PEER SUPPORT FOR BEREAVED SURVIVORS

January 2017

Systematic Review of Evidence and Identification of Best Practices

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A "word cloud" is used to show a portion of the actual responses provided by Subject Matter Experts in peer support who were interviewed for this project. Word frequency is indicated by size and shade; larger and darker words were mentioned more often. The word cloud was generated with the help of the WordSift program (wordsift.org)

About this Publication

This work was sponsored by the Tragedy Assistance Program for Survivors (TAPS), the national non-profit organization dedicated to providing support and care to all those grieving the loss of a loved one in America's armed forces, regardless of the circumstance of death or the relationship to the deceased. Find more information at www.taps.org.

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Preface

The number and variety of peer support programs has grown dramatically in the last 15-20 years. These programs aim to help people cope with problems ranging from severe mental and physical illness and disabilities, to the more common challenges of everyday life such as maintaining a healthy diet and exercise. A particular area of growth has been in peer support programs which aim to assist those affected by sudden or traumatic loss, such as death of a loved one or coworker.

As peer support programs and applications have advanced, there has also been an increase in research aimed at assessing the effectiveness of peer support, and identifying standards of care and best practices. Unfortunately, much of this work is scattered across different disciplines and is often unavailable to practitioners and policy makers who could use it. The present study helps to address this problem by providing an up-to-date review and assessment of the evidence for efficacy and best practices in peer support programs, with a special focus on programs to assist survivors of traumatic loss. Results should be of value to anyone interested in peer support programs, but especially those engaged in designing and implementing peer support programs for survivors.

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Table of Contents

Executive Summary

This study was undertaken at the request of the Tragedy Assistance Program for Survivors (TAPS) with the aim of providing an up-to-date review of the evidence on peer support for bereaved survivors of sudden death or loss, while also identifying best practices in this area. There are three main parts to the report. The first sets the context with an overview of the research on peer support programs in general. Next, we conduct a systematic review of the literature specifically on peer support programs for bereaved survivors. The third section presents results on best practices in peer support programs for the bereaved, based on in-depth interviews with subject matter experts as well as findings from the literature.

Peer support has been around a long time, under various guises. As early as 1790, recovered mental patients were being used in French hospitals to support and assist patients in their own recovery (Davidson, Bellamy, Guy & Miller, 2012). In recent years peer support programs have grown tremendously, and are being applied more often to assist those with mental and physical illnesses, addictions, disabilities, and a whole host of life challenges. As well, more and more research studies are appearing that address the question, "is peer support effective in facilitating growth or recovery?" In most cases, the answer appears to be "yes," with reviews concluding that peer support programs usually lead to better outcomes such as improved health and well-being, increased engagement, and reduced hospitalizations (Chinman et al., 2014). Peer support programs of various stripes are also being used to assist grieving survivors of sudden death, but research evidence for their effectiveness is scant. In order to answer this question, we thus conducted a systematic review of the literature focused on peer support for bereaved survivors. A systematic review is desirable because it assures that all relevant studies are identified, is replicable, and provides a very high level of evidence regarding the question of concern.

Our systematic review searched multiple databases including PUBMED, PsycINFO, CINAHL, DTIC, and the Cochrane Database of Systematic Reviews for relevant studies going back 25 years, including published and unpublished (eg, dissertations) works. Thirty-two research studies met all inclusion criteria. Studies varied considerably in methods, samples and design. Most of the reviewed studies found evidence that peer support was helpful to bereaved survivors, for example by reducing grief symptoms such as depression and loneliness, and increasing well-being and personal growth. The review also found benefits accrued to those who provide peer support, generally involving increased personal growth and sense of positive meaning in their own loss. Several studies addressed the growing trend of internet-based peer support programs, finding that these are beneficial in part due to their easy 24/7 accessibility. Studies also suggest that peer support is especially valuable for survivors of suicide loss, a result that may be related to a lack of appropriate support from family and friends experienced by many of these survivors.

Ten subject matter experts with extensive experience in peer support programs for the bereaved were interviewed, with the primary aim of identifying the essential elements or best practices in a successful peer support program for survivors. A thematic analysis of the interviews yielded eight best practice categories. The experts agreed that successful peer support programs for survivors should (1) be easily accessible and quick to respond; (2) be confidential; (3) provide a safe environment for the survivor; (4) provide a peer supporter who closely matches the survivor in life experience; (5) carefully select peer supporters in order to assure their suitability for the role; (6) partner closely with mental health professionals; (7) provide thorough training for peer supporters; and (8) assure that peer supporters are monitored and cared for. These essential practice elements were also identified in the literature review. Most often mentioned was the importance of peer supporters having similar life (and loss) experiences as the survivors being supported.

While additional research is certainly desirable, the studies analyzed in the present review provide solid evidence that peer support approaches lead to significant benefits for bereaved survivors. Also, the best practices identified here can serve to inform the efforts of those engaged in providing peer support services to those affected by sudden death or loss.

Abbreviations

ASIST	Applied Suicide Intervention Skills Training
CINAHL	Cumulative Index of Nursing and Allied Health Literature
DCoE	Defense Center of Excellence for Psychological Health and Traumatic Brain Injury
DHHS	Department of Health and Human Services (U.S.)
DTIC	Defense Technical Information Service
EAP	Employee Assistance Program
HRSA	Health Resources and Services Administration
IRB	Institutional Research Board
NREPP	National Registry of Evidence-based Programs and Practices
PRISMA	Preferred Reporting Items for Systematic reviews and Meta-Analyses
PS	Peer Supporter
PSS	Peer Support Specialist
PTG	Post Traumatic Growth
PTSD	Post Traumatic Stress Disorder
SAMHSA	Substance Abuse and Mental Health Services Administration
SME	Subject Matter Expert
SPRC	Suicide Prevention Research Center
TAPS	Tragedy Assistance Program for Survivors

I. Introduction and Study Goals

Peer-to-peer support programs are being implemented with increasing frequency in organizations in order to help people cope with problems ranging from severe mental illness, alcohol and substance abuse, to the whole gamut of work and life stressors including serious illness and death of a loved one. But while peer-support programs have recently become accepted as an effective adjunct to traditional treatment approaches for serious mental illness and addictions (Davidson, Shahar, Staynar, Chinman, Rakfeldt & Tebes, 2004; Dumont & Jones, 2002; Repper & Carter, 2011), the evidence is more limited when it comes to peer support programs applied to other groups, such as those experiencing traumatic loss or bereavement. This report provides an up-to-date review of evidence regarding the efficacy of peer support programs in general, and in particular with regard to survivors of trauma and traumatic loss. Also, available evidence is examined to identify best practices that contribute to positive results in peer support programs in general, and more specifically to peer support programs for those dealing with sudden or traumatic loss.

1. Study Approach and Scope

We first conducted a detailed, general review of the scientific literature on peer support programs, focused on identifying evidence for their effectiveness. This includes a critical examination of existing reviews published within the last 10 years, as well as our own search of the literature from 1990 through 2016. This is followed by a more focused search and systematic review of the literature over the same period covering peer support approaches aimed at those who experienced sudden loss or death of a family member or close friend.

In addition to reviewing the scientific literature on peer support, we also conducted interviews with 10 subject matter experts (SMEs) in peer support. These operational interviews provide a deeper understanding of the peer support process and programs, and also permit the identification of "essential ingredients" and best practices in peer support for those experiencing loss, including survivors of suicide.

2. Organization of this Report

Following the present section, which describes the background and goals for this project, Part II provides a brief history on the use of peer support to aid recovery of persons from mental health and other problems, and also discusses the major theoretical concepts thought to explain how and why peer support works. Part III provides essential context by summarizing the scientific evidence for the effectiveness of peer support programs in general, regardless of where applied. The next sections represent the main effort of this project, which focuses on peer support specifically for bereaved survivors. Part IV presents a systematic review of the literature in this area, analyzing the available evidence bearing on the efficacy of peer support programs for survivors. Part V reports the results of in-depth interviews conducted with subject matter experts experienced in the field of peer support for survivors of sudden loss and death. Next, Part VI distills the expert interview material as well as evidence from the systematic review to identify what are the essential ingredients and best practices in providing peer support interventions for survivors. Part VII gives a summary and conclusions, with some discussion of limitations as well as recommendations for future research on peer support programs aimed at bereaved survivors.

II. Peer Support: A Brief History

The beginnings of peer support are most often attributed to the mental health consumer movement that began in the 1960s. During this period mental health professionals and former patients began to advocate for better treatment of mental patients, including giving them more control and autonomy in their treatment (Chamberlin, 1978; Department of Health and Human Services, 2003). This movement was in part a reaction to the dominant perspective at the time, a "medical model" that regarded mental illness as an organic disease to be managed but not cured, while also denying possible environmental contributing factors such as stress (Mead, Hilton & Curtis, 2001). Without using the term "peer support," a number of mental health providers began to practice and advocate for the use of recovered mental patients as an adjunct to traditional treatment approaches (Carkhoff & Truax, 1965; Cowen, Gardnet & Zax, 1967).

Other experts trace the earliest peer support program to the founding in 1935 of Alcoholics Anonymous, an organization that uses peers to assist alcoholics in recovery (Laudet, 2008). But the use of peers to assist in recovery has a much longer history. In their brief review of peer support programs among persons with severe mental illness, Davidson, Bellamy, Guy and Miller (2012) point out that the value of peer support for mental patients was recognized as early as 1790 at the Bicetre Hospital in Paris. The hospital director at the time, Jean Baptiste Pussin, made it a practice to hire as many recovered patients as possible to work in the hospital, finding that they showed greater empathy and kindness to the patients. Other mental health care providers, to include Harry Stack Sullivan in the 1920s, also made use of recovered patients to aid in the treatment of hospitalized mental patients (Davidson, Raakfeldt & Strauss, 2010).

That said, peer support providers and programs have increased exponentially since about 1990. In 2005, the number of peer providers in mental health settings was estimated at more than 10,000 in the United States alone (Goldstrom, Campbell, Rogers, Lambert, Blacklow, Henderson & Manderscheid, 2006). This number has certainly grown, and peer providers are supporting many other groups as well, to include those with disabilities, addictions, chronic illnesses such as cancer and diabetes, police, firefighters, and military veterans. Further evidence of growth is seen in the number of programs listed by the Substance Abuse and Mental Health Services Administration (SAMHSA) that include peer support. Just from September 2015 onward, four new peer support programs were included in the SAMHSA registry, more than the total number (three) from the entire period 2008 to 2015. Many more peer support programs are appearing in other settings as well.

1. Theoretical Basis of Peer Support

Peer support can be defined as "a system of giving and receiving help founded on key principles of respect, shared responsibility, and mutual agreement of what is helpful" (Mead, Hilton & Curtis, 2001). While peer support programs come in many different forms, they always involve people with similar backgrounds providing emotional, social or practical support to each other. According to Solomon (2004), "peer support is social and emotional support, frequently coupled with instrumental support that is mutually offered by persons…sharing a similar mental health condition, to bring about a desired social or personal change." A key underlying assumption of the peer support approach is that due to shared experiences and life circumstances, peers are better able to establish connections of trust and support with those in need (Castellano, 2012). Peer support services may aim, for example, to promote hope, recovery from illness or trauma, improved life skills, psychological well-being and social integration (Landers & Zhou, 2011). Regardless of the specific program, peer supporters draw on their shared experiences in order to provide empathic understanding, information and advice to those they are helping.

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[1] SAMHSA (Substance Abuse and Mental Health Services Administration), part of the U.S. Department of Health and Human Services (DHHS), operates a searchable online registry of substance abuse and mental health interventions, the "National Registry of Evidence-based Programs and Practices" (NREPP). The registry includes reviews of the quality and efficacy of listed programs. For more, see: http://nrepp.samhsa.gov/02_about.aspx

In addition to the benefits that peer support programs provide for participants, they also appear to have similar positive effects for those serving in peer support roles. Sometimes described as "post-traumatic growth" or PTG, recognized benefits to peer supporters include improved quality of life, increased confidence and self-esteem, hopefulness, coping ability, autonomy and self-control (Solomon, 2004; Salzer & Shear, 2002). Others have also emphasized the reciprocal benefits of peer support activities. For example, Castellano (2012) describes a "Reciprocal Peer Support" (RPS) model used successfully in multiple peer support programs in New Jersey, in which those providing the peer support also benefit from positive recognition and affirmation of their special contributions. In some contexts, the peer relationship is seen more as "one-way street," with the peer provider providing support to the service recipient, and no expectation of reciprocity. This is often the situation for example in the use of peer supporters to facilitate recovery of people with some mental illness (Chinman, George, Dougherty, Daniels, Ghose, Swift & Delphin-Rittmon, 2014).

Peer support providers for behavioral health conditions are also receiving more training and preparation for the role, and in some areas can obtain special certification and credentialing (Cook, 2011; Sabin & Daniels, 2003; Campbell & Leaver, 2003). As well, there have been several efforts to develop systematic standards of care and best practices for the use of peer support services across mental and physical health domains (Daniels, Tunner, Ashenden, Bergesen, Fricks & Powell, 2012; Daniels, Tunner, Powell, Fricks & Ashenden, 2015). A useful state-by-state review of peer specialist training standards is provided by Kaufman, Brooks, Bellinger, Steinley-Bumgarner, and Stevens-Manser (2014). The certification process and development of standards of care have in turn facilitated growing acceptance of peer support services for Medicaid and health insurance reimbursement (Daniels, Cate, Bergeson, Forquer, Niewenhous & Epps, 2013).

