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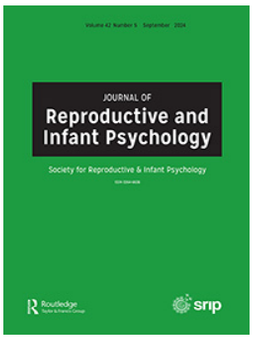

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A realist change model for community-based perinatal mental health peer support from peer volunteers

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ABSTRACT

Aims: To investigate what it is about community-based perinatal mental health peer support from trained volunteers that works, for whom, in what circumstances, in what respects, and why; and build a change model that includes positive and negative mechanisms and outcomes.

Methods: Realist evaluation methods based on semi-structured interviews were used to create a change model for a third sector programme in England.

Results: Mothers who received peer support ($n = 20$), peer support volunteers ($n = 27$), and programme staff ($n = 9$) were interviewed. Positive impact on mothers was primarily based on feeling understood and accepted, social comparison (including normalisation, hope, and gaining perspective) and sharing non-directive information from experiential knowledge. Negative impact on mothers was based on negative social comparison, or absence of key peer support mechanisms. Mothers were affected in different ways, depending on individual contexts: their backgrounds, personalities, social situations, resources, experiences, beliefs, and needs. Some different mechanisms were present in one-to-one and group situations. All participants considered the benefits of peer support to greatly outweigh the risks.

Conclusion: Individual contextual factors affect the multiple mechanisms through which mental health peer support can improve mothers' emotional wellbeing and social participation. Peer support has potential risks as well as benefits, which can be mitigated. Programmes could use this understanding of how contexts and mechanisms interact to produce peer support outcomes to improve training for peer support volunteers and to design future evaluations that take into account diversity of peer support experience.

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Peer support; perinatal; theory of change; realist evaluation; mother; volunteer

Background

Organised peer support for mothers with mental health difficulties during the perinatal period is growing in the United Kingdom and internationally, with third sector

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programmes offering peer support in groups or one-to-one from trained peer supporters with lived experience of perinatal mental health difficulties (Hearts and Minds Partnership, 2020). Although the evidence base for the effectiveness of perinatal peer support in reducing symptoms of depression and anxiety is limited (Dennis, 2014; Huang et al., 2020), it is now recommended as an alternative to professional support for women with mild mental health difficulties, and alongside or after professional support for those with more serious difficulties (Royal College of Psychiatrists, 2021).

Mothers with perinatal mental health difficulties may experience stigma that leads them to conceal their feelings (Jones et al., 2014). Receiving peer support from others with lived experience can enable them to feel accepted and have their experiences normalised; gain hope for recovery; receive credible advice about self-care and coping with mental health and parenting; and have the opportunity to support others in groups (Anderson, 2013; Carter et al., 2019; Chen et al., 2000; Dennis, 2010; Duskin, 2005; Eastwood, 1995; Montgomery et al., 2012; Pitts, 1995; Prevatt et al., 2018). The social psychological mechanisms of peer support have been explained through theories including social comparison (Festinger, 1954), overcoming stigma through reflected appraisal (Goffman, 1963), experiential knowledge and expertise (Borkman, 1976), multi-dimensional social support (Cutrona & Russell, 1990), stress-buffering through coping assistance (Cohen & Wills, 1985), helper-therapy (Riessman, 1965), peer support groups as normative narrative communities (Rappaport, 1994), and attachment theory (Bowlby, 1969/1982).

Less is known about the negative impacts of perinatal peer support, but social exchange theory directs attention to the costs as well as the rewards of social interactions (Homans, 1961; Thibaut & Kelley, 1959). Mothers may have anxiety reinforced by social comparison with others in a group; may become upset at hearing other mothers' stories; may feel that their concerns have been minimised by their peer supporter; and may worry about coping when support ends (Carter et al., 2019; Dennis, 2003a, 2010; Duskin, 2005; Pitts, 1995; Prevatt et al., 2018; Sembi, 2018; Shorey & Ng, 2019).

The literature does not address who benefits from community-based perinatal peer support and who does not, nor why different participants benefit in different ways (McLeish et al., 2023). In order to improve perinatal peer support, it is important to understand which social psychological mechanisms may be activated for individuals in different circumstances. Because of its multiple interacting psychological and social components, community-based peer support is a complex intervention requiring complex evaluation (Moore et al., 2015). Realist evaluation (Pawson & Tilley, 1997) can be used to investigate *'what it is that works, for whom, in what circumstances, in what respects, and why'*. The realist understanding of causation is generative rather than predictive (Bhaskar, 2008) – the latent mechanisms (M) of causation (*what is it that works and why?)* are activated only in specific contexts (C) (*for whom and in what circumstances?*), and interact with each other to produce different outcomes (O) for different people or in different situations *(what works and in what respects?)*. These key realist terms are explained in Box 1. As social programmes have the capacity to cause unintended harms (Merton, 1936), which may be masked by untested assumptions of benefit (Oakley, 2000), it is also important for realist evaluators to. develop a 'dark logic' model (Bonell et al., 2015) addressing the contexts and mechanisms that may lead to potential negative outcomes.

