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EDITORIAL

Supporting Peer Supporters

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The COVID-19 pandemic has created tremendous personal and work-related stress for physicians, nurses, and other health care professionals. Numerous studies have documented concerning rates of anxiety, depression, burnout, and post-traumatic stress disorder among health care workers since the pandemic began. Although the COVID-19 pandemic has exacerbated these challenges, the National Academy of Medicine declared occupational distress in health care workers a population health crisis for the United States several months before the onset of the pandemic.¹ Structural characteristics of the health care delivery system, workload, inefficiencies in the practice environment, and elements of professional culture are the root of this problem. As detailed in the 2019 National Academy of Medicine Consensus Study Report on systems approaches to reduce health care professional burnout, authentic efforts to reduce distress must address those issues.²

In addition to these upstream efforts to prevent distress, it is critical to provide emotional support to health care professionals when distress occurs. Even when the practice environment is optimal and the workload appropriate, events common in the life of health care workers (for example, exposure to patient suffering, moral distress, ethical challenges related to medical decision making, dealing with the death of a patient, and medical errors) can create substantial emotional distress. One study found that 79% of physicians had experienced an adverse patient care event or traumatic personal event within the preceding year.³ Health care professionals also often have a perfectionistic mindset and hold themselves to standards that are impossible to meet. Against this backdrop, it is critical that organizations and systems provide easily accessible (available 24/7, free or low-cost), psychologically safe (confidential, independent of performance evaluation and credentialing) and destigmatized support for health care workers experiencing distress. Such support should include mental health resources as well as support for other challenges, such as suboptimal teamwork, unprofessional behavior by coworkers, mistreatment experiences, sexual harassment, or conflict with a peer, coworker, or leader. Establishing low stigma and easily accessible support was specified as one of six core goals by the National Academy (with the other five goals focused on improving the work environment).²

Peer support is a foundational component of such system supports. Peer support involves clinicians engaging

with trusted peers who are able to acknowledge and normalize experience, engage in reflective listening, assist with reframing, and support coping.⁴ Because peer supporters are typically not mental health professionals and receive a modest amount of training, most programs are structured to enable peer supporters to meet with individuals for one to three sessions followed by a referral to additional resources (for example, ombudsman, professional coach, mental health professional) if additional support is needed.

Many peer support programs grew out of the recognition that clinicians involved in medical errors and adverse events suffer significant distress related to guilt, shame, loss of confidence, or fear of causing additional harms, often referred to as “second victim syndrome.”⁵ Evidence suggests that emotional distress and burnout are common after clinicians are involved with adverse clinical events and that peer support may mitigate the risk of such outcomes.⁶ It was subsequently recognized that personal and professional distress can arise from a host of causes in addition to adverse clinical events. Further, several studies revealed that, when physicians were involved in an adverse patient outcome or other professional challenges, they preferred support from physician colleagues over support from family members, employee assistance programs, or mental health professionals.^{3,7} A qualitative study by Horne and colleagues evaluating why and when physicians seek peer support identified three factors: (1) dealing with a strenuous situation with need for guidance, (2) fear of not being able to cope in the face of excessive stress and conflict, and (3) assistance with reentry when out of practice.⁸ Initial efforts were designed to provide peer support for physicians, but recognition that all clinicians can experience the significant occupational distress has led to the expansion of many programs.

Most publications on peer support to date have focused on describing approaches to structure programs and deliver peer support effectively.^{4,9,10} Less is known about the experience of peer supporters.¹¹ Providing peer support can be incredibly meaningful for the supporters who are able to assist colleagues at a critical time. The experience, however, can also be challenging for peer supporters who have a front-row seat to the suffering of their colleagues, frequently feel powerless to address underlying organizational factors that contribute to distress, and may, in some circumstances, feel ill-equipped to provide the support required. In the present issue of the *Journal*, Godfrey and colleagues detailed results of a mixed methods study evaluating the personal

experience and needs of 375 peer supporters across five organizations during the first six months of the COVID-19 pandemic.¹² On several fronts, the results of the survey were reassuring. Peer supporters reported low secondary trauma, with 81.6% reporting low degrees of secondary trauma and none reporting high levels. In addition, 93.9% of participating peer supporters reported moderate to high levels of compassion satisfaction. Other results were less reassuring, with approximately 40% of peer supporters having concerning levels of emotional exhaustion (arising from their clinical work rather than their role as a peer supporter). Although no differences in secondary trauma were observed by demographic characteristics, younger peer supporters had higher levels of burnout and lower degrees of compassion satisfaction. In addition, 91.3% of peer supporters surveyed identified challenges to being effective in their role. The three most common challenges were (1) excessive workload and inadequate time to fulfill the duties of being a peer supporter, (2) the impact of COVID-19 on their role (isolation from colleagues), and (3) personal stress, which can make it difficult to provide support to others. Half of the participants also identified specific needs for peer supporters, including more training and resources, administrative support for program management, and resources to assist the peer supporters with self-care.

These findings provide important insights and raise a number of important questions. First, the results are consistent with previous studies indicating high levels of meaning and personal satisfaction among peer supporters.¹¹ Second, they indicate the necessity of an organizational commitment and resources to foster an effective and sustainable peer support program. The authors provide a holistic set of recommendations for organizations, teams, and individuals to facilitate this. Protected time for the leader of the program and administrative support are key components. Third, the findings raise questions regarding the optimal characteristics and qualifications for peer supporters. The current study suggests increased risk of burnout and lower compassion satisfaction among younger and early career peer supporters. Indeed, many programs focus on recruiting and training mid- and later career clinicians with a greater foundation of professional experience for the role. The present results would suggest that if early career clinicians are recruited as peer supporters, they may benefit from additional support to mitigate negative personal consequences. Finally, the findings illustrate the importance of support and training for individual peer supporters. Emotional support for peer supporters should include regular times for peer supporters to come together and provide support to one another so that they can remain engaged and compassionate in the work they provide colleagues.¹⁰ A process to regularly check in regarding peer supporters' own well-being may also be beneficial. Future studies of peer supporter research could examine potential differences between the experiences of peer supporters across professional

groups and whether customization of training and support is needed to optimize effectiveness.

The well-being of health care workers is a critical component of a high-functioning health care system, and holistic efforts to reduce the high rates of occupational distress among health care professionals are needed. The primary focus of these efforts should be improving the practice environment to reduce distress and promote professional fulfillment. Due to the nature of the work, however, individual health care workers are likely to periodically experience distress even in optimal practice environments. Many organizations have created formal peer support programs to provide clinicians in distress access to timely, psychologically safe, and low-stigma support from colleagues. For such programs to be sustainable, it is essential that we care for the peer supporters who provide assistance to colleagues in need.

Conflicts of Interest. All authors report no conflicts of interest.

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