A number of psychosocial processes and theories have been applied to help explain why peer support approaches may be effective in helping people facing difficult circumstances. One of the key processes thought to underlie peer support is social support – the perception that one has people around who can be relied upon to provide emotional and practical assistance (Solomon, 2004). Social support may include emotional support, information and advice, practical assistance, and help in understanding or interpreting events (House, 1981). There is ample evidence that social support is linked to good health and positive outcomes for people in general, and especially when they are facing stressful conditions (Reblin & Uchino, 2008). While social support can come from multiple sources, social support from peers appears to be especially helpful (House, 1981; Grauwiler, Barocas & Mills, 2008). For example, in studies of Vietnam veterans, Stretch (1991) found that returning veterans who experienced greater social support from peers showed less Post Traumatic Stress Disorder than those who for various reasons were more isolated from their fellow soldiers. Bartone (2000) likewise found that perceived peer social support (horizontal cohesion) together with hardiness served to reduce the ill effects of combat exposure in U.S. military Gulf War personnel. By providing social support then, peer supporters can have beneficial effects for those they are serving.

Social learning theory (Bandura, 1977) also has application to peer support. The theory posits that people learn in large part by modeling themselves after others they observe, especially others they perceive to be in similar circumstances. Related to this is *social identity theory*, which indicates people are attracted to others who are seen as similar to themselves (Turner, 1991). For clients receiving peer support, the peer supporter who has experienced similar circumstances is readily seen as "like me." The peer supporter can thus become an inspirational role model, as someone who has succeeded in coping with similar problems and challenges (Chinman, Lucksted, Gresen, Davis, Losonczy, Sussner & Martone, 2008). This social identification process is reinforced by the sharing of "*experiential knowledge*" between client and peer supporter (Shubert & Borkman, 1994). Experiential knowledge is specialized knowledge and perspectives acquired by people based on life and work experience. Having gone through similar experiences, the peer supporter can more readily understand the client's position, and offer grounded advice on potential coping and problem solving strategies. Furthermore, based on the experiences they have in common, the client is more willing to trust and listen to the peer supporter's advice.

III. General Review of Evidence on Peer Support Effectiveness

As peer support programs have grown in popularity, more attention is being devoted to assessing their effectiveness. In general, the most rigorous research in this regard has focused on evaluating the range of peer support programs aimed at supporting recovery from various mental illness conditions.

An early and influential report by Solomon (2004) reviewed the evidence for peer support in mental health programs, and concluded that there was a "very high level of support" for the effectiveness of peer providers in influencing positive outcomes for recipients. For example, studies by Christensen and Jacobson (1994) and Gould and Glum (1993) found that self-help therapy by paraprofessionals or peers was equally effective, and in some cases superior to therapy provided by professionals for reducing mental health problems like depression and improving life skills. Reviews of peer support for individuals with more severe mental health problems have also found positive evidence, although studies varied greatly in methods and rigor. For example, Davidson and colleagues reported that self-help peer run groups reduced symptoms for participants, and increased their social connections and quality of life (Davidson, Chinman, Kloos, Weingarten, Stayner & Tebes, 1999).

Peer support programs also resulted in fewer and shorter hospitalizations (Kennedy, 1989), improved coping skills and satisfaction with health (Raiff, 1984). Solomon and Draine (2001) provided a review of peer or consumer operated mental health services, concluding that while research to that point was limited, these programs showed promise of being as effective or more effective than professionally run services. An early systematic review by Simpson and House (2002) identified five randomized controlled studies and seven comparative studies examining the impact of using peers or consumers in mental health services. None of these studies showed any detrimental effects of including peers, and several showed positive effects, including greater patient satisfaction and less hospitalization. Other studies in this realm have also found lower rates of hospitalization, improved self-esteem and quality of life in patients when peers or consumers are involved in treatment (Chinman, Weingarten, Stayner & Davidson, 2001; Clarke, Herinckx, Kinney, Paulson, Cutler & Oxman, 2000; Felton et al., 1995).

A more recent review is provided by Repper and Carter (2011), who also examined studies on the value of incorporating peer support into mental health services. They identified 38 relevant studies published from 1995 to 2010. Seven of these were randomized control trials, with the remainder being group comparison without randomization, and longitudinal follow-up studies using surveys and/or interviews. Their findings agreed with earlier reports in showing that as compared to programs in which peers are not used, peer support programs showed equivalent or improved outcomes. Documented improvements include fewer hospitalizations and longer time living in the community (Min, Whitecraft, Rothband & Salzer, 2007); increased sense of control and independence, improved self-esteem and confidence (Dumont & Jones, 2002; Davidson et al., 1999; Ochocka, Nelson, Janzen & Trainor, 2006; Salzer & Mental Heath Association of Pennsylvania Best Practices Team, 2002); more extensive social support networks and engagement in the community (Yanos, Primavera & Knight, 2001; Ochocka et al., 2006) and enhanced social skills (Forchuk, Martin, Chan & Jensen, 2005). This review also found evidence that peer support programs result in an increased sense of hope and belief in a better future (Davidson, Chinman, Sells & Rowe, 2006); a reduced sense of stigma (Ochocka et al., 2006); and greater feelings of acceptance, empathy and understanding (Davidson et al., 1999; Sells, Davidson, Jewell, Falzer & Rowe, 2006).

Subsequent to the Repper and Carter (2011) report, a brief review of studies on peer support in persons with mental illness was published by Davidson, Bellamy, Guy & Miller (2012). They concluded that available evidence shows peer support programs provide three main benefits or advantages over traditional mental health approaches. These are: (1) an increased sense of hope through positive self-disclosure; (2) use of similar background and experience, "experiential knowledge," to facilitate positive role modelling; and (3) greater trust,

understanding and empathy between the peer supporter and the recipient. In addition to studies previously identified in other reviews, Davidson et al. (2011) describe a randomized control trial (RCT) conducted by their research team, in which participants in two different peer support groups were compared with a control group receiving traditional care. Results indicate that participants in the peer support groups increased in their sense of control and ability to make life changes, were more hopeful and engaged in managing their own care, and were more socially connected and involved in their communities (Tondora et al., 2010).

In another longitudinal randomized controlled trial (RCT) conducted by the same lab, participants were randomly assigned to a either a traditional care control group, or an experimental group in which care included a "recovery mentor," a peer provider who served as a mentor to assist in recovery. Over a 9-month period, the group with peer recovery mentors showed multiple benefits over the control group, including fewer and shorter hospitalizations, less substance abuse, lowered depression, and increased sense of hope, well-being, and autonomy (Sledge, Lawless, Sells, Wieland, O'Connell & Davidson, 2011).

In the most recent review available, Chinman et al. (2014) identified 20 studies published between 1995 and 2012 addressing the effectiveness of various peer support approaches to assist mentally ill patients. Study methods included 11 randomized controlled trials, six quasi-experimental, and three correlational or descriptive designs. Most of these studies demonstrated a moderate level of effectiveness for peer support, with improved outcomes in programs that added peers to traditional clinical services, and also when peers were used in teaching roles. As compared to professional clinical staff alone, peers were more effective in facilitating recovery and also in reducing the use of inpatient services. Notably among the reviewed studies was an RCT in which outpatient participants in a peer-based recovery program showed reduced depression and anxiety symptoms, improved hopefulness and quality of life at 6-month and 8-month follow up (Cook, Copeland, Floyd, Jonikas, Hamilton, Razzano, et al., 2012; Jonikas, Grey, Copeland, Razzano, Hamilton, Floyd, et al., 2013). Similar findings emerged for another RCT in which outpatients in a peer-led education program showed increases in empowerment, hopefulness, and self-advocacy, and decreases in (self-reported) symptoms (Cook, Steigman, Pickett, Diehl, Fox, Shipley et al., 2012; Pickett, Diehl, Steigman, Prater, Fox, Shipley et al., 2012).

Most of studies identified in the Chinman et al. (2014) review were rated at a moderate level of methodological quality. Despite a number of study limitations, the overall pattern of results supports the conclusion that including peers as adjuncts in traditional service and educational programs for those with mental health problems results in a number of benefits to those receiving services. Improved outcomes include reduced use of inpatient services, improved relationships with health care providers, increased engagement with care activities, and an improved sense of empowerment, activation, and hopefulness.

The effectiveness of peer support programs has also been explored in other health areas. For example, Parry and Watt-Watson (2010) summarized the results of six RCTs conducted with heart disease patients, finding that peer support was associated with improved health, self-efficacy and well-being. A recent report by Peers for Progress (2014) summarizes evidence on the benefits of peer support interventions in improving outcomes for a range of health problems across the globe. For example, 21 of 22 studies reviewed showed significant health improvements following peer support interventions for diabetic patients, including lowered plasma glucose levels (Dale, Caramlau, Friede & Walker, 2009; Heisler, Vijan, Makki & Piette, 2010). The Peers for Progress (2014) report also cites substantial evidence that the involvement of peer supporters in health care often leads to cost reductions (Campbell, 2014; Sledge et al., 2011).

IV. Systematic Review of Peer Support for Survivors

Next, a systematic review of the literature was conducted to identify studies of peer support approaches aimed specifically at those experiencing grief or bereavement related to the death or sudden loss of a family member, friend or co-worker. By the standards of evidence-based medicine, the systematic review provides a very high level of evidence regarding a particular question (Oxford Centre for Evidence-Based Medicine, 2009). To date, there has not been a systematic review of studies looking at peer support for the bereaved. The following sections describe the methods used in conducting the review, and provide a summary and synthesis of results.

1. Methods

We searched the databases ***PubMed, PsycINFO*** and ***CINAHL*** for references in English over a 25-year period from January 1991 to December 2016, to include journal articles, books, book chapters and dissertations. Table 1 lists the search terms used in the PubMed search. Equivalent terms were used to search the other databases. Studies were retained for further consideration if any term from the level 1 set (grief) AND any term from the level 2 set (peer support) appeared in the title or abstract. We also searched the ***Defense Technical Information Service (DTIC)*** and the ***Cochrane Database of Systematic Reviews*** for any reports dealing with peer support and grief, bereavement or death. We searched the references in all included reports, and also sought recommendations from several recognized experts in the field. In addition, several journals were searched directly for articles dealing with death, grief and peer support. These included: ***Death Studies; Omega: Journal of Death and Dying; Bereavement Care; Crisis: Journal of Crisis Intervention and Suicide; Mortality; Illness, Crisis and Loss***, and ***Suicide and Life-Threatening Behavior***. The database ***ProQuest*** was used to obtain full text of any identified dissertations or theses.

Table 1. Search terms used in the PubMed search

LEVEL 1 TERMS	LEVEL 2 TERMS
Grief	Peer support
Bereavement	Peer assistance
Bereaved	Peer counselor
Death	Peer to peer
Dying	Peer specialist
Sudden loss	Consumer provider
Survivor	
Suicide	

a. Inclusion and exclusion criteria

We ***included*** any empirical study dealing with peer support services provided to adults who have experienced death or sudden loss of a family member, friend or co-worker. We particularly sought studies that evaluate the effects of peer support programs for this target population, and any studies that address what are the essential ingredients or "best practices" in providing peer support services to this population. Studies were included across the range of methodologies, whether experimental, observational or qualitative in nature. Studies were ***excluded*** that dealt only with children, chronic illness, or loss or trauma not related to death. We also excluded any reports that did not contain original research, such as program descriptions without empirical results, community policy studies, editorials, conceptual articles, or reviews without any new data.

The initial database search of titles and abstracts yielded the following results: PubMed = 129; PsycINFO = 203; CINAHL = 131 for a total of 463 potentially relevant studies. These results were exported into the Endnote program for further processing (Thompson Reuters, 2016). A duplicates search revealed 136 redundant studies which were subsequently excluded. The search of other sources yielded 45 potentially relevant articles, with 16 from Cochrane's Database of Systematic Reviews, two from DTIC, 16 from the search of article references, and 11 from the direct search of journals dealing with death and dying. This resulted in 372 unique articles identified from all sources. In order to assess if studies met inclusion criteria, all abstracts were read, and in uncertain cases the full text article was consulted. Articles were excluded that did not deal with death, grief or bereavement (179), did not report original research (111), did not deal with peer support (28), addressed children only (15), and other reasons including not in English (1), no full text available (2), repeats results reported elsewhere (2), and community studies (2). Figure 1 displays the search results in a PRISMA flow diagram (Preferred Reporting Items for Systematic reviews and Meta-Analyses; Moher, Liberati, Tetzlaff & Altman, the PRISMA Group, 2009).

Selected studies were rated for quality and applicability using criteria adapted from Buckman et al. (2011), Smith, Bambra, Joyce, Perkins, Hunter & Blenkinsopp (2009), and the Cochrane Handbook for Systematic Reviews (Higgins & Green, 2008). Study designs were classified as (a) experimental or quasi-experimental; (b) observational (cohort, cross-sectional, case-control); or (c) qualitative, as described by Clancy (2002) and Mann (2003). Higher quality ratings were assigned to experimental and quasi-experimental studies, and lower ratings to qualitative studies. Other quality rating factors included selection method (random – representative or not), prospective design, use of control group, multiple methods, sample size, response rate, controlled for confounds, appropriate statistics, conclusions justified by results, and whether or not the study was approved by an ethics or institutional review board. Quality ratings made by the author were cross-checked by a second investigator, with 98% agreement. Table 2 summarizes the quality criteria and scoring method used.