The aim of this research was to explore how one-to-one and group perinatal mental health peer support offered by trained volunteer peer supporters works for individual

Box 1. Key realist terms (Pawson & Tilley, 1997)

Context (C): Factors that cause mechanisms to be activated (or not), such as socio-cultural values and norms, the setting for the programme, and the personal characteristics of those involved. In this article the focus is on personal factors, but inevitably these arise in a wider social context.
Mechanism (M): The reasoning and reactions of mothers and volunteers in response to the resources provided by the programme.
Outcome (O): The consequence of this reasoning or reaction – an emotional or psychological change, or an action.
Context-mechanism-outcome (C-M-O) configuration or programme theory: A strand of the explanatory logic of the programme forming part of its change model, such that *in this context (C), the participant responds to the resources provided by the programme with this reasoning or reaction (M), leading to this outcome (O).*

mothers, and to build an evidenced change model identifying the positive and negative mechanisms of change, the individual contextual factors that trigger those mechanisms, and the proximate outcomes that result. The research reported here is part of a wider realist evaluation of the pilot of Parents in Mind, a third sector community-based perinatal mental health peer support programme. Other aspects of the evaluation will be reported separately, including the change model for volunteer peer supporters and issues affecting take-up of peer support in different communities.

Methods

This research was guided by the RAMESES II quality and reporting standards for realist evaluations (Wong et al., 2016, 2017). Realist evaluation involves first developing specific hypotheses that explain how, why, for whom, and in what circumstances the programme has impact (expressed as context-mechanism-outcome (C-M-O) configurations), and then collecting evidence to test these hypothesised C-M-O configurations, which together form the 'change model'. A qualitative, retroductive process was used for data collection and analysis, iterating between deductive and inductive reasoning. Hypothesised C-M-O configurations were tested against primary data from interviews, and primary data were also used to generate new C-M-O configurations, which were tested in subsequent interviews, to develop a final evidenced change model (Astbury & Leeuw, 2010; Wong et al., 2017).

Setting

The Parents in Mind pilot was run by national charity NCT at three sites in England in 2016–19. It offered face-to-face peer support to pregnant women and mothers with a child under two, who had self-defined mild-to-moderate mental health difficulties. Support was based around non-directive, strengths-based, active listening; sharing ideas for self-care and parenting; and signposting to services. Local mothers who had past experience of mental health difficulties, but were currently well, were recruited as unpaid peer supporters who could volunteer for at least 2 h a week. They received 24 h of training and were supported by a local programme manager, trainer, and mental health professional. Peer supporters led small, unstructured, weekly face-to-face group meetings, or were matched with

mothers to give one-to-one support. A group or individual session lasted 60–90 min, and initially, there was no limit to the sessions a mother could attend, although during the pilot two sites began to encourage mothers to move on after eight sessions. Peer support groups usually had up to six participants, but attendance was often irregular and at two sites they rarely reached this size. Access was through professional referral or self-referral. During the pilot, 182 mothers were supported by 77 peer supporters, with two-thirds of mothers only using group support and one-fifth using both one-to-one and group support.

Development of the initial change model

An initial hypothesised change model was developed by the research team during the early months of the pilot when the sites were being established, by combining research evidence from a realist review (McLeish et al., 2023) with the insights of staff gathered during preliminary interviews and the views of a project advisory group gathered during meetings (Patton, 2010). The C-M-O configurations for this initial change model are identified alongside those of the final change model in Table 2.

Data collection

Semi-structured, in-depth interviews were used, combining realist and non-realist questions to explore both C-M-O configurations and participants' lived experiences (see Additional file 1 for initial topic guides). Participants were purposively recruited for their knowledge and experience of the programme: mothers who received peer support, volunteer peer supporters, and all programme staff. Mothers and peer supporters were invited to participate by their local programme manager, and their contact details were passed to the researcher. Two mothers and one volunteer did not respond when contacted by the researcher. Staff were invited directly by the researcher. Participants were offered the choice of being interviewed by telephone or face-to-face; a participant information leaflet was emailed at least 48 h before the interview; and informed consent was given and recorded in writing. Interviews were audio-recorded and transcribed professionally (for mothers and peer supporters) or by the researcher (for staff). All names used are pseudonyms, with (M) denoting a supported mother and (V) a volunteer peer supporter.

Local programme managers and national staff were each interviewed every 6 months during the pilot (5–6 interviews each), and other participants were interviewed once. Recruitment of mothers and peer supporters continued until saturation was reached – interviewees were repeating similar information and there were no new codes identified (Saunders et al., 2018). The researcher had a previous professional relationship with two programme staff but no previous contact with any other interviewees. Throughout data collection and analysis, the researcher (JM) reflected on the impact of her own background as a mother without lived experience of mental health difficulties, and on the changing dynamics as relationships were built programme staff through repeated interviews.

Data analysis and development of final change model

Data analysis was based on realist coding for context-mechanism-outcome (C-M-O) configurations (Wong et al., 2017). Analysis began as soon as the first interview transcript was available. Transcripts were read repeatedly for familiarity. The initial change model was used as a heuristic, and all data were also coded with unanticipated C-M-O configurations. The realist question 'what must be true for this to be the case?' was used to theorise abductively how partial C-M-Os could be developed, working backwards from effects to the conditions that would be necessary for those effects to be produced (Jagosh, 2020), and focusing in this analysis on personal contextual factors. Questions supporting exploration of these developing C-M-Os were incorporated into subsequent interviews. Particular attention was paid to anomalous findings, as these could indicate theory failure, an alternative theory, or negative mechanisms (Maxwell, 2012). A final change model was constructed in which every C-M-O configuration was evidenced by primary data and had been discussed with programme staff.

