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Introduction

The use of peer support as a method of supporting survivors of critical illness is gaining momentum internationally (1-4). Following critical illness, many patients and their loved ones are left with lingering physical, emotional, cognitive and social problems (5-7). Despite an absence of evidence proving efficacy, peer support-based interventions have emerged in an attempt to ameliorate these issues (1,8). Evaluation of these programs is required to understand their mechanisms of effectiveness with the aim of measuring clinical impact.

We undertook a secondary analysis of an existing dataset to explore what patients believe to be the key mechanisms of effectiveness of peer support interventions during intensive care unit (ICU) recovery. Previous analysis has explored the key mechanisms of ICU recovery services; this analysis is distinct in that it critically examines the role of peer support and how peer support provided benefit within these services. (8). Uniquely, it sought to elucidate these effective mechanisms from a patient perspective.

Methods

The study was approved by Western Health Research Ethics Committee (Australia); Vanderbilt University Institutional Review Board and the South West (Cornwall and Plymouth) Research Ethics Committee (UK).

Participants were recruited from ICU recovery services through the Society of Critical Care Medicine's (SCCM)THRIVE program. Patients were approached by their treating clinician. If patients wished to participate, their contact details were passed onto the core researcher team, who then organised participation in the study. Consent was established prior to undertaking interviews.

THRIVE was established to bring together critical care clinicians who were using ICU follow up clinics

and peer support models to improve patient and family outcomes. Within the THRIVE Collaboratives, six models of peer support are utilised and represented within this study (1). All programs involved in the THRIVE ICU follow-up clinic collaborative utilise a multi-disciplinary approach.

Purposive sampling strategies were utilized. Semi-structured interviews were undertaken with patients from THRIVE sites across the US, UK and Australia. Patients who received no recovery service (intervention) were also interviewed to contextualize the perceived benefits of and to understand any negative consequences of peer support. Patients who were not part of the THRIVE program were recruited through the SCCM social media page. Caregivers/family members were interviewed separately. Interviews were undertaken via telephone with no repeat interviews. A semi-structured interview schedule was used (*SF One*). All interviews were audio recorded and transcribed verbatim.

Interviews were undertaken by four researchers (JM , LB, EH, JJ); all researchers were female apart from JJ. All staff undertaking interviews were clinicians, trained in qualitative enquiry and critical care clinical practice (nursing, physiotherapists and psychology backgrounds). Participants were given the opportunity to ask any questions about the study before it commenced. Furthermore, all researchers described their professional background and their role in the research and those interviewing patients were not part of the clinical care team who had cared for them. Interviews lasted between 20-60 minutes.

Framework analysis was used as a systematic and transparent thematic-analysis method, with matrices produced to compare the occurrence of themes (8). Data was coded by two members of research team (JM and LB) and data analysis was undertaken by three researchers (LB, JM, TJI). Data was initially listed under broad repetitive themes and synthesised for specific mechanisms related to

peer support effectiveness, utilising the Framework method. Utilising this approach, themes were generated. An audit trail was uploaded onto a secure site for researchers involved in the analysis. Member checking was undertaken, and peer review of the final analysis was provided by members of the research team not directly involved in data analysis or collection (KH, CS).

Findings

Interviews were conducted with 52 patients from 14 THRIVE sites across the US, UK and Australia. Fourteen former ICU patients receiving no recovery service were interviewed (total interviews n=66). Interviews took place between July 2018 and February 2019. Interviews were stopped after discussion with the broad authorship team, as no new themes were emerging from the data.

Of those who participated in these interviews, the median age was 52 (Interquartile Range (IQR) 40-62.5) years and 40 (60.1%) were female. All patients approached consented to being interviewed.

Patients described three primary mechanisms by which peer support provided benefit: 1) Sharing experiences, 2) Care debriefing and 3) Altruism (**Figure 1**). Illustrative quotes and how these mechanisms manifested are shown in **Table 1**. No distinct differences were found between those who did and did not take part in peer support programmes.

Sharing Experiences

Sharing experiences supported recovery in several ways. Anxiety appeared to reduce as patients felt reassured others had similar issues. Participation described increased hope and motivation with a subsequent reduction social isolation, especially when patients interacted with those further along the recovery trajectory; patients could visualise and understand their condition could improve (*internal validation*).

Care Debriefing

Understanding the recovery trajectory and interacting with others allowed patients to better comprehend their ICU illness narrative, while simultaneously supporting the navigation of often complex healthcare systems. Care debriefing helped to support realistic goal setting and calibrated accurate expectations of recovery and related timeframes (*external validation*). Patients could understand why challenges existed and could visualise their progress when interacting with others on the same pathway (*expectation management*).

Altruism

The sense of giving back to other patients, the hospital system and ICU was an important beneficial effect of peer support. Patients believed this was advantageous to a variety of stakeholders including other patients, caregivers and staff from the ICU. Taking part in peer support programs also gave patients a sense of purpose.

Discussion

This Research Letter illustrates the perceived benefit of peer support in a critical care cohort, using international patient perspective data. The use of peer support has been established in other populations; this research adds to the growing body of evidence about its mechanisms of effectiveness with critical care survivors (2). Providing a sense of purpose was an important component of peer support effectiveness, distinct from that provided by post-ICU clinics (8). Sense of purpose is a modifiable risk factor significantly associated with all-cause mortality (10). Peer support could therefore be a low-cost solution providing important psychosocial benefits after critical illness. Peer support also appeared to reduce social isolation in patients. Social isolation and loneliness have been shown to increase mortality across a wide range of disease pathways (11). Peer support may mediate this isolation, however more work is required to understand this relationship.