Figure 1. PRISMA flow diagram of search results

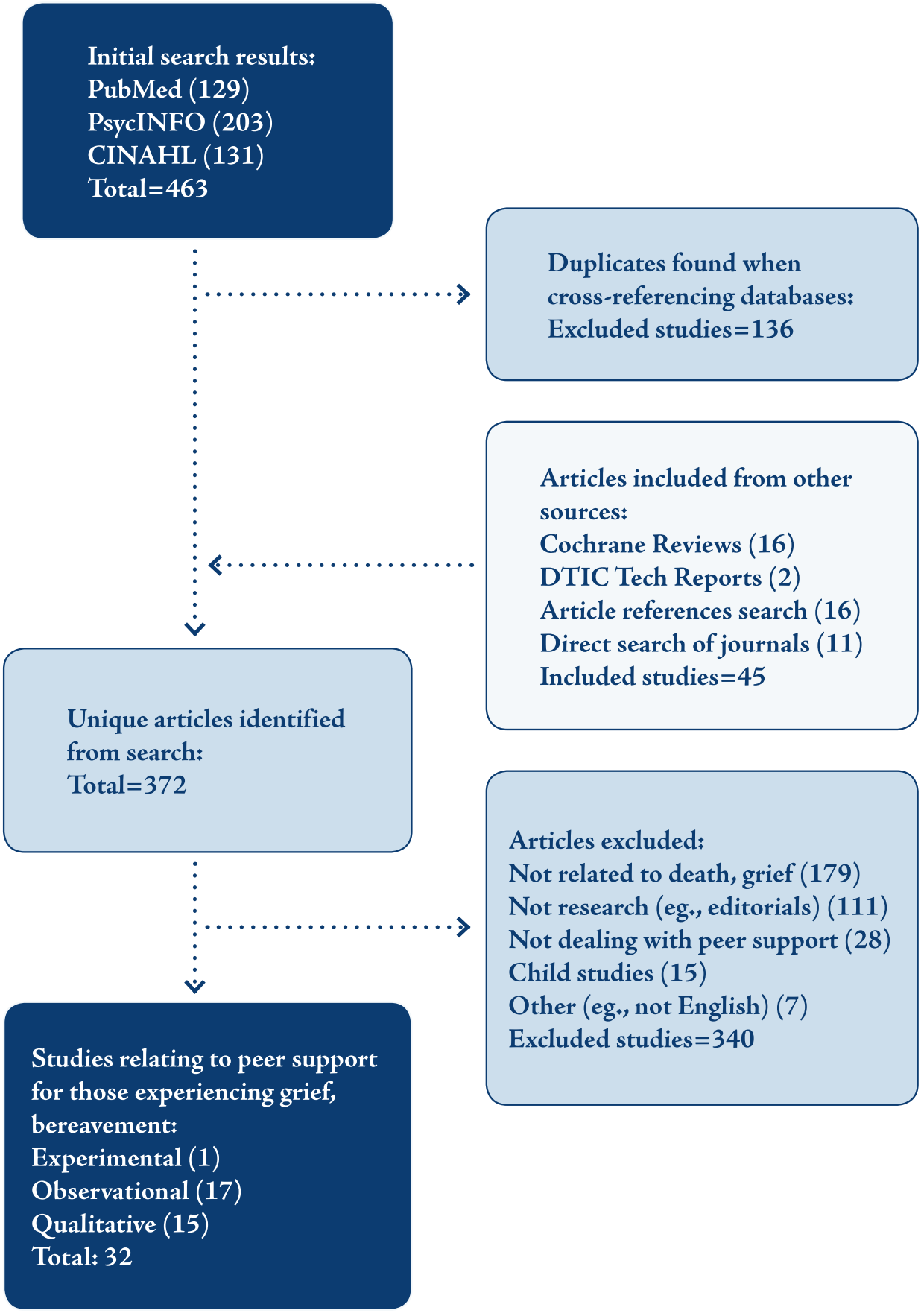


Table 2. Criteria and scoring method for rating the quality of studies reviewed

RATING CRITERIA	SCORING		
Study design	3: Experimental	2: Observational	1: Qualitative
Selection method	2: Random or representative	1: non-random or non-representative	
Prospective	1: Yes	0: No	
Appropriate control group	1: Yes	0: No or NA	
Multiple assessment methods	1: Yes	0: No	
Sample size	2: N > 100	1: N=11 to 100	0: N= 1 to10
Response rate > 60%	1: Yes	0: No or NA	
Controlled for potential confounders	1: Yes	0: No or NA	
Appropriate statistical tests used	1: Yes	0: No	
Conclusions justified by results	1: Yes	0: No	
Ethics or IRB approval	1: Yes	0: No	

Note: Adapted from Buckman et al. (2011), Smith et al. (2009), and Higgins & Green (2008).

2. Results

The systematic review yielded 32 studies that met all inclusion criteria. Of these, one applied an experimental or quasi-experimental design; 17 were observational, and 14 were qualitative studies. Five dissertations were among the included studies, with the remainder (27) coming from peer-reviewed journals. As to overall quality, nine studies were rated at 9 to 12, considered to be of high quality for studies of this type; nineteen studies were rated at 6 to 8, considered medium quality, and four studies were rated at 4-5, considered to be somewhat low in quality. It should be noted that qualitative studies, while generally rated at lower quality when compared to more carefully controlled studies, may nevertheless provide important preliminary insights into novel areas of investigation. Also, studies varied in the form of peer support they considered, from more formal programs providing support services face-to-face or over the phone, one-on-one or in groups, to more informal types of peer support such as from friends and co-workers. Table 3 provides a summary of included studies, showing study author(s), location, design, measures, sample description, quality rating, and the key findings related to peer support.

Table 3. Characteristics and key findings of studies on peer support for bereaved survivors

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
1	Aho et al., 2014	Finland	Qualitative	Surveys, Interviews	N=16 peer supporters providing assistance to bereaved parents	87%	25-55 42	9	Peer supporters see their main strength as shared experience; having also lost a child creates a bond. Valuable personal resources are open-mindedness, tolerance for uncertainty, positive mind set, communication skills, commitment, motivation, future orientation – hope. Peer supporters describe their own joy in helping others survive and go on; desire for more training & professional support
2	Aho et al., 2012	Finland	Qualitative	Internet messages	N=4 bereaved mothers in internet support forum; 631 messages collected over 5 year period	100%	NA	6	Bereaved mothers joined group 3 months after own child's death. They both received and gave support, including (1) emotional support; (2) informational support; and (3) communality (shared experience and acceptance). Peer support via internet was perceived as valuable, in part because not bound by place and time
3	Aho et al., 2009	Finland	Qualitative	Surveys, Interviews	N=8 bereaved fathers whose children died of illness	0%	29-49 35	7	The most important source of support for bereaved fathers came from peers who also experienced death of a child. Support from family, friends and professionals was more mixed
4	Aho et al., 2011	Finland	Quasi-experiment	Surveys	Bereaved fathers, N=62 in peer support intervention group; N=41 in control group	0%	20-59	12	Peer support intervention included phone calls and personal visits with other bereaved fathers. At 6-month follow up, intervention group showed fewer grief symptoms and more positive coping and post traumatic growth than controls

Table 3. Characteristics and key findings of studies on peer support for bereaved survivors (continued)

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
5	Archibong et al., 2006 (diss.)	USA	Qualitative	Interview	N=10 African-American parents of child killed by murder	NA	NA	5	Bereaved parents perceived support and counseling from peers with similar experience as more beneficial than professional help, in part due to stigma around seeking mental health support and mistrust of professionals
6	Barlow et al., 2010	Canada	Observational	Surveys, Interviews	N=19; 10 suicide survivors and 9 peer supporters	81%	22-66 26.9 (10)	10	Both peers and survivors showed benefits from 4-month intervention. Results showed medium to large effect size decreases in despair, disorganization, detachment, panic behavior, blame and anger; and increases in personal growth
7	Baugher et al., 2012	USA	Qualitative	Interviews	N=22, 20 peer supporters and 2 professional staff	91%	NA	6	Training peer supporters to focus clients on talking about feelings ("talk therapy") can have negative results for some. Also in supervision, peer supporters should not be forced into discussing emotions
8	Baumgarten, 2000 (diss.)	USA	Qualitative	Interviews Surveys	N=7 teenage peer group leaders whose parents died (4) or were ill (3) with cancer	57%	15-19	5	In dealing with their parent illness and death, teenagers report most helpful was peer support group. Support from family was often not available, as families were dealing with parental death/illness
9	Boyle et al., 2015	Australia	Observational	Survey	N=24 volunteer peer support telephone workers for bereaved parents	100%	20-50+	8	Peer supporters report benefits from role; provides a way to honor own dead child, giving back. Clients speak more openly on learning peer supporter also had a child die. Frustrations are not knowing what happens to client after phone call, and balancing work-family-volunteer demands

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
10	Cohen, 2005 (diss.)	USA	Observa-tional	Surveys	N=302 bereaved teenagers	52%	18-19	11	Informal peer support is associated with less depression, greater mastery and engagement in life, better functioning at school and work
11	Diamond et al., 2016	USA	Qualitative	Survey, Focus group	N=24, 13 peer support parents and 11 parent clients	96%	NA	8	Peer supporters benefit by "giving back" and honoring their dead child; clients report peer support helped by "normalizing" experience, talking with someone who also went through it; Reduced isolation; Timing is important – grieving parents are sometimes not ready to talk with others; Face-to-face initial meeting is important to establish trust relationship; more fathers are needed as peer supporters
12	Feigel-man et al., 2008	USA	Observa-tional	Survey	N=401 suicide survivors; 104 received support via internet only; 297 received face-to-face peer support	85%	35-66+	10	Both internet and face-to-face peer support groups were helpful in reducing symptoms and improving adaptation. But face-to-face participants showed less depression and suicidal thinking. Reported advantages of internet support were 24/7 availability and easy access. Internet support users report more unhelpful responses from family, friends
13	Feigel-man et al., 2009	USA	Observa-tional	Surveys	N=462 survivors of death by suicide	85%	35-66+	9	Over long term (more than 5 years since death) more frequent participation in peer support groups, is linked to increased personal growth. Professional support is not linked to growth. More religious participation is also linked to growth
14	Forster et al., 2015	Australia	Qualitative	Interviews	N=10 health care professionals caring for dying children	NA	24-57	5	Seeking and receiving peer support was the primary coping strategy reported. Professionals also "compartmentalize" feelings of grief and sorrow in order to perform duties effectively

Table 3. Characteristics and key findings of studies on peer support for bereaved survivors (continued)

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
15	Gold et al., 2016	USA	Observational	Surveys	N=476 bereaved mothers (stillbirth) with 416 in internet peer support group, and 60 in in-person peer support	100%	31 (5.5)	10	Groups did not differ on depression symptoms. Mothers in both groups highly endorsed the value of peer support, most importantly a "recognition that I am not alone"
16	Harrington-LaMorie, 2011	USA	Observational	Surveys	N=52 adult survivors of military suicide attending a TAPS peer support seminar	79%	20-78 48.03 (13.8)	7	More seeking and use of peer support is associated with recency and young age of the deceased, and also with more avoidance, intrusion and hyperarousal PTSD symptoms (IES)
17	Kaunonen et al. 1999	Finland	Observational	Surveys	N=464 widows and widowers whose spouse died more than 6 months prior	76%	30-77 56.3	8	Support from various sources aided adjustment – family, friends, co-workers. Those who lacked social support networks showed more anxiety (panic attacks) and avoidance on Hogan Grief Scale. 16.7% participated in bereavement support group, with 85% reporting it was helpful. Many reported that helping others to deal with grief was helpful to themselves
18	Kramer et al., 2015	Netherlands and Belgium	Observational	Surveys and interviews	N=270 suicide survivors participating in internet peer support group	87%	49.9 (12.4)	11	Internet peer support participants showed decreased depression and increased well being over 12 month period. Still, by WHO standards 61% still showed signs of clinical depression. 65% reported primary benefit was finding recognition from others in similar situations

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
19	Linke et al., 2002	United Kingdom	Observational	Surveys	N=44 Community Mental Health team members exposed to suicide	67%	NA	6	Respondents identified the most helpful support came from team colleagues – peers, followed by family and friends. Also helpful is open discussion of suicide, and for some attending the funeral
20	Oulanova et al., 2014	Canada	Qualitative	Interviews	N=15 peer counselors bereaved through suicide	87%	56 (9.4)	6	Results show peer counselors find meaning and benefit in helping others bereaved by suicide, transforming a bad event into something positive; peer support also counters the silence and loneliness around suicide survivors
21	Pector et al., 2004	USA	Observational	Survey	N=70 bereaved parents of neonatal dead	94%	20-40		Bereaved parents reported benefit from a variety of support resources, formal and informal; found peer support helpful; desired more contact with other bereaved parents
22	Rice et al., 2014	USA	Observational	Survey, Focus groups	N=9 oncology nurses exposed to 20+ dying patients yearly; participated in avatar based online support group	100%	39.5 (10.0)	8	Over a 10-week period, online peer storytelling participants experienced benefits including: help in making sense of death; felt support from the group; and satisfaction in helping others. Through storytelling in peer group, nurses were able to reveal more openly thoughts and feelings about death and grief. Some participants reported technical problems interfered with group process, and stated desire for face-to-face interactions
23	Richardson, 2015	USA	Observational	Survey	N=55 widows of firefighters killed in 9/11 attacks	100%	49.5 (6.4)	8	The most important and frequent source of social support (for 70% of sample) came from other 9/11 widows. Peer support was seen as valuable due to shared experience, greater trust and openess. Participation in peer support groups was associated with more PTG (r=.37, p<.01)