Results

Participants

Mothers who received peer support ($n = 20$), peer support volunteers ($n = 27$), and all programme staff (local staff ($n = 4$), national staff ($n = 2$), trainers ($n = 3$)) took part in interviews. There were 78.5 h of interviews; mean lengths were 37 min with mothers (range 20–58 min); 54 min with volunteers (range 38–82 min); 101 min with staff (range 36–210 min). Ten interviews were face-to-face and the rest were by telephone. The socio-demographic characteristics of mothers and volunteers are shown in Table 1.

Table 1. Demographic characteristics of mothers and volunteers interviewed.

	Volunteers (n = 27)	Supported mothers (n = 20)
Ethnicity		
White British	15 (55.6%)	18 (90%)
White Other	5 (18.5%)	1 (5%)
Asian British	5 (18.5%)	1 (5%)
Black British	1 (3.7%)	0
Black Other	1 (3.7%)	0
Age		
Age 20-30	5 (18.5%)	9 (45%)
Age 31-40	13 (48.2%)	10 (50%)
Age 41-50	7 (25.9%)	1 (5%)
Age 51+	2 (7.4%)	0
Mental health experience (current and/or previous)		
Depression	22 (81.5%)	15 (75%)
Anxiety	10 (37%)	18 (90%)
Post-traumatic stress disorder	5 (18.5%)	3 (15%)
Obsessive compulsive disorder	1 (3.7%)	3 (15%)
Other	2 (7.4%)	2 (10%)
Postcode quintile using Index of Multiple Deprivation		
1 (most deprived)	Not available	6 (30%)
2		4 (20%)
3		3 (15%)
4		3 (15%)
5 (least deprived)		4 (20%)

Findings

All participants reported experiences showing that perinatal peer support could have a beneficial impact on mothers through multiple C-M-Os. They also described ways in which peer support could sometimes make a mother feel worse, although all believed the positives far outweighed the negatives, and that negatives could in many cases be mitigated through skilled group facilitation by peer supporters. The final context-mechanism-outcome configurations are shown as Figures 1 (positive) and Figure 2 (negative). The positive and negative C-M-O configurations for mothers are shown in more detail, with illustrative quotations, in Table 2.

Individual contexts

Mothers came to peer support with widely differing personal contexts: needs, personalities, resources, backgrounds, motivations, and mental health and parenting experiences; consequently, a variety of mechanisms were activated leading to a variety of proximate outcomes. Most mothers had experienced mental health difficulties prior to motherhood: many had low self-esteem and a negative attribution style and some had a perfectionist approach to parenthood, all of which affected their responses to peer support. Some mothers primarily wanted to talk about themselves, some mainly wanted to listen to others, while some wanted both. Some mothers sought reassurance and validation, while others

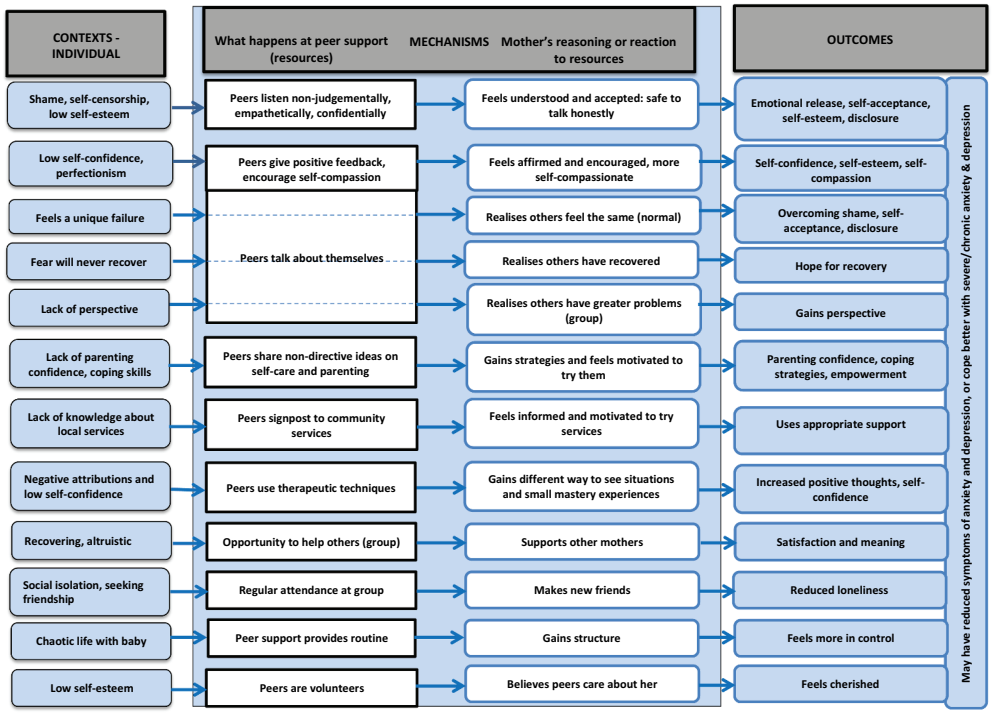

Figure 1. Parents in Mind POSITIVE context-outcome-mechanism configurations for mothers receiving peer support.pdf

