professionals to promote PSW roles to diminish social hierarchy. Additionally, because many of the Chilean users' perceptions about peer support work are similar to those documented in studies conducted in other contexts, strategies to promote PSW roles that have been demonstrated to be effective elsewhere are likely applicable in Chile as well. For example, there is also a need to advance the recovery orientation through policy advocacy in order to promote PSWs' true value to the users and the mental health professionals, which Chile and other Latin American countries are poised to lead in future efforts.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

Funding:

This study was funded by the U.S. National Institute of Mental Health (U19MH095718 and U19Mh095699). PhuongThao D. Le is funded by a grant from U.S. National Institute of Mental Health (T32MH103210).

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Table 1.

CTI workers' roles and target

PSW role and targets	CMHW role and targets
Engagement: Establish rapport with users, family members, and staff of local mental health centers (MHCs) and primary care health centers (PHCs). Increase awareness and understanding about CTI-TS.	
Strengthen old and create new user ties to informal community supports (self-help groups, leisure activities).	Strengthen user/family ties to community mental health center and primary care services. Establish a crisis plan with users and family.
Help users improve their role in the family by increasing self-sufficiency and positive user contributions to family functioning	Engage family members and improve family support.
Help the user build a recovery plan utilizing user's interests, strengths, and vulnerabilities to improve quality of life.	Reduce family burden of caregiving and facilitating sources of support for caregivers.

Table 2:

Characteristics of CTI-TS Users Interviewed

Participant	Gender	Age Range	Diagnosis
1	Female	50–65	Affective
2	Male	30–39	Non-affective
3	Male	21–29	Affective
4	Female	40–49	Non-affective
5	Male	50–65	Affective
6	Male	30–39	Non-affective
7	Female	30–39	Affective
8	Male	30–39	Non-affective
9	Male	30–39	Non-affective
10	Male	21–29	Affective
11	Female	40–49	Affective
12	Male	40–49	Non-affective
13	Male	30–39	Affective
14	Male	40–49	Non-affective
15	Female	40–49	Affective

Table 3:

Summary of findings according to Watson's (2017) mechanisms

Mechanisms	User's Perceptions	Quotes
Provision of strengths-based social and practical support	PSW's availability, openness, and practical support was the most cited benefit received that complemented users' mental health treatment	*"What helped me with the trained peer was that they were there and reminded me that we were in a process and that we have to move on."* (Participant 1)
Use of lived experiences	Shared experiences of mental illness typically provided hope and facilitated the users' connection with the PSWs; however, it was not directly linked to users' recovery	*"There are diseases that stay forever… So, the idea is to understand that it may remain the same, but you can have a normal life. That's the interesting thing about knowing the peer support worker."* (Participant 7)
		"It isn't like 'oh, it improved my life, my life got worse, [or] it made me something'… it didn't help me much." (Participant 10)
Love labor	PSW's investment to the work was evident and appreciated allowing some users to develop a deep personal relationship with them	*"[The relationship] was very affectionate. They called me to know how I was, and this is uncommon to me…They were concerned about me."* (Participant 9)
Helper role	Although less evident to users, the peer role was perceived to affect the PSW's recovery: positively (e.g., receiving support from users) and negatively (e.g., potential for increasing emotional burden and relapsing)	*"It's good because it gives [the PSW] an opportunity to help others…He told me: 'I also don't want to wake up in the morning, but I have to go to work because I do nothing in my house'"* (Participant 15)
		"If in that moment I had told [the PSW]…about the sadness that I have… Wouldn't that have affected him?" (Participant 4)
Liminal position within mental health services	Mixed attitudes towards PSW emerged: overall. positive for their work, and lowering their position compared to mental health professionals	*"What happens to me is that when [I am with] the psychologist…I feel that I am with someone superior.…With [the PSW] we were like peers, both equal. I don't want to look down at [the PSW], but we couldn't get into deep matters, regardless that he also had suffered from a disease."* (Participant 3)
		"I saw [in the PSW] a person who is worse than me and copes in a similar way or even better way. It's like there is a person who is running and another in a wheelchair. The person who is running [the user] thinks he is very bad and suddenly he sees the other person in a wheelchair [the PSW]…I saw [the PSW] as a patient, I saw him as a peer. And I see the professional as [somebody who] will help me." (Participant 10)