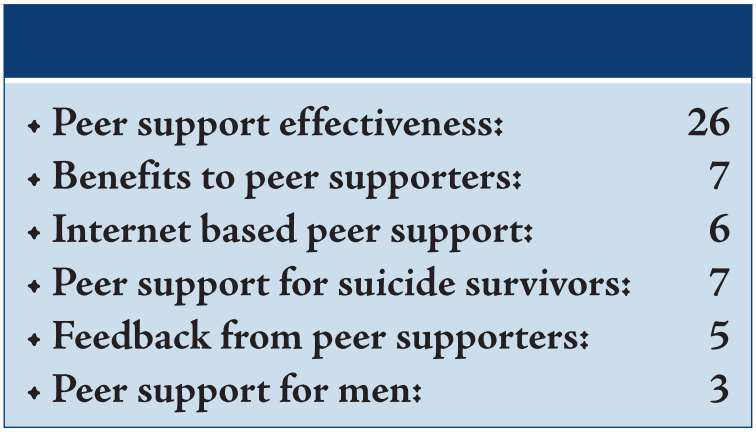
Table 3. Characteristics and key findings of studies on peer support for bereaved survivors (continued)

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
24	Riley et al., 2007	USA	Observational	Surveys	N=35 bereaved mothers drawn from support group meetings	100%	44 (8.8)	7	Support seeking is associated with fewer complicated grief symptoms, and more personal growth. Support from others who also lost a child was especially valuable
25	Roose et al., 2014	USA	Observational	Surveys, Focus groups	N=33 bereaved parents, 17 peer supporters and 16 clients	97%	NA	7	For peer supporters (peer parents), greatest reward was "giving back by helping others with same experience." Parents receiving support stated it helped to have support from someone with similar experience
26	Rudd et al., 2013	USA	Qualitative	Interviews	N=16; 6 bereaved parents (child died of SIDS or SUDC) and 10 helping professionals	NA	NA	7	Support needs of bereaved varied over time, with early need for information and practical assistance. Need for emotional support / compassion holds throughout bereavement process. After first 2 weeks desire for contact with peers with similar experiences – peer support - increased
27	Stewart et al., 2001	USA	Observational	Surveys, Focus groups, Interviews	N=28 widows, with 80% widowed for 5 years or less	100%	54-77 66	8	Support groups with peer leaders (widows) for 5-20 weeks resulted in increased positive affect, decreased loneliness and social isolation, enhanced ability to cope with bereavement stresses. Benefits maintained at 3-month post intervention follow-up

ID	Author & year	Study Location	Study	Measures	Sample	% Female	Age Range and/or	Quality	Key findings related to
28	Swartwood et al., 2011	USA	Qualitative	Text analysis of internet messages	N=564 first responses to new grief postings	NA	NA	9	Majority (66%) of responses used self-disclosure to lend support to bereaved. Central themes: Exchanging hope, Validating the grief experience; Providing information and support. Online grief support is accessible and inexpensive
29	White, 2001 (diss.)	USA	Qualitative	Inteviews, Focus groups, Surveys	N=10 hospice practitioners from a single agency	90%	38-53 46	6	Hospice workers showed evidence of compassion fatigue, and secondary traumatic stress. Peer support from other hospice workers, eg. during staff meetings) was important for coping; "compassion satisfaction" was also noted
30	Wittenberg-Lyles et al., 2014	USA	Qualitative	Interviews	N=10 oncology nurses participating in nurse peer support group	80%	27-58 46 (11)	6	Nurse report feeling stress, isolation and secondary grief. Peer support group relieves isolation – nurses see that others have similar responses. Benefits are improved self-care, morale, well-being, teamwork, and improved patient care
31	Worden, 1993	USA	Observational	Survey, Interviews	N=70 newly bereaved parents, Boston area	71%	42	8	Increased depression scores were associated with lack of peer support, and difficulty mobilizing and using social support
32	Yopp et al., 2013	USA	Qualitative	Focus group, Observations	N=6 newly bereaved fathers (wives died of cancer)	0%	NA	4	Participants in a newly established fathers peer support group report it was helpful in reducing grief and isolation. Previous experience in mostly female grief support groups was not helpful – peers were seen as too different from themselves

The included studies addressed a number of questions related to peer support, with some covering more than one question in the same study. Twenty-six studies focused on whether peer support is effective or beneficial to those receiving it. Seven studies explored the benefits to peer supporters, while 6 examined internet-based forms of peer support. Five studies primarily collected peer supporters' feedback on questions like what qualities are valuable for peer supporters, what challenges they face, and what training is needed. Seven studies dealt with peer support for suicide survivors, and 3 focused exclusively on peer support for men (the number of studies adds up to more than 32, since some studies address multiple questions or issues). In the presentation of results to follow, the rated quality of studies is indicated in parentheses beside the year, with 1=high quality, 2=medium quality, and 3=low quality.

Figure 2. Number of studies addressing various topics



a. Benefits of peer support for bereaved survivors

Out of seven high quality studies that assessed peer support effectiveness, six found significant benefits for bereaved persons who received peer support, either in terms of reduced grief symptoms or increased personal growth. One study (Gold et al., 2016, 1) found no difference in depression symptoms between bereaved mothers who received peer support via the internet, versus face-to-face peer support. In this case however, both groups reported that peer support was helpful in reducing the sense of isolation.

In the most methodologically rigorous study reviewed, N=103 bereaved fathers who had lost a child within the previous 6 months were randomly assigned to either a peer support intervention group, or a control group that did not receive peer support (Aho et al., 2011, 1). At six-month follow up, fathers in the peer support group showed significantly greater personal growth, and fewer grief symptoms (Hogan Grief Reactions Checklist; Hogan, Greenfield & Schmidt, 2001). Studies by Cohen (2005, 1), Kramer et al. (2015, 1) and Barlow et al. (2010, 1) all find significant reductions in depression and despair for bereaved receiving peer support, as well as increased personal growth. A long term study by Feigelman et al. (2009, 1) found that among 462 survivors of a suicide death, those that received more peer support also showed more personal growth and better grief resolution. Interestingly, support from mental health professionals was not associated with personal growth, but more religious participation was.

Studies in the medium quality range provide further evidence of positive benefits to bereaved people who receive peer support. Peer support is linked to reduced symptoms in several studies reviewed. For example, Kaunonen et al. (1999, 2), found lower anxiety and avoidance in widows and widowers who received peer support. Similarly, Worden & Silverman (1993, 2) reported that lack of peer support in bereaved parents was associated with increased depression. And Riley et al. (2007, 2) found fewer complicated grief symptoms in bereaved parents who received peer support.

Recipients of peer support also show reduced feelings of isolation and loneliness, and an improved ability to cope and "make sense" of the loss (Diamond et al., 2016, 2; Rice et al., 2014, 2; Stewart et al., 2001, 2) . Reduced feelings of isolation and loneliness were also found in studies by Rice et al. (2014, 2), Stewart et al. (2001, 2), and Wittenberg-Lyles et al. (2014, 2). Increased personal growth and satisfaction in helping others was reported in studies by Rice et al. (2014, 2), Riley et al. (2007, 2), and Richardson (2015, 2). An exception to this trend is found in the study by Harrington-LaMorie (2011, 2), who administered surveys to 52 suicide survivors attending a peer support conference. This study found that higher expressed need for and use of peer support was correlated with more symptoms of PTSD, such as avoidance, intrusion and hyperarousal. Although the cross-sectional study design does not allow for causal inference, the author interprets this finding as indicating that those with greater distress related to the suicide are more likely to seek out and use peer support services.

Three studies in this group, while not directly addressing potential benefits of peer support, still find that bereaved persons perceive peers – people with similar loss experiences – to be the most helpful source of support in dealing with grief (Roose et al, 2014, 2; Pector, 2004, 2; Aho et al., 2009, 2). The study by Aho et al. (2009, 2) also found that for bereaved fathers who lost a child, support from family and friends was mostly not perceived as helpful.

Consistent with studies in the high and medium quality ranges, the four studies rated at lower quality showed similar benefits of peer support accruing to various groups of bereaved. Archibong (2006, 3) found that for bereaved parents of murder victims, support from peers who had also lost children was seen as most beneficial, while at the same time professional help was generally avoided. Looking at teenagers with a dead or terminally ill parent, Baumgarten (2000, 3) reports that peer support groups were the most helpful source of support. The study by Forster et al. (2015, 3) found that seeking and receiving peer support was the most effective coping strategy for professionals caring for dying children. And Yopp et al. (2013, 3) report that for fathers whose wives recently died, peer support group participation was associated with reduced isolation and grief symptoms. These fathers also reported that previous participation in mostly female peer support groups was not helpful, as the other participants had experiences that were "too different" from their own.

To sum up, 18 of the reviewed studies reported evidence that peer support was perceived as helpful by bereaved individuals. Eleven studies showed peer support was associated with lowered grief symptoms, such as depression, loneliness and sense of isolation. And 13 studies indicated that peer support was linked to personal growth and well-being. Twenty-one studies found evidence that having had similar loss experiences to those of the bereaved is an important characteristic for peer supporters. Table 4 provides a checklist summary of evidence for the key benefits of peer support to recipients, as well as benefits to the providers of peer support.

Table 4. Positive effects of peer support identified in systematic review
Note: ✓ **= positive finding; 0** = negative finding; blank = question not addressed, or no relation found.

	Benefits to recipients - bereaved				Benefits to peer supporters		
STUDY	Reduced grief symptoms, depression, isolation	Improved function-personal growth, well-being	Peer support perceived as helpful	Similar experience is seen as important	Satisfaction of helping others in similar conditions	Personal growth	Similar experience is seen as important
Aho, 2014					✓		✓
Aho, 2012			✓	✓	✓		✓
Aho, 2009			✓	✓			
Aho, 2011	✓	✓	✓				
Archibon, 2006			✓	✓			
Barlow, 2010	✓	✓				✓	
Baugher, 2012							✓
Baumgarten, 2000			✓	✓			
Boyle, 2015					✓		✓
Cohen, 2005	✓	✓	✓	✓			
Diamond, 2016			✓	✓	✓	✓	
Feigelman, 2008	✓	✓		✓			
Feigelman, 2009		✓					
Forster, 2015			✓	✓			
Gold, 2016				✓			
Harrington, 2011	0						
Kaunonen, 1999	✓		✓				
Kramer, 2015	✓	✓		✓			
Linke, 2002			✓	✓			
Oulanva, 2014					✓	✓	
Pector, 2004		✓		✓			
Rice, 2014		✓	✓	✓			
Richardson, 2015		✓	✓	✓			
Riley, 2007	✓	✓		✓			
Roose, 2014			✓	✓	✓		✓
Rudd, 2013			✓	✓			
Stewart, 2001	✓	✓	✓	✓			
Swartwood, 2011				✓			
White, 2001		✓	✓	✓			
Wittenberg, 2014	✓	✓	✓	✓			
Worden, 1993	✓						
Yopp, 2013	✓		✓	✓			

b. Benefits to the peer supporters

Seven of the reviewed studies address the issue of what benefits, if any, accrue to those who give peer support. In their study of support messages posted to an internet based peer support forum by bereaved mothers, Aho et al. (2012, 2), mothers expressed satisfaction in helping others, and also identified the importance of having similar experiences (in this case, having had a child die). In this case, those who had also lost a child were viewed as having a greater understanding of what the newly bereaved mother was experiencing. Three studies identified personal growth as a positive benefit to peer supporters (Barlow et al., 2010, 1; Diamond et al., 2016, 2; Oulanva et al, 2014, 2). In the Diamond et al. (2016, 2) study for example, peer supporters of bereaved mothers indicated that "giving back" and helping others was a way of honoring their own dead children, and bringing about some positive good from the experience. Peer supporters in this study also indicated that the timing of support is important; parents who experience the death of a child are not always receptive to peer support in the early aftermath of the loss. Studies by Boyle et al. (2015, 2), Feigelman et al. (2008, 1), Oulanva et al. (2014, 2) and Roose et al. (2014, 2) all found evidence that peer supporters derive personal satisfaction from helping others in similar circumstances. Overall then, these studies indicate that peer supporters derive considerable benefits from the experience of providing support. This is consonant with other studies of peer support showing multiple benefits to those who provide peer support (e.g., Gammonley & Luken, 2001).

c. Internet based peer support

The development of communications technologies and spread of the internet have led to an upsurge in online support and discussion forums for people experiencing various difficulties. Perhaps reflecting this trend, six of the studies reviewed here examined peer support services available to the bereaved over the internet. While the studies varied in methods and goals, all but one showed evidence of benefits to users. For example, Aho et al. (2012, 2) examined 631 messages posted by bereaved mothers to an internet forum. Their analysis showed that mothers both received and gave support in three main areas: emotional support, information, and communality, or the acceptance into a group of others with similar loss experiences. The peer support obtained on the forum was seen as helpful for both givers and receivers, who also saw their similar experiences as valuable for establishing trust and connection. Looking at N=410 suicide survivors, Feigelman et al. (2008, 1) compared a group receiving peer support over the internet only, versus a face-to-face support group. While both groups showed significant reductions in grief symptoms, the face-to-face participants were lower in depression and suicidal thinking. Respondents reported that the internet forum offered advantages of easy access and availability 24/7. They also indicated that responses from family and friends were often unhelpful, leading them to prefer the internet support forum.