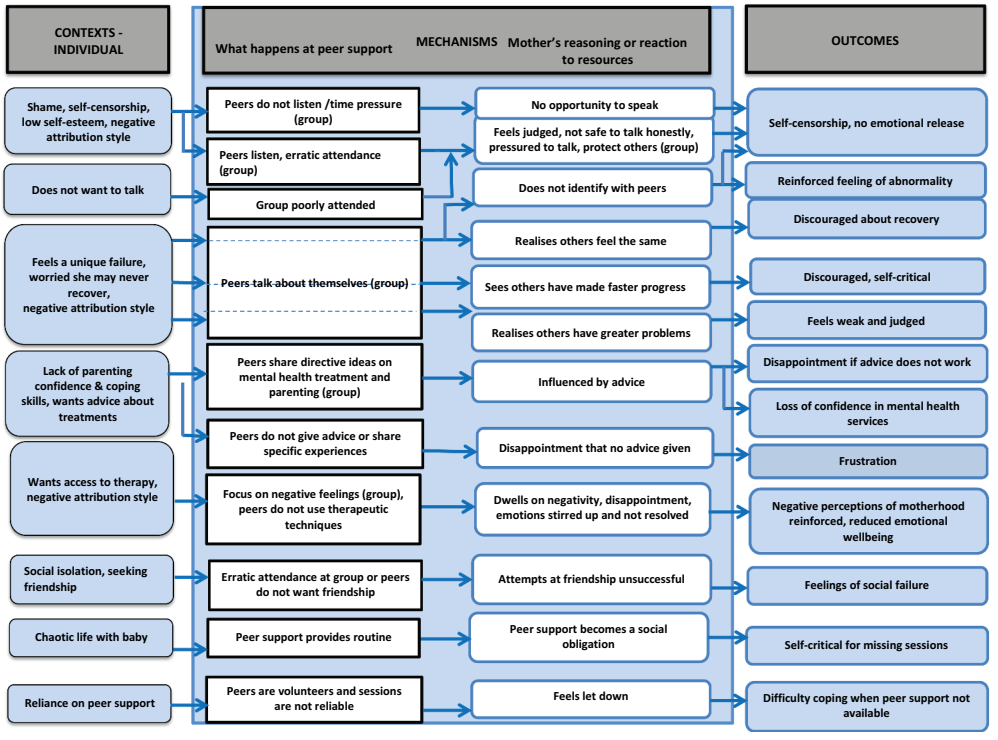

Figure 2. Parents in Mind NEGATIVE context-outcome-mechanism configurations for mothers receiving peer support.pdf

wanted practical strategies for managing mental health and parenting challenges; some were lonely and hoped to make new friends, while others did not want new social relationships. Some had already received perinatal mental health treatment, others wanted professional support but had been unable to access it and were using peer support to fill the gap.

Mechanisms – resources

Peer support was a series of interlocking activities, and different mechanisms might be activated depending on the activities in any individual encounter. These included peer supporters listening non-judgementally, talking about their own lived experience, giving mothers positive feedback, sharing ideas on self-care and parenting, and signposting to community services and mental health services. At groups, mothers also had the opportunity to talk and listen to each other as peers, and to make new social relationships. Some peer supporters spontaneously used basic therapeutic techniques which were beyond their peer role and training, such as reframing, gently challenging negative cognitions, and enabling mothers to build their confidence through small mastery experiences.

Table 2. Parents in Mind peer support context-mechanism-outcome configurations for mothers with supporting quotations.

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Shame: feels a unique failure as a mother. Hides feelings from partner, family & friends & can't meet needs for authenticity in relationships. Avoids new parent groups as these make her feel worse.	Peers listen non-judgementally, empathetically, confidentially	Feels understood and accepted: safe to talk honestly	Emotional release, self-acceptance, self-esteem, Disclosure to family and friends	✓	✓	*'It's almost like a sigh of relief. You don't have to pretend, or you can explain the bad day you've had and you don't feel like anybody is judging you for making it worse than it sounds'*. Grace(M) *'There were certain things that I could say to [the peer supporter] that I would feel guilty if I said to someone else . . . It was such a weight lifted off my shoulders. She listens like it's okay not to be okay . . . She made me feel like speaking to my family about it, which made me feel confident do it'*. Annie(M)
	Peers do not listen or time pressure	No opportunity to speak	Self-censorship, no emotional release	x	✓	*'Sometimes, especially when we have six or seven people in the group, that didn't feel enough time to get around everybody . . . When you walk in and you think, "I've really something to say", and one week [another mother] walked in and just took over the whole conversation'*. Brooke (M)
Low self-esteem, negative attribution style.	Peers listen, erratic attendance at group	Does not feel safe to talk honestly	Self-censorship, no emotional release	x	✓	*'Some people only come occasionally . . . it can be hard if there's people who you've only seen once or twice. It makes you more anxious while you're in there, social anxiety. I hold back a bit'*. Keira (M)
Low self-esteem, negative attribution style.	No strong relationships at group	Feels judged	Self-censorship, no emotional release, reinforced shame	x	✓	*'With [another mother] discussing what her circumstances were, I felt that mine was minuscule, and seemed a bit of a joke compared to her life. Me being me, typically thought, maybe she looked down on me because I'd only had very small amount of depression, where she'd battled with it for most of her life. Maybe she thought, "Now why is this girl moaning?" That's what I felt'*. Cora (M)

(*Continued*)

Table 2. (Continued).