Our study has limitations. Interviews were undertaken with patients recovering from critical illness who were actively engaged in programmes of support; therefore, it may not represent the views of patients out with these support structures. Further, although we have utilized contemporary qualitative methods, with several processes utilised to enhance rigor, other interpretations of this data could have been possible.

In conclusion, peer support appeared to improve outcomes through three main mechanisms. Future work should examine outcome measures which align with these mechanisms of effectiveness to understand the clinical impact of peer support programs in the post-ICU period.

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Figure Captions

Figure One: Mechanisms by which peer support provided benefit

Mechanism		Supporting Quotes
Shared Experiences	<i>Reduction in Anxiety and Concerns</i>	P35: 'I'd tell them the situation I was in...whether it's two of us or seven of us, a lot will come out. You will lose stress. I lost stress. You'll feel better about everything.'
	<i>Increase in Motivation and Hope</i>	P34: 'I felt such comfort in everybody else's misery and solely for the only purpose and reason is that I'm not alone...it was such a level of comfort.'
	<i>Reduction in Social Isolation</i>	P2: 'It's the isolation part of it, like you think that you're the only one in this situation...until you hear other people's stories you feel isolated and alone, you know, and soon as I started hearing other people's stories...I finally realised I am not on my own, I am not isolated, there [are]other people and that's really important.'
	<i>Internal Validation of Progress</i>	P4: '...got him to come over and chat with you, he had went through exactly the same as you and he is great now—he is living normal.'
Care De-Brief	<i>Care Understanding/Navigation of Healthcare System</i>	P66: 'it was good to talk about the experience. It was good to talk to other people who had the same thing, that my experience wasn't unique. And they talked about some coping mechanisms and stuff.' P10: 'And everybody is really attentive...we can give you some advice from where we are, what we have been through, rather than coming from a medical perspective...because we have walked a path.'
	<i>External Validation of Progress and Feelings</i>	P46: '...that people have it worse than I do and made me feel like I'm not alone. I'm not just going crazy, this is a big deal.'
	<i>Internal Validation of Progress and Feelings</i>	P33: 'Just being able to talk to somebody who understands what you're talking about. People can sit there and nod their heads...but if they ain't been through it, they have got no idea what's going on.'
	<i>Expectation Management</i>	P41: 'You've got to make compromises. You can't just quit living. You've got to take some risk...learning to navigate through that process.' P9: 'It's not that you want other people to be miserable and in the same boat, it's that you want to be reassured you aren't odd or unique. It is reassurance.'
Altruism	<i>Sense of Purpose</i>	P24: 'It has helped me, to try and help other people.'

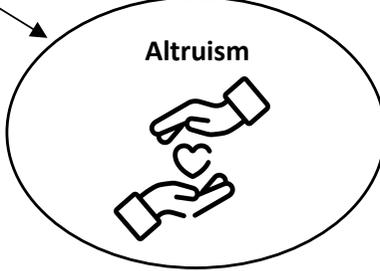
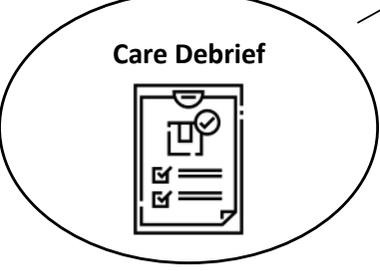
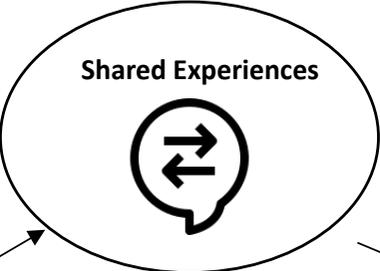
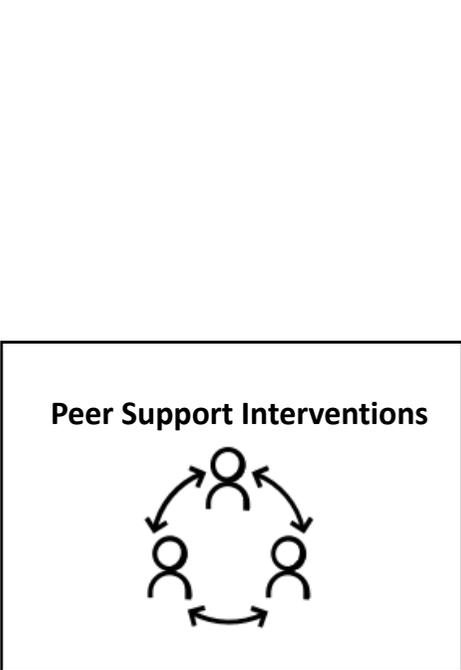
P25: 'There was a sense of common purpose, of support, quiet support for each other and being in the presence of other people who knew what it was like to be incapacitated.'

Giving Back/Helping Others

P34: 'I went through hair loss....people that are like, oh, my gosh, what's happening. I love being able to [say] hey...it'll grow back. I'm proof in the pudding.'

P3: 'I felt that I could give something back.'

P44: 'Part of my recovery is that I'm helping others. I'm giving back.'



Reduction in Anxiety and Concerns

Increase Motivation and Hope

'I'm not alone' Reduce Isolation

Internal Validation of Progress

Care Understanding/Navigation of Healthcare System

External Validation of Progress

Expectation Management

Sense of Purpose

Giving Back/Helping Others