In a similar study, Gold et al. (2016, 1) found no differences in depression levels for bereaved mothers who received peer support via the internet versus a face-to-face mode. A study on suicide survivors in the Netherlands reported decreases in depression and increased well-being over a 12-month period for participants in an internet only support group (Kramer et al., 2015, 1). Despite these clear benefits of peer support, it is noteworthy that these suicide survivors still showed clinically significant depression symptoms. Using a somewhat different approach, Rice et al. (2014, 2) applied an internet based virtual world peer support intervention to oncology nurses who were regularly exposed to dying patients on their jobs. Over a 10-week period, participants reported an increased sense of meaning and support, reduced feelings of isolation, and satisfaction in helping others in similar circumstances. Another internet study in our review examined 564 first responses to new postings made by recently bereaved individuals. These authors found that a majority of responses included self-disclosure of

[2] In this peer support group as in quite a few others, the boundary lines are blurred between who is giving and who is receiving peer support, since most participants do both at various times.

similar experiences, and focused on providing hope as well as useful information (Swartwood et al., 2011, 1). As also reported by others, respondents indicated that advantages of online grief support include easy accessibility and affordability.

In summary, the studies reviewed indicate that internet-based peer support modalities for the bereaved are quite promising, showing evidence of effectiveness as well as a number of practical advantages including 24/7 accessibility. Technical difficulties can sometimes interfere, as for example when connections are slow or unreliable. Anonymity can also be a drawback, and some internet support group participants express a desire for face-to-face contact with peers (Rice et al., 2014, 2). Additional research is needed in this area in order to understand what internet peer support approaches may be most beneficial for bereaved persons.

d. Peer support for suicide survivors

Survivors of death by suicide are believed to experience grief reactions that are in some ways different, and perhaps more difficult than those of non-suicide death survivors. For example, suicide survivors often feel a greater sense of shame and stigma surrounding the death, feelings of rejection and abandonment, feelings of guilt and self-blame, and self-destructive thoughts (Jordan & McIntosh, 2011). To the extent this is true, suicide survivors may benefit more from peer support that comes from other suicide survivors like themselves, rather than survivors of non-suicide deaths (Harrington-LaMorie & Ruocco, 2011). Of the studies included in our review, seven dealt with peer support specifically to survivors of suicide. For six of these, peer support was provided by others who were also bereaved by suicide (Barlow et al., 2010, 1; Feigelman et al., 2008, 1; Feigelman et al., 2009, 1; Kramer et al., 2015, 2; Linke et al., 2002, 2; & Oulanova et al., 2014, 2). Whether the support was provided via the internet (two studies, Feigelman et al., 2008, 1 and Kramer et al., 2015, 1) or face-to-face, clear benefits accrued to recipients in terms of decreased grief symptoms, depression, suicidal thinking, and increased personal growth and well-being. It was also shown that receiving support from others in similar situations – suicide survivors – was of primary importance to recipients (Kramer et al., 2015, 1). Recipients also reported that responses of family and friends were not helpful, making peer support from fellow suicide survivors even more important (Feigelman, 2008, 1). According to one study in this group, while peer support from suicide survivors was tied to personal growth, help from professionals was not (Feigelman, 2009, 1). In the same study, more religious participation also was linked to personal growth. Thus, though not addressing the question of whether grief is somehow different for survivors of suicide, the studies reviewed here do provide evidence that peer support from fellow suicide survivors is the most helpful kind.

V. Subject Matter Expert Interviews – Best Practices in Peer Support for Survivors

We conducted semi-structured interviews with 10 subject matter experts (SMEs) in peer support. The interviews aimed to get a deeper understanding of the peer support process and programs, and identify what are the best practices in peer-support approaches for those experiencing grief and bereavement.

1. Methods

Subject matter experts were identified by the researcher in consultation with the TAPS program leadership. Potential interviewees were sent an email describing the purpose of the study and inviting their participation. Of 11 experts invited, 10 agreed to be interviewed. There were six women and four men, with an age range of 45-72. All had extensive experience as peer supporters and managers of peer support programs for those affected by sudden unexpected death. Interviews were conducted in person or telephonically, and lasted from one to two hours in length. With the consent of the interviewees, all interviews were recorded and later transcribed verbatim. The following general questions or content areas were covered in the interview:

Figure 3. Key questions addressed with Subject Matter Experts

- **What is your experience with peer support, how did you first get involved with peer support activities?**
- **How do you know if peer support is effective… what's the evidence?**
- **What are the essential features or best practices for a successful peer support program?**
- **What qualities are important in peer supporters?**
- **What training is needed for peer supporters?**
- **How are peer supporters sustained – who supports the supporters?**

While these questions guided the interview, the format was semi-structured, allowing the interviewee to branch off into other areas as desired.

A thematic analysis of responses identified the common or recurrent themes in each of the content areas. The procedure was as follows. First, the transcribed interviews were read completely by two independent researchers, highlighting or marking off each unique response for questions 2-6 (question 1 contained personal information, and so was not analyzed in this way in order to protect the confidentiality of interviewees). The researchers then compared and discussed their observations. Next, the interview material was re-ordered such that all responses to each question were grouped together. The material was read through once again by each researcher, highlighting or marking off each unique issue. Where possible, each researcher also identified common superordinate categories within which to group specific responses. The researchers met to discuss and agree on categories for each question.

In the interviews, issues related to training and support for peer supporters emerged spontaneously when discussing the essential features or best practices of a good peer support program. For ease of presentation, we will thus discuss these results together under the essential features section.

2. Results

a. Background – experience with peer support

The first question inquired as to what background or experiences the respondent had with peer support programs. Professional experience of respondents included law enforcement, psychology, social work and business administration. Their answers revealed that many of our interviewees had had personal encounters with sudden and unexpected death, and had themselves benefitted from some kind of peer support. In several instances, the subject matter experts (SMEs) established peer support programs for groups and organizations where none had existed before. A common sentiment was the desire to "give back" by assisting others, as they had been helped in dealing with their own losses. Responses also provided insights into the special value of similar, shared experiences for quickly establishing a trust bond and easing communication. To illustrate, we provide exemplary paraphrased excerpts from the interviews. All interview excerpts are paraphrased and in some cases edited for clarity and in order to maintain confidentiality.

For me it was truly like, this person understands me! There are unspoken things that she understands about me so that I don't have to turn myself inside out with this person. There's already a level of understanding that brought me comfort, so that I didn't have to… I didn't have to dig deep and share details and things like that.

(After my husband died) one of the things that I craved the most was to talk to another spouse who lost her husband. Going to counseling, meetings, all those things were a little bit helpful. But what I really wanted the most was to talk to someone else who had walked this journey…. When I went to my first peer support group, it was the first time that I felt like I am not alone in this. Because even though I had a lot of friends, and a lot of family, and a lot of support systems and I had gone to counseling, it was the first time that someone else had talked out loud about some of the things I had been thinking and worrying about and struggling with.

b. Evidence for peer support

We asked the SMEs to report what they saw as the evidence for effectiveness of peer support approaches. Responses fell into six broad categories: (1) Personal observations; (2) Feedback from clients who received support; (3) Feedback from peer supporters; (4) Usage statistics (eg,, number of first contacts and repeat contacts); (5) Surveys; and (6) Published research studies on peer support.

In addressing this question, SMEs indicated there is a lack of good outcome research on peer support, a shortfall they ascribed to multiple difficulties that arise in trying to conduct such research. Primarily, for newly bereaved individuals seeking support, the initial goal is to establish a trusting and supportive relationship with a peer, and any request to collect research data is likely to impede that process. Related to this are concerns about confidentiality felt by persons seeking support. Another point mentioned relates to the ethics of assigning bereaved persons to a control group that would not receive needed assistance. Despite these obstacles, most SMEs expressed a desire to see more rigorous outcome research on the effectiveness of peer support for bereaved individuals.

1) Personal observations

SMEs referred to their own personal observations and experiences that supported peer support as a beneficial intervention for bereaved individuals. They reflected on their experiences as peer support program managers, and also as individuals who were helped by peer support in their own grief recovery process.

I know (peer support) works based on my own practical experience. I've had experience with it. I've liked it. And I've used it. I've been successful with it. If you want to take that as qualitative evidence, then that's fine.

So that was my first connection with peer support and how powerful it could be - there was actually another - a husband in there who had lost his wife to suicide. And he expressed some of the same feelings and emotions that I had. And so from there we kind of built a peer support relationship where, you know, when things and emotions would come up we would counsel one another. And it turned out to be the most helpful part …. more helpful than going to therapy.

It's automatic. If they meet someone who is another survivor, who's had that shared loss, they don't feel alone. They don't have the sense that 'I'm all alone in this' which is one of the more common statements we hear from survivors. So we know that peers helping peers creates an instillation of hope and an endorsement for getting help.

It's things like this, the fact that we are still in existence fifteen years later!

2) Feedback from clients-survivors

As another line of evidence that peer support works, SMEs referred to regular feedback they receive from clients who have benefited from peer support through their programs. Here, there were also some references to professional support services or other support sources that were not always helpful.

> *It's hard to quantify, obviously. Particularly because we are dealing with emotions. I know that it's been successful when I get positive feedback from the survivor that says, 'I don't know what I would have done without you. You called me at just the right time. I was feeling this way (like giving up), and now I feel like I can keep going for today.' So qualitatively or subjectively I know that I, and the whole rest of the team, we get calls, we get emails from people on a regular basis saying, 'I know you've been reaching out to me for a whole year and I've never responded to you. I never told you that I got all of your voice mails. I never told you I got all of your emails and texts. But now I'm finally ready to talk. You have no idea how meaningful it's been to me. When everybody else in my life dropped off the face of the earth three weeks after the funeral. But you were the constant. I always knew that I was going to hear your voice on my answering machine' That's what tells me that it's working.*

> *We had one situation where there was a park police officer that ran her car into a tree and was killed. And we went down to assist the park police and went to their roll call, and we were with them. And they were going to do debriefs, and their department head said, 'Well we have an EAP (Employee Assistance Program) so we'll send the people from our EAP to do the debrief.' The people that were involved - the park police officers that we had been talking to - kicked the EAP people out of the room because they didn't want to deal with them. They wanted to deal with us (peer supporters).*

> *The officers I work with tell us it (peer support) works. When we go out and we deal with a particular person, we'll do a follow up and we'll say, 'glad you are feeling better. It's been awhile but you got there. It was a tough thing to go through, but it's just an abnormal situation happening to a normal person, because cops aren't supermen.' We would ask them,'What worked for you? What did we do wrong? What did we do right?' And it's anecdotal evidence I guess you would call it. It's just the feedback we get from the people that we go out to assist, when they say 'This has meant a lot to me and my family.'*

3) Feedback from peer supporters

Feedback that comes from those who are providing peer support was also cited as evidence for program effectiveness. Benefits to the peer supporters were frequently related to finding greater purpose and meaning in their own loss, by helping others in similar circumstances.

> *From my standpoint, (evidence comes from) feedback that I get from peer mentors, and when I get mentees (recipients) that are interested in becoming peer mentors because they had such a good peer mentor themselves, that they want to give back. That's always a good sign too. And we seem to be getting a lot more of them lately.*

> *What I see within my population is that not only are the peers within the program surviving, but eventually they are thriving. And they are showing us what we would call post traumatic growth. After years working with peer support, that they're at some point able to use their own loss and get some meaning out of it, and some new purpose in their lives by becoming peer mentors. And when they come back to us they stay within the program and start mentoring others, you can just see in that person, that they are forever changed, but in a positive way. And that there are gifts of that grief that they see, gifts of that journey and they see some growth in themselves that they attribute to walking a journey and then being able to give back and offer peer support to newer survivors.*

4) Usage statistics

Several of the SMEs pointed to statistics and metrics that are routinely collected within their programs in order to document peer support contacts and activities. They also expressed a desire to see more definitive data related to program effectiveness, while admitting there are many inherent difficulties in doing so.

> *We have a very detailed (anonymized) data base where we can track our contacts. We have very detailed documentation.*

> *We actually - our (peer supporters) check boxes when they do these tasks, and so we can look, during episodes of care, at what tasks they're doing and not doing by peer, by branch of service, by program, by year. We have the capacity to look at that.*

> *We do a lot of use statistics. We have an enormous data base that's got, I would say, probably close to 70,000 (client – peer) contacts in it. So weekly, I would say we have a -not just weekly, but we put out monthly statistics where we know exactly how many outreaches we've done collectively, to the survivor community over the course of a month.*

5) Surveys

SMEs described surveys that are done periodically to gather feedback from peer supporters as well as clients-recipients. One interviewee described ongoing assessments that are being done in the organization to measure specific desired outcomes, such as increased hopefulness and engagement. Others discussed the difficulties for a service organization to conduct outcome research of this sort.

> *We do surveys at the end of the year. We survey our mentors and we survey our mentees. So they can - they have a way of letting us know if it's working or not. They're all anonymous so we don't know who is returning them, so we're asking them to give us their honest feedback.*

> *We have done focus groups with depression scales, and family assistance scales and quality of life stuff from SAMHS. (Results) really show that we're on to something.*

> *We're a big service delivery system… research is not embedded in anything we do here. And so we're always trying to turn a data set that we didn't design to be evidence-based into something that means something for outcome research, and it hasn't worked well.*

> *We did extensive research, that's where we came up with our metrics for the outcomes we want to see. So it is connectedness, engagement, it's increased knowledge and skills, and hopefulness. Now you can or cannot add a feature of wellness which may or may not be defined as depression which is very hard to measure, because it's a self report measure. You are usually not giving a standardized test. But, we already have metrics: Connectedness, engagement, knowledge, skills, hopefulness, those are the things we evaluate our programs on in terms of effect.*

6) Published studies

As general evidence for the effectiveness of peer support, SMEs also pointed to some published studies. The bulk of work in this area has focused on peer support for those recovering from some form of mental or physical illness. The relative lack of outcome studies on peer support for the bereaved is attributed in part to difficulties in applying standards developed for the medical profession to programs focused on providing timely support services to a non-clinical population of people in immediate need.