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Empathy	Meets mothers with different situations or mental health experiences	Seeks to protect other mothers' emotional wellbeing by concealing own experiences or feelings	Self-censorship, no emotional release	x	✓	*'The first session I went to, there was only me and this pregnant girl there. I felt that I couldn't really give her the gory details. I didn't want to scare her . . . [At later sessions] I'd think, "Should I really be saying how great things are with psychology and medication, if people aren't feeling the same?". . .One of the girls had been on medication for weeks and felt no different . . . I didn't really want to say then how good I felt'*. Cora (M)
Does not want to talk about herself	Group poorly attended	Feels pressured to talk	Discomfort	x	✓	*'[The mother] didn't really want to talk herself. I think she expected to have more people there. But it happened that she was alone with me and I think she didn't feel confident about it, maybe also a bit disappointed'*. Wanda(V)
Low self-confidence, perfectionism	Peers give positive feedback, encourage self-compassion	Feels affirmed and encouraged, more self-compassionate	Self- confidence, self-esteem, self-compassion	✓	✓	*'[The peer supporter] was very good at celebrating the things that you'd managed to achieve, even if it was quite a small thing. Even coming to the group was, "You got out of the door, you've got both of you dressed and you're here!" All the way through she's really helped me to feel like, "Yes, I am doing better and I can do these things".'* Di(M) *They tell me I am just human, and it's all right to just have my off days and cry"* Tilly (M) *'I was so down, I was like, "Oh, I can't do this", and [the peer supporter] was like, "Stop, you can so bloody do this!" . . . [The local project manager] came and seen me, and she was like, "Wow, you are doing amazing!" . . . I felt so empowered by what she'd been saying. I felt like I am doing a good job . . . The praise has given me* [crying a little] *. . . I feel empowered by them, like they've got my back'*. Sal(M)

(*Continued*)

Table 2. (Continued).

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Shame: feels a unique failure as a mother	Peers talk about themselves	Realises others feel the same (normalisation – horizontal social comparison)	Overcomes shame, self-acceptance, disclosure to family and friends	✓	✓	*'One mum mentioned that [she had similar fears], and my mind and my heart – I felt weak! I thought, "Oh my God, this is normal! This is not just me that's scared of everything!". . . And as soon as you start to think it's normal because you've got other mums that are going through it, I accepted that it's OK to feel like that'.* Hema(M)
Shame: feels a unique failure as a mother Negative attribution style	Peers talk about themselves	Realises others feel the same (horizontal social comparison)	Feels discouraged about recovery	x	✓	*'I don't feel comfortable around [another mother with the same diagnosis], because she keeps reminding me of my issues and it makes me feel discouraged about getting better'.* Flo(M)
		Does not identify with peers	Reinforced feeling of abnormality, no emotional release	✓	✓	*'I would like to say it would be good to have as much as diversity in those groups as you can. But I think the reality of it is, in those times of vulnerability and stress you need to connect with people who are similar to you and we just really weren't that similar'.* Wendy(M)
		~~*Normalisation feels like minimisation*~~	~~*Feelings are not validated*~~	✓	x	
Worries she may never recover	Peers who are more recovered talk about themselves	Realises others have recovered (upward social comparison)	Hope for recovery	✓	✓	*'Mums do tend to like the fact that we've been where they are, but look at us now. We're dealing with it. There is a future . . . . It helps them to see that there's light at the end of the tunnel'.* Laura(V)
Worries she may never recover Negative attribution style	Peers who are less recovered talk about themselves	Sees others have made faster progress (upward social comparison)	Discouraged, self-critical	x	✓	*'There are cases where they leave more disappointed than they come . . . Even if it's someone you like and feel connected to, it's still that comparison and competition in your head: "Why am I not getting better? . . . We started at the same point, and she's ahead of me".'* Emilia(V)

(*Continued*)

Table 2. (Continued).

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Lack of perspective	Peers talk about themselves	Realises others have greater problems (downward social comparison)	Gains perspective	✓	✓	*'Listening to other people's stories . . . helped me appreciate the things I did have as well, because other people weren't as lucky . . . It helped me to get that perspective and gauge that some things in my life are wonderful'*. Di(M)
Shame: feels a unique failure as a mother. Negative attribution style	Peers talk about themselves	Realises others have greater problems (downward social comparison)	Judges self and feels weak and judged Fear about deterioration	✓	✓	*'[Another mother] had these great horrible things to deal with, and I felt guilty for having my issues when I'm not going through a similar thing'*. Lena(M) *'One woman said to me, "It gets really bad. You've got to get yourself to rock bottom", and I was thinking, "Oh my gosh. So it gets even worse than this?" And that really knocked my confidence. You hear other people's experiences and some of it is not what you want to hear'*. Rosie(M)
Lack of parenting confidence or coping skills	Peers share non-directive ideas on self-care and parenting	Gains strategies for self-care and parenting and feels motivated to try them	Parenting confidence, coping strategies, empowerment	✓	✓	*'[The volunteer] has so much experience, it's as if she has experienced everything that all of the ladies in the group have experienced . . . she will say, "Have you tried this?". . . It's very much example-based so you believe it, it's not from a textbook'*. Brooke(M)
Lack of parenting confidence or coping skills Wants advice about treatments	Peers share directive ideas on mental health treatment and parenting	Influenced by directive advice from others in group	Disappointment if advice does not work Loss of confidence in mental health services	✓	✓	*'We have had one or two that say, "CBT didn't work for me" or "I was on those tablets and they didn't work". We had one mum who listened to what everyone said, and . . . she felt like she needed to change everything she was doing . . . A volunteer took her to one side and explained to her that just because it had not gone right with one person doesn't mean she needs to go back and change everything she did'*. Laura(V)
Wants advice about treatments	Peers do not give advice or share details of treatment	Disappointment that no advice given	Frustration	x	✓	*"One of the ladies kept saying to me, 'I want to be fixed!" and I didn't know what to say to her"* Quirat(V)

(*Continued*)

Table 2. (Continued).

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Practical problems e.g. financial, housing	~~*Peers offer support to solve practical problems*~~	~~*Help to solve practical problems*~~	~~*Reduced stress*~~	✓	x	
Lack of knowledge about local services	Peers signpost to community services	~~Feels informed and motivated to try community services~~	~~Uses appropriate support~~	✓	✓	*'We talked about different groups going on, we looked at things that might be good or interesting to do. I started going to a few more groups and finding out what was going on in the area'*. Natalie(M)
Needs professional mental health support	Peers signpost to mental health services	*Feels informed and motivated to try mental health services*	*Uses appropriate support*	✓	x	
Low self-confidence, negative attributions	Peers spontaneously use therapeutic techniques	Gains different way to see situations and small mastery experiences	Increased positive thoughts, self-confidence	✓	✓	*'A lot of it would be suggesting, or trying to come up between us, little things that she could do during the week to make those tasks that seemed huge, smaller . . . She was so panicked that she sometimes just couldn't see the simple solutions'*. Bridget(V)
Wants access to therapy, negative attribution	Focus on negative feelings, peers do not use therapeutic techniques	Dwells on negativity, disappointment that no techniques used, emotions stirred up but not resolved	Negative perceptions of motherhood reinforced, reduced emotional wellbeing	✓	✓	*'We've had one lady who said, "If I'd realised it was this hard I wouldn't have done it". We applauded her honesty, said that we'd all felt like that at some point . . . They always ask [the volunteers], "How's your week?" It is important to say, "I've had a terrible week" . . . it normalises the feelings they have'*. Cathy(V) *'I think it could be a place where you're just encouraged to whinge. What would have been good is to have a slightly more structured discussion of everything that's really annoyed you or got you down, and then finish by saying "Can anyone say what's made them feel really happy?" so you can finish on a positive'*. Wendy(M)

(*Continued*)

Table 2. (Continued).

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Recovering from symptoms, altruistic	Opportunity to help others at group	Supports other mothers	Satisfaction and meaning	✓	✓	*'I am back to being me and if I can encourage somebody else . . . it's good to be able to offer that to other people'*. Grace(M) *'It's nice, because then you feel like you've not gone through it for nothing'*. Morgan(M)
Social isolation, seeking friendship	Regular attendance at group	Makes new friends	Reduced loneliness	✓	✓	*'Finding friendships has been a real achievement. I was totally new to the area and Parents in Mind has helped me to feel more settled'*. Tilly(M)
Social isolation, seeking friendship	Irregular attendance at group, other mothers do not want friendship (group only)	Attempts at friendship unsuccessful	Feelings of social failure	✓	✓	*'I didn't build up a friendship with anyone else in the group because they would sometimes drop in and sometimes not'*. Wendy(M) *'It's very much turn up, have the relationship there and then that's it, which I think is helpful . . . If you have to build a friendship then you've got to maintain it and I think as a new parent, you can have difficulties in terms of what time you've got available'*. Oona(M) *'One lady was quite attached to the first one who left. She was there in the group when her new friend said, "I'm moving on". Her face dropped, and we realised she was very uneasy about it. She stopped coming the next week . . . She just cut contact with everyone, with us and with her new friend'*. Emilia(V)
	~~*Peers form friendship cliques (group only)*~~	~~*Feels excluded from clique*~~		✓	x	
	~~*Peer support is time limited*~~	~~*Ending leaves mother feeling bereft of social support*~~		✓	x	

(*Continued*)

Table 2. (Continued).

Context – individual level	Mechanism		Outcome	Initial theory of change	Final theory of change	Illustrative quotation
	Resource – What happens at peer support	Mother's reaction or reasoning				
Life with a baby feels chaotic and lacks structure	Peer support provides routine	Gains structure	Feels more in control	x	✓	*'It's nice to have some routine as well . . . It breaks the month up so you can go from Tuesday to Tuesday and then you can talk about it, and then you have to go to another Tuesday'.* Keira(M)
	Peer support provides routine	Peer support becomes a social obligation	Self-critical for missing sessions or arriving late	x	✓	*'It's hard to get out of the house and there were days when if I was five or ten minutes late, I would feel awful and I would really pile a lot of pressure on myself'.* Vicki(M)
Low self-esteem	Peers are volunteers	Believes peers really care	Feels cherished	✓	✓	*'To feel like people have given up their time to help . . . it feels like a family . . . As you walk into the group, the first thing that one of the ladies says is, "Oh, do you want a brew?" I know it sounds like a stupid thing, but it's the only brew that anybody makes me in the week'.* Oona(M)
	~~1:1 support from peer who is a volunteer~~	~~*Feels she is individually worth a volunteer's time*~~	*Increased self-esteem*	✓	x	
Reliance on peer support	Peers are volunteers and sessions are not reliable	Feels let down	Difficulty coping when peer support not available	x	✓	*'It's been a bit hit and miss . . . I understand completely that she is a volunteer, and obviously, she's got a life, and she works as well, but on my bad days, I don't care about that. It's like, "Oh, I need you now!"'* Sal(M)

Mechanisms – mother's reaction or reasoning leading to proximate outcomes

The most important peer support mechanisms concerned feeling accepted and understood, social comparison, and the sharing of experiential knowledge. In addition, peer supporters' use of basic therapeutic techniques helped some mothers to develop a more positive perspective on their situation and their own abilities as a parent.

The unintended negative consequences were usually generated by the same peer support activities as the positive outcomes where personal contextual factors had triggered different mechanisms, or sometimes by the absence of activities that a mother had wanted. Positive and negative mechanisms and outcomes are explored in detail below. A key difference between the initial and final change models was that there was no evidence of mothers becoming motivated to try mental health services, which programme staff expected to be one of the most important outcomes of peer support, and there was only limited evidence for helper-therapy (mothers benefiting from supporting each other at a group).