> *Well, there's not a lot of evidence; and here's why. Professionals write the evidence based criteria. You can go to the NREPP (National Registry of Evidence-Based Practices). You can go to the SPRC (Suicide Prevention Research Center) or whatever bunch of initials people like to quote. But if you go to the National Registry, you've got a 12 -18 month application period with all kinds of professional reviews, etc. It is not in any way peer-friendly in my opinion.*

> *There is some research that has been done. Some of it by the VA (Veterans Administration). For instance, it showed that peer support increases compliance among patients who are diabetic. It also increases compliance and healing amongst those who have recently had heart attacks. So there is evidence on both the medical and non-medical or behavioral health side that as a component of a health or recovery program, that it (peer support) is beneficial.*

c. Essential elements of successful peer support programs

This section of the interview elicited extensive comments from our SMEs as to what are the important elements of a successful peer support program. Responses to this question overlapped to some degree with the question of what qualities are needed in a good peer supporter. However, we asked the SEMs to tell us what features they considered to be essential for a successful peer support program. These can also be understood as "best practices" according to the expert judgment of the subject matter experts. Responses fell into eight categories, as displayed in Figure 4 and discussed below along with paraphrased quotes from the interviews.

Figure 4. Essential elements of successful peer support programs

1. **Easily accessible and responsive**
2. **Confidential**
3. **Provides a safe environment**
4. **Close match of peer supporter to client**
5. **Careful selection of peer supporters**
6. **Partnered with mental health professionals**
7. **Thorough training of peer supporters**
8. **Peer supporters are monitored and cared for**

1) Easily accessible and responsive

Regardless of the mechanism for providing support (whether on site crisis response teams, telephone hot lines, face-to-face, or some other modality) the experts agreed that the services must be easily accessible 24-hours a day, and provide rapid response. Just as death can happen at any time, a survivor may reach out for help at any hour of the day or night. When the call comes, it's important that peer support be available and that response is prompt.

> *Anonymity, and availability 24 hours a day are both essential.*
>
> *Just the fact that we are out there within an hour makes a big difference, tells that person that the department cared enough to put together this (peer support) team that is now out there to help them. Because a lot of times you kind of feel abandoned by the higher-ups.*
>
> *So getting to those (suicide) survivors very early in the process - preferably right at the scene, can really help shift that family into a healthier grief process.*
>
> *The sooner we can get there, the better. It can decrease a lot of suffering. It can decrease all those feelings of isolation, disconnection people often go through for a very long time. Sometimes that can lead to some self-destructive behavior, and other type of problems. (These are) people who feel very isolated and misunderstood. So the sooner we get to them and make that connection, it's always - it can only help.*

2) Confidential

Clients seeking peer support program place a high value on confidentiality. Most do not want their personal circumstances, feelings, and reactions to become public information. Thus it is essential that the program have procedures in place to assure privacy is maintained, and communicate this to clients and potential clients.

> *Well, confidentiality is very, very important. One of the reasons there is a mistrust of mental health professionals among officers in that they are going to go back to the organization and tell the story to them about you. That is something that turned off a lot of officers toward external programs such as EAPs (Employee Assistance Programs).*
>
> *Keep your mouth shut. That's the biggest thing. Do not discuss cases outside of your element, outside of your peer support people.*
>
> *Once you lose trust, your program is going to go down the toilet. And I've seen it happen in other departments, you know. You get a peer supporter who starts talking in small talk with some other officer, and, 'Hey, you know John Jones down there, we just had him in here. He's a drunk. You know he's got depression' or something like that. The next thing you know, nobody comes in any more. So keep quiet. It's a private - it should be a private conversation. It should stay that way.*

3) Provide a safe environment

Our SMEs described the importance in a peer support program of providing a "safe environment," a place where the survivor feels welcome and respected, and is not being judged. This includes the physical environment in face-to-face support scenarios, as well as the socio-emotional environment which is set primarily by the peer supporter. The ability of the peer supporter to "just listen" contributes to an atmosphere of safety and respect.

lf people are coming for emotional support, they need to know they are coming to a safe place. They want to at least feel safe. Confidentiality is a part of that. And part of that is the organization making sure that whoever their peer facilitators are, they follow the standards.

We're just there to provide support to the bereaved, and point them towards help when they are ready. So one metaphor is we are like a lighthouse. We sit on a rocky shore and point towards safe harbor.

Usually there are is a sense of some kind of an informal structure that provides - whether it's just time or the regularity of meetings, or what occurs in a meeting, or how people are allowed to share, or the responses that people were allowed to give and when they can respond. There's some kind of structure that helps control chaos.

Convey a sense that the connection will be ongoing – not a one shot deal.

Role model healthy coping skills to empower the mentee to learn to deal with their grief and serve as a beacon of hope for their recovery and post-traumatic growth.

4) Close match of peer supporter to the client

SMEs all emphasized the importance of finding the closest possible match between the peer supporter and the person seeking support. The more similar the peer supporter is to the client, the more readily the client will form a connection of trust and openness with the peer supporter. The most important aspect of this match is that the experience of loss is similar. For example, if the client experienced a death by suicide, it is best if the peer supporter has also dealt with a suicide death. Fathers who have lost a child have more common experience with other bereaved fathers, than they do with bereaved mothers. In the same fashion, clients will more readily connect with and trust a peer supporter who has lived and worked in the same occupational environment as them, as for example police, firefighters, or military personnel. Cops make better peer supporters for other cops, and soldiers for other soldiers. There are many aspects of the job and culture which are implicit, and can be taken for granted when the peer supporter belongs to the same culture. This extends also to family members, whether spouses, parents or children. Military wives have in common a broad experience of the military lifestyle and culture, which helps in forming a social bond with a newly bereaved military widow.

Well I think the similarity and type is very important. When you have people that match your population - that's essential. We broke it up sometimes, if you were a patrol officer, we had a patrol officer peer support person talk to you. If you were a Sergeant or a Lieutenant we had a Sergeant or Lieutenant talk to you. That helps in getting a counselor or patient relationship going.

So to me the peer support, I realized, had to be kind of specific to my loss. And the more specific it was, the more powerful it was. The more specifics I could connect with, the more it helped me.

They all (peer supporters) have their own experiences, so they know how to relate and that's what you've got to have. Because a (survivor), whether it's a soldier a marine, a cop, a fireman, is not going to talk to a stranger. Period. Because they haven't been there. They haven't walked the walk.

All they (the person needing support) want to know is, 'how do you know how I feel?' And when you can say, 'Well, I've been through something similar. I didn't see this guy get shot in the head, but I did see my buddy's legs get blown off, and this is what I experienced.' Then you've got the guy you are talking to going, 'yeah, yeah I understand that, I'm going through something similar.' And they're beginning a dialogue. And once they begin a dialogue, once they start talking, it's unbelievable how therapeutic just the conversation is. So, we're there, we're present, and we get them to open up, and they start talking, and we build the trust.

The way we do it here, we match according to the cause of death, and the relationship to the deceased. Those two things are primary. And then we will go to geographical location, what branch of (military) service, and any type of connection. The more connections we can find between the two people, we believe the better the connection between them will be.

Our team spends a lot of time matching those peers together. Matching them based on some of the things we talked about… Relationship, cause of death, location of death, branch of service, area in the United States. The closest we can match, we do.

5) Careful selection of peer supporters

Interviewees discussed the importance of choosing peer supporters who have coped successfully with their own loss, and who are not presently dealing with unresolved issues or other life problems. Also, prospective peer supporters should be self-aware, and understand their own motivations for volunteering. The general view was that if the volunteer is motivated to help others in similar circumstances, he/she could be trained to be an effective peer supporter. More detailed comments on what qualities are desirable in a peer supporter are covered in section 4 to follow.

You have to be very careful when you choose a peer supporter, you have to know why they want to do this, because some people they don't know why they want to do this. I think you need to get someone who understands the reason why they are doing this. You don't want someone who wants to do this who is going for control.

You don't want someone in there who is going through a problem right now. Maybe they had a problem and got through it, that's OK. But if they are presently involved in one, you don't want them in there. So you need to find that out somehow. We didn't have a way to find that out. But in our background interviews, we tried our best to determine if anything was going on with them psychologically. We certainly don't want them (as peer supporters) if they have their own problems. They are not going to be able to handle the absorption of someone else's problems if they've got their own going on at the same time.

Definitely look at the records of the people you select if you can. See what they've been through. See if they are going through anything right now themselves. You don't want them bringing their own problems into the middle of someone else's. I think those things are important.

Now you know, it's not for everyone. And that's okay. Everyone has their own thing that they do well. It is pretty amazing because what we have found is that the peer mentors, they have gotten to a place in their grief process that is a safe place. They have to be 18 months out (beyond their own loss) before we would even consider them, and be in a safe place. What we have found is that by then, offering their support to others, they are growing too, like it is helping them. It's a pretty cool win-win situation.

Yes, and with what I observe in their interactions with other people. That's probably the best more so than my interaction with them because I'm in a safe place. But how do they do with people that might be crying, or are sitting there obviously upset? When I see somebody go and run toward somebody who is upset and trying to comfort them, that's a good sign that they are ready. You see it quite often.

6) Close partnership with professional mental health care providers

Another essential element of the good peer support program identified by our interviewees concerns the need for partnering with professional clinical staff who can step in and assist a survivor when the situation calls for it. Clinical staff also provide training for peer supporters, which includes knowing where to set boundaries in terms of what kind of assistance to give to survivors.

> *A successful program is based on trust, confidentiality, and good training, good connections with the mental health field, professionals taking care, giving your people a chance to vent on their own about their own feelings. Put those things together and you have a successful program.*

> *We have a protocol in place, and (our peer supporters) let us know if the person is giving signs of risk…. We have people on staff that are clinicians that are able to take over and support people. … All staff have been trained in ASIST – Applied Suicide Intervention Skills Techniques. My hope would be to offer it to (peer supporters) as well.*

> *Often times we teach our survivors who are doing outreach that if you are feeling overwhelmed, with these conversations and you are feeling like, "Wow, I can't help her," and you're talking about things that are not related. It's above and beyond peer based grief support, then it's time for them to say, 'Whoa.. I am getting into an area that is above and beyond what I should be offering.' So when that happens we have clinical support. Myself and others who are clinicians who can talk to them about how to set a boundary and also find the professional care that that person will need (in addition to) peer support.*

> *When we are taking about peer support, we are talking about mainly one-to-one communication. Like barstool therapy. Because you are just sitting next to somebody and you are talking to them, and you are saying all the right things, and you are doing the right things to help him feel better about the situation. At the same time you are giving him information, you are looking to make a referral if that's needed. You are achieving a lot of different things.*

7) Thorough training of peer supporters

In the views of our SMEs, good peer support programs take the time to train their peer supporters. The type of training and content will vary to some degree across programs, but some training is seen as essential. It should always include listening skills, guidance on how to assess risk levels in clients, and knowing when to seek professional clinical support. Some SMEs pointed out that peer supporters are not always adequately trained, which can lead to a range of problems.

> *You want someone who really wants to do this I guess is how I want to put it. You train those people and get people who are fairly intelligent I guess to understand the basics of counseling.-basic counseling - how to listen…. Something simple like how to listen to someone.*

> *One of the challenges of peer support is that they can traumatize survivors, they can re-traumatize survivors, it just depends. They are often overwhelmed by the grief of others. One of the things we saw the most is inadequately supervised and trained peer supporters.*

> *So really good training on what are appropriate boundaries and basic skills is incredibly important. And then monitoring and support and education along the way, because peer support especially with a population like suicide loss where they often have trauma and mental health issues and others, regular check-ins, monitoring, education are really important so they don't burn out or become overwhelmed.*

That is something we actually address during their training: when they undergo the peer mentor training, so that they understand roles. Understanding their roles, their roles with other people, understanding boundaries, when does it cross the line from what would be peer support, to when your peer (client) is struggling and needs professional care.

Survivors just need to have somebody there to lean on while they go through their grief. It's not about trying to fix someone or trying to take their pain away or anything like that. We just want to be there for them. So they go through that. There is role playing that is involved where they practice their first call. And they're critiqued by the class and by themselves. And it can be - that's probably the most challenging piece of the training. But at the same time it's also the most beneficial to them.

An important ability in establishing that first connection is understanding the (culture of the client). We train about the culture. We start off with cultural competency, leading with strength, that we're combating stigma and isolation. We encourage [peer supporters] to focus on 'do no harm.' Nobody is getting social security numbers. Nobody is trying to look up IDs. We're just about making that connection, and working with the clinician. [We want] the best peer match; we encourage peers - if you don't like somebody, if they trigger you in terms of your own trauma and experience, we are going to assign them to somebody else.

And self-care, they learn about self-care. They learn about what to do if a survivor that they are matched with is at risk of maybe harming themselves. So we teach them what the protocols are for that, communication skills, listening skills. And then the basics of how we match, and what is expected of them as peer mentors.

8) Monitoring and care of peer supporters

Being a peer supporter to those who have experienced a sudden death is a difficult job, and can be emotionally trying. Our SMEs described a number of ways that peer supporters receive support in their work, including from staff and other peer supporters. It is important that peer supporters be able to monitor themselves, and realize when they should ask for help. It was also seen as necessary that there be some system in place for monitoring the peer supporters and providing assistance and guidance when needed.