Feeling safe to talk honestly and normalisation (lateral social comparison)

For many mothers, a sense of shame about their negative feelings had led them to hide these feelings from family and friends, because they believed they were uniquely failing to conform to a social norm of contented motherhood. Non-judgemental, empathetic, confidential listening by peer supporters made them feel understood and accepted, which enabled them to express negative feelings freely and gain emotional release, self-compassion and self-acceptance. Self-acceptance was also a consequence of hearing peer supporters and other mothers talk about their own perinatal mental health. For some mothers, discovering that others had similar feelings enabled them to expand their understanding of the range of 'normal' reactions to motherhood to include unhappiness and anxiety. This powerful experience of normalisation enabled some to overcome shame, disclose their feelings to family and friends, and participate in 'normal' new parent groups, while for others who lacked social support it was the basis of strong new friendships within the group.

By contrast, there were also situations (particularly where mothers had a negative attribution style) where normalising mothers' negative feelings at a group created a narrative that most mothers of young babies are unhappy and anxious but hide this. This enabled mothers to withstand their alienation from the positive presentation of motherhood they had encountered online and in real life, but did not enable them to move past negative perceptions of themselves and their babies or to move on from peer support (where they felt mothers were honest) into other social settings. This negativity could make some mothers feel more depressed and risked a loss of 'peer' identification or suppression of authentic feelings when a mother's mental health began to improve.

There were also group situations where mothers did not feel able to talk honestly, for example because an empathetic mother would self-censor to protect other women's feelings, because she did not feel others in the group were listening, or because she felt she was different from the others at the group. Some mothers did not find peers to be a useful reference group for social comparison unless they had more in common than lived experience of perinatal mental health difficulties, citing social

class and education (although unexpectedly not cultural background). Some mothers did not automatically feel safe with other mothers who had mental health difficulties: mothers with social anxiety or a negative attribution style might actively expect to be judged even by these peers, and they only opened up about their feelings when their trust had grown, which meant that authentic self-disclosure was inhibited when group attendance was erratic or new people joined. Alternatively, a mother who primarily wanted to listen to others' experiences might feel unexpectedly pressured to talk about herself if the group was poorly attended.

Upward and downward social comparison

For upward social comparison, meeting another mother at a group who was 'ahead' with her recovery could fill an optimistic mother with hope for recovery, and this could be a strong mechanism promoting coping and wellbeing. However, a mother with low self-esteem and a negative attribution style might reproach herself as weak because she was not recovering as fast. For downward social comparison, hearing the experiences of another mother whose mental health was worse could lead an optimistic mother to reflect that her own situation was not so bad, while a mother with a negative attribution style might react to the same encounter with fear that things would get worse, or self-criticism for failing to cope with lesser problems.

Sharing of experiential knowledge

Peer supporters were trained to share non-directive information about self-care and parenting, offering mothers strategies to try which they were inclined to trust because they came (or appeared to come) from experiential knowledge. This could lead to improved parenting confidence, improved ability to cope with mental health challenges, and a sense of empowerment because the mothers were not given advice or told what to do. On the other hand, there were mothers who were frustrated at this limitation of peer support because they did not have access to professional support and wanted advice on how to improve their mental health. Additionally, mothers in groups sometimes shared their own experiences in the form of directive information about what had or had not not worked for them, and this could lead to a mother believing she should change her treatment or losing confidence in mental health services.

Outcomes – mental health recovery

The main proximate positive outcomes reported were emotional release, confidence, overcoming shame, self-compassion, hope for recovery, perspective about current problems, empowerment, parenting and coping strategies and overcoming loneliness. This methodology could not, however, link individual C-M-Os to clinical recovery from perinatal mental health difficulties. Some mothers whose mental health had improved attributed this to other factors such as returning to work, using medication or therapy, or their baby becoming more settled. However, some mothers credited peer support directly with improving their mental health:

> Parents in Mind helped me get through my pregnancy and feel sane . . . I feel so much better. It does feel like a bit of a miracle! Annie (M)

Discussion

This research has provided insight into the complexity of how peer support works in a variety of ways to produce a range of positive and negative outcomes for mothers with perinatal mental health difficulties, depending on personal contexts and different peer support activities. The strongest peer support mechanisms concerned overcoming stigma (Goffman, 1963) and experiencing emotional release through feeling accepted and understood; social comparison with peers who were more recovered (upward comparison), the same (lateral comparison) or less recovered (downward comparison) (Festinger, 1954); and the sharing of experiential knowledge and expertise around self-care and parenting (Borkman, 1976). Positive mechanisms and outcomes were far more prevalent than negative ones, but highlighting unintended consequences is important so that they can be mitigated through peer supporter training and in the design of future programmes (Bonell et al., 2015). This is particularly important because some perinatal mental health peer support programmes have reported high rates of drop out by mothers (Sembi, 2018), in line with those reported from peer support groups for people with serious mental illness generally (Davidson et al., 1999), and this may be due to personal contexts triggering negative mechanisms and/or peer support not meeting individual needs.

Most of the positive C-M-O configurations in Parents in Mind indicate similar benefits to those reported from other perinatal mental health peer support studies (Anderson, 2013; Carter et al., 2018, 2019; Chen et al., 2000; Dennis, 2003a, 2010, 2013; Duskin, 2005; Eastwood, 1995; Montgomery et al., 2012; Pitts, 1995; Prevatt et al., 2018; Sembi, 2018; Shorey & Ng, 2019). However, those studies and previous peer support change models (Gillard et al., 2015) did not include the impact of personal or social contexts in explaining how peer support affects individuals differently. This realist evaluation adds ontological depth and understanding by linking contexts, mechanisms and outcomes to explain how and why perinatal mental health peer support works differently for different mothers.

A distinctive feature of Parents in Mind, compared to previous perinatal peer support studies, was that it offered both one-to-one and group support, enabling the C-M-O configurations for these modes of peer support to be explored in parallel. Many of the positive C-M-O configurations for mothers were evidenced in both group and one-to-one settings, although only a peer support group offered mothers the opportunity for downward social comparison, helper-therapy, and increased social support through making new friends. By contrast, most of the negative mechanisms and outcomes were *only* identified for interactions between mothers in groups, highlighting the importance of skilled group facilitation (Helgeson & Gottlieb, 2000) and training for peer supporters to enable this.

Mead et al. (2001) defined the basis of mental health peer support as 'understanding another's situation empathically through the shared experience of emotional and psychological pain' (p6). This study demonstrates that although peer experience was the basis for the key psychological mechanisms of feeling able to talk openly, social comparison and experiential knowledge, this should not be interpreted simplistically to mean that people with similar mental health experiences automatically trust

and empathise with each other. Some mothers did not feel safe talking openly in a group where everyone attending also had perinatal mental health difficulties, and some actively imputed judgemental thoughts to their peers. For some, the mechanisms of social comparison were not activated if all they had in common was lived experience of perinatal mental health difficulties, reflecting previous peer support work with people who are minoritised by ethnicity, migration status or sexual orientation (Billsborough et al., 2017).

The concept of peer support as a 'normative narrative community' (Rappaport, 1994) can be used to frame the findings of this study. Peer supporters helped mothers to overcome the internalised stigma of perinatal mental health difficulties by offering their own experiences to affirm that a mother who is unhappy or anxious was not a unique failure but within the range of 'normal' and with a prospect of future recovery. Alongside this strong positive mechanism was a weaker negative one, where the group might normalise negative emotions to the exclusion of positive ones, and mothers might self-censor to avoid telling other mothers they were feeling better. Simply providing the opportunity to vent feelings does not help a person move past their distress (Nils & Rimé, 2012; Rimé, 2009). If mothers felt pressure to supress their positive emotions to affirm negativity and maintain a 'peer' feeling, a peer support group could become a mirror-image of the 'normal' mother's groups in which mothers with perinatal mental health difficulties may feel a need to pretend things are better than they really are (Jones et al., 2014). This reinforces the need for peer supporters have the skills to adapt their support sensitively to a mother's current needs and to encourage mothers to reflect on positive aspects of their experiences without minimising their distress, which was reported as a problem by Dennis (2003a).

Previous research has shown that effective training and support for peer support volunteers is essential for a successful and safe programme (McLeish et al., 2016). Dennis (2003b) cautioned that, while training is essential, too much training may lead to professionalisation and a loss of 'peerness'. Future research could investigate whether – in the scenario where peer support may be the only mental health support to which a mother has access – there may be benefit in formally training peer supporters in basic therapeutic techniques as well. This must be set against the risk of peer support being inappropriately used in a local perinatal mental health system to fill the gaps in over-stretched professional services, instead of being understood as a service that supports mothers in different but complementary ways (Wood, 2020).

Strengths and limitations

This study combined multiple perspectives of mothers, peer supporters and staff at three sites. Using a blend of realist and non-realist approaches in interviews ensured that lived experience was centred and reduced the risk of confirmation bias while enabling exploration of developing ideas on C-M-O configurations. It was a limitation that the mothers who participated in this study did not reflect the ethnic diversity of mothers who had received peer support, and mothers and volunteers who agreed to be interviewed may have had more positive experiences than those who did not agree, or who left the programme after limited participation. It was also a limitation that data collection and analysis was carried out by one researcher, although the potential bias was mitigated by

the iterative process of discussing the development of C-M-O analysis with programme staff and the wider research team at regular intervals.

Conclusion

This change model shows how perinatal mental health peer support from trained volunteers in groups or one-to-one is a complex intervention comprising non-judgemental listening, talking about lived experience, giving mothers positive feedback, sharing ideas on self-care and parenting, signposting to community services and mental health services, and facilitating conversations at groups. Peer support can help mothers through multiple social psychological mechanisms, including overcoming stigma and experiencing emotional release, social comparison, and sharing experiential knowledge; and these mechanisms can lead to improvements in mothers' emotional wellbeing and wider participation in society. Peer support works differently for different mothers because all of these mechanisms are dependent on individual contexts, including needs, personalities, resources, backgrounds, motivations, and mental health and parenting experiences. Peer support has potential risks as well as benefits, but these can be mitigated, and benefits greatly outweigh risks. Programmes could use this understanding of how contexts and mechanisms interact to produce peer support outcomes to improve training for peer support volunteers and to design future evaluations that take into account diversity of peer support experience.

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Authors' contributions

All authors contributed to the development of the research question and methodology. JM carried out the interviews and data analysis. JM drafted the manuscript and all authors read and approved the final manuscript.

Ethics approval and data availability

Ethical approval was granted on 23 December 2016 by the Research Ethics Committee of the School of Health Sciences, City, University of London (Ref: PhD/16-17/08). Following the consent process, the individual qualitative interview transcripts will not be made publicly available.

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