So it's the same thing with peer support. When you're dealing with people's problems, you're kind of in a similar situation to the "sin eater," in that all that anguish and pain and suffering that they are going through, you take it on yourself. So there's got to be a way for you to dump that. So that's where we use each other. And that's where we use our monthly meetings and if we knew a particular call was bad, somebody else on the peer support team would call the people that were involved on the peer support team and say, I understand you had a rough one last night." And then it would go from there. And so we took care of each other.

We do follow-up with them through our peer mentor staff. They'll check back in and say, 'How is the match going between the two of you? Do you feel like it's a good match? Are you able to connect? Are you needing any guidance with anything?' So throughout our program we really try to offer that ongoing support.

We have a quarterly newsletter (for peer supporters). We have a monthly chat, and it's just for them, and we talk about what's going right, and what needs fixing, what's broken, and what can we do better.

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[3] "Sin eater" refers to an ancient ritual of unknown origin in which a hired person takes on the sins of the deceased by eating bread over the body. See https://en.wikipedia.org/wiki/Sin-eater

In most cases the (peer supporters) will tell us when things are bad. Like we may know it, but I like to have them make that decision and then I point it out to them: 'It sounds like you've got a lot going on. Maybe it's time for you to step back and focus on what's going on as opposed to trying to support other people at this point in time. When things settle down for you come talk to us and we'll put you back on the roster.' So that definitely happens.

We are constantly talking about it and supporting each other. We know that we can say to our teammates, 'you know what, I need a break. I need to go take a nap, I need to go for a walk. I can't talk to this person right now. I'm filled up.' So we become each other's real strong support system. And that's really how we built the team builder job. It's an understanding that this is difficult work, it's complex, and it can be exhausting and there might be times when you need to take a break.

Well, care for the caregivers, self-care, that's very important. Part of it is we practice what we preach, or try to. There's a real high potential for burnout. One of the benefits of affiliating with a group like […] is to have other staff who can be listeners, who can be mentors, who can help come along side when the situation is challenging.

We had regular meetings where people would come and we would talk about issues that had come up. Various calls that we had run, and then it would serve as sharing information; but also it was a way for us to kind of debrief each other as to what we had gone through and what was tough for us.

The monitoring piece tends really to, from my research in peer support and my experience, the monitoring piece really gets dropped. And that's why there's kind of a high rate of burnout and dropout. Sometimes it has a negative effect on peer support.

We use tech, online supports a lot. So, we do Google hang-outs and we drop an email to somebody. I've sent flowers to a staff member before on an anniversary when they were having a hard time. So, we do a lot of little things in addition to the, 'okay we're all here for team building,' this formalized training, and things like that. So we are trying to diversify.

Another important element of support to the peer supporters is described by Castellano (2012) as "resilience, affirmation and praise." By this she means primarily that peer supporters provide praise and reinforcement to clients for their progress and positive steps. But it also applies to the peer supporters, who themselves benefit by receiving recognition and positive feedback from their superiors for their accomplishments. This feedback reinforces the sense of meaning and importance for peer supporters, and serves to build their resilience.

d. Qualities that make a good peer supporter

Our interviewees had clear ideas regarding what qualities are desirable in a good peer supporter. These qualities are summarized in five key themes, which were repeated in various forms by all of the SMEs. There was strong consensus that a peer supporter should: (a) be a strong role model; (b) be a good communicator; (c) be authentic and trustworthy; (d) have good judgment - aware of boundaries; and (e) have a calm, agreeable disposition. These categories also overlap, and some of the same points were made earlier by the SMEs when discussing what are the essential elements of a good peer support program.

Figure 5. Qualities of a good peer supporter

1. Strong role model
2. Good communicator
3. Authentic – trustworthy
4. Good judgment – aware of boundaries
5. Calm, agreeable disposition

1) Strong role model

This was the most frequently mentioned set of qualities. It includes first of all having similar background or experience to the person being assisted. The peer supporter is also able to draw on this shared life experience in order to form a rapid connection to the client. The peer supporter should have successfully coped or recovered from whatever the difficult experience was, and so is able to provide an inspirational role model who demonstrates that adversity can be overcome.

> *It really is I think through the role modeling too. Being able to say, 'I am not just telling you to do this. I have been through it myself.' You can really - You've been there. So through modeling the behavior it can be really powerful. In a way that sends a message to them. You can even say, 'In the beginning I didn't think I could make it. But I made it. I have survived. And you will too.' It's giving them the hope.*

> *…someone who has a set of relational skills and experience that they can tap into so that the person they are talking with gets the feeling that they really are connected to that person. Like I was saying with […], there was just something when we were in the room together that I knew that I didn't have to tell every final detail. That she just kind of got it.*

> *We do our best when we are connecting people to try to connect them on as many criteria as we can that are relevant for them. So that they can - we can kind of skip past that initial them getting to know each other so much and we can make sure that they are connected to people that it's going to be relevant for them. Their experiences are going to be relevant.*

2) Good communicator

Good communications skills were seen as essential. This means in large part the ability to listen, focusing completely on the person being supported. SMEs spoke about empathy, being non-judgmental, and being aware of body language. These abilities allow the peer supporter to establish a connection with the client, and help to create an environment in which the survivor can feel safe in revealing highly sensitive thoughts and feelings.

> *(You want) someone who has good empathy and is compassionate, and a good listener. Somebody who can be present. You see some people have a lot of skills, but if they can't be present when they are with the person. By "present" I mean they are listening. They are engaged. They are hearing what*

[4] According to Castellano (2012), the four essential tasks of peer support are (1) establish connection; (2) gather information and assess risk; (3) case management and goal setting; and (4) resilience, affirmation and praise.

the person is saying and reflecting it back. And really using those skills to connect with that person. So being present is really important, and sometimes it's a hard one to teach. Some of our best outreach workers have very little training in clinical skills, counseling skills, but they are very empathetic. They are very compassionate. They have good listening skills. They are able to be present among very difficult emotions, very difficult topics, and they are able to stay present with a survivor who maybe is having the worst pain and grief that anyone can have.

Empathy, sense of humor, the communication skills absolutely, knowledge of the importance of body language, be able to be a good listener, and someone that has a good reputation within the department.

The ideal person would be someone who is a good listener - first and foremost a good listener; someone who has a comfort level with the subject matter, who can be in that space even when it's an uncomfortable topic, and be low stress; who has a set of relational skills and experience that they can tap into so that the person they are talking with gets the feeling that they really are connected to that person.

Non-judgmental. They need to be able to allow people that they are mentoring to sort of go where they need to go without feeling that it's necessary to direct that process.

[You don't want] someone who talks too much (that's a biggie). Just as much as listening was at the top of my list for someone who would be ideal, the opposite of that would be someone who talks too much. For lack of a better way to put it - a know-it-all, someone who sizes up too quickly and again, judges.

3) *Authentic – trustworthy*

Here the SMEs talked about the importance of peer supporters being sincerely motivated out of a desire to help others who have experienced loss, as opposed to some personal gain. The peer supporter must have successfully coped with and moved beyond her/his own loss, and have the maturity and wisdom to put the needs of the survivor to the fore. The peer supporter is authentically motivated to assist the survivor, and is seen as someone who can be trusted.

I think being authentic, coming from the right place, being able to empathize and share the similar experiences. There does have to be a level of - I am not sure of the exact words - they do have to be at a level of their own healing that they can put their pain aside just enough to companion that second person…. So I think self-awareness is probably a key component

So if they are not open, trained and accepting of the role of being a resource to the survivor, to the survivor's needs and being flexible in their training and be able to meet those needs, then to me they are no good. If their ego is in the way, I don't want them. And I had staff that I had to say to them, 'you seem to be more invested in the survivor thanking you for what happened, than in then survivor getting what they need.' So, they didn't like that. But they have to be pretty ego neutral in my opinion if they are going to be professionals

…an ability to put the other person first, but be aware of their situation and circumstance and respond appropriately to their (usually) emotional needs at the time

Authenticity in this sense is likely a key contributor to building up the survivor's sense of trust in the peer supporter. This makes good theoretical sense. As described by Rotter (1971) trust is the generalized expectancy that the other person is (1) honest, (2) unselfish, not going to take advantage of me, and (3) reliable, or "knows his stuff." The authentic peer supporter is thus one who is honest, unselfish, and knowledgeable.

4) Good judgment – aware of boundaries

Good judgment involves the awareness of one's own limitations, strengths and weaknesses, and sound knowledge and judgment about boundaries for peer support. Our SMEs spoke about the importance of recognizing when to step back and seek help from a clinical professional, which likewise requires a modest and realistic understanding of one's own capabilities.

> *So in that regard it is really important that they understand the nature of what a peer relationship is. What would their role be as a peer as opposed to understanding this has gone over the boundary.*
>
> *Because there are just some people who for a variety of reasons are not appropriate to provide peer support. Either they are still working on their own trauma, or they're mentally ill themselves, or they may not have good boundaries, or learned how to use their skills yet.*
>
> *This is another very, very important one - I think it is crucial for any peer to peer relationship, for the person who is doing the mentoring to be able to exercise appropriate and timely self-disclosure. Had I not appropriately self-disclosed in that moment, she would not have crossed to that next level of comfort with me to continue sharing to the next level, to the next level and so on. So I think there is a very fine line between over-sharing and under-sharing. I think it's got to be to a degree an intuitive process that you go through with that person where it is a back and forth sharing of information.*
>
> *So in that regard it is really important that they understand the nature of what a peer relationship is. What would their role be as a peer as opposed to understanding this has gone over the boundary. 'They are calling me all of the time. And they really need to be calling a therapist about some of these issues.'*

5) Calm, agreeable

Here, the SMEs spoke about the importance of the peer supporter having a calm, pleasant manner, with a sense of humor and desire to help without being judgmental. It's also regarded as helpful that the peer supporter have a pleasant voice, and a sense of humor.

> *Do they have a nice calm voice, or are they - or is the voice irritating. Unfortunately that can be problematic. And do they connect well with other people. I am always watching how they connect with others. Some people are loners and they want to be left alone. And obviously those people aren't probably going to be the best mentors.*
>
> *They can't be a high stress. If they have a hectic, high paced, fast paced speaking voice, it doesn't tend to help….we're dealing with a peer to peer scenario where there's a lot of grief involved. So there needs to be a calm, and an underlying peace about the person.*
>
> *There needs to be a calm and an underlying peace about the person. Non-judgmental. They need to be able to allow people that they are mentoring to sort of go where they need to go without feeling that it's necessary to direct that process. And I think that judgment is one of the ways people do that.*
>
> *Likeability, the desire to help people, the desire to a make difference, tenacity. 'Don't give up' type people.*

These then are the key qualities that are desirable in a peer supporter, according to our SMEs. As discussed earlier, the careful selection of peer supporters is recognized as a key element for a successful peer support program. Processes for selecting peer supporters vary across programs, but all seek in some way to identify candidates who possess these characteristics.

VI. Best Practices in Peer Support for the Bereaved

While a number of organizations have developed level of care guidelines for peer support programs, unfortunately none of these specifically address peer support for bereaved persons or survivors of sudden loss. Most of these best practice guidelines are focused on peer support programs for patients recovering from mental illness (Daniels et al., 2011; Daniels et al., 2013). Recommendations have also been presented for applying peer support more broadly in "whole health" services, which includes services for people dealing with mental illness, substance abuse and chronic illness, and more recently to wellness promotion and life skills coaching (Daniels et al., 2012) Another set of best practices was offered by the Defense Center of Excellence for Psychological Health and Traumatic Brain Injury (DCoE), based on a selective literature review and interviews with eight subject matter experts engaged in peer support programs (DCoE 2010; DCoE 2011). However, the DCoE review was limited in scope, and restricted to programs aimed at military personnel or those working in similar environments such as police and first responders.

The best practices for peer support identified in the present report derive primarily from our in-depth interviews with 10 subject matter experts working in peer support programs for those experiencing sudden loss or death, and are further supported by the systematic literature review. Best practices correspond with the eight essential elements of successful peer support programs discussed earlier.

1. Easily accessible and responsive

> ***The sooner we can get there, the better. It can decrease a lot of suffering. It can decrease all those feelings of isolation, disconnection people often go through for a very long time.***

Ease of access, both in terms of location as well as hours of operation, is a critical ingredient for the success of peer support programs. Considering the fears and stigma that often attach to seeking mental health support, access needs to be as easy and convenient as possible for survivors of loss. Programs that operate only Monday through Friday and during normal business hours are less effective. Death can strike at any time, including nights and weekends, and survivors may seek assistance at odd hours. Ideally, peer support services should be available 24 hours a day, 7 days a week. Timing of response is also important. Support services should be offered to survivors as soon as possible after the loss, while at the same time recognizing that survivors will vary in their need for and readiness to accept support (Diamond et al., 2016). Our SMEs emphasized that making contact with the survivors quickly and offering support from peers is extremely helpful in reducing the sense of isolation that usually follows sudden loss. The value of rapid contact with survivors is also supported in the studies we reviewed (Diamond et al., 206; Rudd & D'Andrea, 2013). It is noteworthy too that one of the most frequently mentioned advantages of internet-based peer support services for survivors is the easy and around-the-clock accessibility provided by this modality (Feigelman et al., 2008; Feigelman, Jordan, McIntosh & Feigelman, 2011).

[5] Many of these peer support resources and training materials may be found at the SAMHSA-HRSA Center for Integrated Health Solutions web site: http://www.integration.samhsa.gov/workforce/team-members/peer-providers

2. Confidential

> *You could never say, 'your call might be monitored for quality assurance' because the confidentiality is such a primary issue in all peer support.*

All of the experts we interviewed noted the importance of confidentiality for effective peer support. For the survivor, the assurance that her/his personal information will remain private is essential to the formation of a trust bond with the peer supporter. Those seeking support often are fearful that engaging professional mental health services will result in disclosure of sensitive information they would prefer to keep private. Even the act of seeking support can be difficult for many, especially within organizations such as the police or military where the culture emphasizes strength and toughness, and asking for help may be seen as a sign of weakness (Roland, 2011). Our SMEs indicated it is critical to the success of peer support programs that confidentiality be maintained, and that cases not be discussed outside of the limited group of individuals involved in providing support. At the same time, it is recognized that there may be situations where actions are required that involve disclosure of personal information, as for example when a client may be at high risk of self-harm, and a professional referral is appropriate. In this regard, peer support programs should have clear policies guiding when and how to handle such disclosures (Roland, 2011; DCoE, 2011). As discussed by our SMEs, this is also a reason why it is important that peer supporters have ready access to trusted mental health professionals who can provide guidance in difficult or ambiguous situations.

3. Provide a safe environment

> *We're there to provide support to the bereaved, and point them towards help when they are ready. We are like a lighthouse. We sit on a rocky shore and point towards a safe harbor.*

Confidentiality contributes to another key element of good peer support programs, which is the creation of a safe environment, one in which the survivor feels welcome and respected, and is not being judged or evaluated. According to our SMEs, peer supporters establish such an environment most notably by their willingness to listen closely to the survivor, and not impose any judgment or viewpoints of their own. The ability to listen without judging was also frequently mentioned by our SMEs as an essential quality for good peer supporters, and has been noted as a peer support best practice in other studies (Feigelman et al., 2011, p. 202). Providing a safe environment is thus largely about allowing the survivor to feel protected against any harsh judgments or criticisms. This also helps to establish and maintain trust, which our SMEs recognized as a major advantage and essential ingredient for peer support.

4. Close match of peer supporter to client

> *They all (peer supporters) have their own experiences, so they know how to relate and that's what you've got to have. Because a (survivor), whether it's a soldier a marine, a cop, a fireman, is not going to talk to a stranger. Period. Because they haven't been there. They haven't walked the walk.*

Another best practice or essential element of successful peer support programs identified by our experts involves making the closest possible match between the peer supporter and the survivor being supported. First and foremost, this means the peer supporter has experienced a similar loss to the client being supported. There should be similarity as well in terms of occupation, relationship to the deceased, age and gender. These factors generally reflect shared experiential knowledge, or knowledge that is based upon actual life experience. This is an essential aspect of what Castellano (2012) describes as the first task of effective peer support – establishing a connection with the client. Peer supporters who have similar experiences to those being supported, whether they be soldiers, cops, firemen, or surviving family members, have greater credibility as experts in dealing with the problems and challenges faced by the client (Salzer & Associates, 2002; Grauwiler, Barocas & Mills, 2008). Having similar experiences and backgrounds is known to influence social cohesion in groups, through a process of social identification (Hogg, 1992). The same social identification process occurs on a smaller scale when the peer supporter is closely similar to the survivor, enabling the survivor to more easily see the peer supporter as "like me" (Rutherford & MacCauley, 2013). A close similarity between peer supporters and clients also means that peers are more likely to win trust quickly due to their common experience base. While it is not always possible to provide a peer supporter who matches the survivor in every way, the consensus view of our SMEs was that the closer the match the better for the peer support relationship. This corresponds also with findings from our systematic literature review. Of the 32 studies reviewed, 23 indicated that shared experience is an important element in the beneficial peer supporter – survivor relationship.

5. Careful selection of peer supporters

> ***The ideal person would be someone who is a good listener - first and foremost a good listener; someone who has a comfort level with the subject matter, who can be in that space even when it's an uncomfortable topic, and be low stress.***

Different programs have different approaches for selecting peer supporters, but all of our SMEs agreed that careful selection of peer supporters is critical to the success of any program. A variety of qualities are desirable in peer supporters, as discussed in a previous section (V-2-d). Most important, the person serving as a peer supporter for survivors of unexpected death should have experienced some similar loss, and have coped successfully with their own bereavement. This is described earlier as providing a "strong role model." The peer supporter also must be able to listen empathically to the experiences and grief expressions of the survivor, without being overcome emotionally or losing focus on the needs of the survivor. Excellent communication skills (and listening ability), authenticity, good judgment and recognition of boundaries, and a pleasant demeanor are additional factors identified by our SMEs as desirable in peer supporters. As noted by Roland (2011), providing peer support to survivors of sudden loss can be especially demanding work, and requires people who can tolerate a high level of psychological and emotional discomfort. Recognizing it is not for everyone, selecting good peer supporters is seen as a critical step in establishing a successful peer support program. Again while procedures vary across programs, all of the approaches described by our SMEs include some trial or practice activities during which new peer supporters are closely monitored in order to verify that they are well-suited for this role.

6. Partnered with mental health professionals

> *We have a protocol in place, and (our peer supporters) let us know if the person is giving signs of risk. We have people on staff that are clinicians, able to take over if needed with professional support.*

There was a broad consensus among the experts we spoke with that peer supporters function best when they have trusted mental health professionals nearby and accessible for consultation, training and supervision. Mental health professionals provide an essential knowledge resource that peer supporters can consult when dealing with difficult or ambiguous situations. In the ideal case, mental health personnel are on-site and immediately accessible to peer supporters who may encounter a problem situation, and can provide quick advice. Often, these mental health professionals themselves have shared experience that may include their own loss experience, and deep familiarity with the population and culture they are serving. As discussed below, one of the critical roles they fill involves providing support for the peer supporters, as for example affording them opportunities to discuss especially difficult cases and vent their own feelings and reactions. Several studies covered in our literature review similarly point to the importance of peer supporters working together with professional mental health personnel to deliver highly effective peer support services (e.g., Aho et al., 2014; Barlow et al., 2010).

7. Thorough training of peer supporters

> *Really good training on what are appropriate boundaries and basic skills is incredibly important. And then monitoring and support and education along the way, because peer support especially with a population like suicide loss where they often have trauma and mental health issues….regular check-ins, monitoring, education are really important so they (peer supporters) don't burn out or become overwhelmed.*

While selection of peer supporters is important, our experts also agreed that training is an essential aspect of any successful peer support program. The specific training will vary with the program, but common focus areas that were mentioned include communication skills, in particular knowing how to listen attentively; understanding boundaries, or what is the appropriate role of the peer supporter, and knowing when to seek professional assistance or make a referral; cultural competency, having a deep understanding of the culture and context of those being supported; knowledge of the grief process, and recognizing that there is no fixed timetable for how this proceeds in individuals; and self-care, which includes recognizing and admitting when one may need to step back and take a break from the hard work of peer support. Here also multiple studies in our literature review identified the need for thorough training of peer supporters (e.g., Baugher et al., 2012; Barlow et al., 2010). Other scholars have also commented on the importance of training for peer supporters (e.g., Chinman, Shoai & Cohen, 2010; Feigelman et al., 2012; Roland, 2011; Castellano, 2012). Our SMEs further indicated that training should be ongoing for peer supporters, with periodic refresher training in various skills. This is also a point that is echoed in the literature we reviewed (Aho et al., 2014, Roland, 2011).

8. Peer supporters are monitored and cared for

> *We are constantly talking and supporting each other. We know that we can say to our teammates, 'you know what, I need a break. I need to go take a nap, I need to go for a walk. I can't talk to this person right now. I'm filled up.' So we become each other's real strong support system.*

The final theme that emerged regarding best practices or essential features recognizes that providing peer support for the bereaved is an emotionally difficult job, and peer supporters themselves may need support and care as well as continuing training. SMEs described a number of mechanisms for doing this. Many programs sponsor weekly or monthly meetings at which peer supporters can discuss their experiences and share advice. Some of this is simply "blowing off steam." Peer supporters also meet informally and support each other in various ways. Supervisory staff keep in close touch with peer supporters, soliciting feedback on how their activities are going and offering assistance if needed. Electronic communications are also used for this purpose, including email and group chat programs. Despite its acknowledged importance, monitoring the well-being of peer supporters is one area that is sometimes neglected, according to some of our SMEs. The essential point made by our experts is that providing peer support to bereaved survivors is difficult work, and successful programs will include systems for monitoring and supporting the peer supporters who are doing this work. The importance of supporting the peer supporters is also recognized in the literature on peer support for survivors (Roland, 2011). In this regard, the report by Castellano (2012) emphasizes the value of providing positive recognition and praise to peer supporters as a powerful way to counter job stress and reinforce resilient responding.

> *A successful program is based on trust, confidentiality, and good training, good connections with the mental health field, professionals taking care, giving your people a chance to vent on their own about their own feelings. Put those things together and you have a successful program.*

VII. Summary and Conclusions

A growing body of research shows that peer support programs have positive effects on people recovering from some form of physical or mental illness (Chinman et al., 2014). However, few studies have examined peer support programs for survivors of sudden, unexpected death. The present study addresses this gap by taking a close look at peer support programs applied to bereaved survivors of sudden death or loss. The dual aim is to assess the evidence for effectiveness of peer support programs for survivors, and also identify current best practices in this area. A systematic review of the literature was performed, searching major medical and psychological databases for all studies reported from 1991 forward addressing peer support programs for bereaved survivors of sudden death or loss. Despite increased use of peer support programs for survivors, research in this area is limited. A total of 32 studies were identified that met all inclusion criteria, and these varied in focus and methods. A majority of studies did find benefits of peer support for the survivor-recipients, either in terms of reduced grief symptoms (eg, depression, isolation) or increased personal growth and well-being. Seven studies also documented benefits accruing to those providing peer support, in terms of personal growth and satisfaction in helping others in similar circumstances. Twenty-five studies observed that the value of peer support for bereaved survivors hinges on similarity of shared experience between the survivor and peer supporter. Thus, the weight of the evidence available to date indicates that peer support is beneficial to bereaved survivors of sudden loss or death.

In order to identify best practices in peer support programs for bereaved survivors, we conducted focused interviews with 10 subject matter experts who have worked extensively in the field. Based on these interviews as well as the literature reviewed, we identified eight essential elements or best practices for successful peer support programs. Peer support programs for survivors should (1) be easily accessible and responsive; (2) be confidential; (3) provide a safe environment; (4) make a close match between peer supporter and survivor; (5) carefully select peer supporters; (6) partner closely with mental health professionals; (7) provide thorough training of peer supporters; and (8) assure that peer supporters are monitored and cared for. Subject matter experts all viewed these practices as important for the success of a peer support program for survivors. Several of the reviewed studies also noted the importance of these factors, most notably shared life experience between peer supporters and survivors, and the maintenance of confidentiality.

Some limitations of this study should be noted. The studies identified in the systematic review employed a range of designs and methods, and many of these were qualitative in nature relying on fairly small samples. Thus, caution is required in generalizing these findings to other groups. In addition, there were few longitudinal designs that would allow more definitive conclusions regarding causative influence of peer support interventions, as well as long term effects. Future studies in this area should strive to provide more controls as well as consistent outcome measures in assessing the effects of peer support programs for survivors.

Another consideration concerns the bias against reporting negative results. Researchers as well as journal editors are more inclined to report positive findings, and studies that show negative findings are less likely to be submitted or accepted for publication. This tendency can influence the results of literature reviews, since studies showing negative results may be under-represented in the literature (Matosin, Frank, Engel, Lum & Newell, 2014). While it is impossible to know if this is a factor in the studies reviewed for this report, it seems that this potential problem is outweighed by the relative shortage of any kind of outcome studies in this area. Additional research is needed to more fully evaluate the effectiveness of peer support approaches for bereaved survivors, as well as to clarify what are the best practices and procedures to assure an effective program.

Although the importance of research on the effectiveness of peer support programs is widely acknowledged, there are a number of obstacles. One is a shortage of necessary resources. Conducting research usually requires additional staff time and money, which many peer support programs are not able to provide. When budgets are

limited, it is unlikely that resources will be taken away from providing services in order to fund research. It can be hoped that government agencies such as SAMHSA will provide additional funding opportunities specifically for research on peer support programs. It is also desirable that existing programs will find ways to build more outcome research efforts into their normal operations.

Another research obstacle is inherent in the nature of the services provided. When the clients and potential research subjects are bereaved survivors voluntarily seeking peer support assistance, controlled studies may simply be impossible. Considering the available evidence that peer support is beneficial, it could be unethical and even cruel to withhold treatment from some survivors by assigning them to a control group. If experimental studies are not possible, quasi-experiments may be that take advantage of naturally occurring group differences. Something like this was accomplished by Aho et al. (2011), who studied bereaved fathers of children who died in Finnish hospitals. At two hospital locations all bereaved fathers received the peer support intervention and formed an experimental group, while at three other hospitals bereaved fathers received only routine care, forming a control group.

A parallel may exist for organizations such as TAPS that seek to provide peer support services to bereaved survivors nationwide. If it is the case that services are more available and accessible in some states than others, survivors in these states could be compared against those living in states with more limited services as a way of determining effects of peer support services. Another approach that may be more feasible for many programs is simply to examine the correlation of some measure of amount of peer services received with measures of grief symptoms over time. A variety of standardized instruments are available for measuring relevant grief-related outcomes, and could include for example the CES-D (Center for Epidemiological Studies Depression) scale (Radloff, 1977), or the Impact of Events scale (Horowitz, Wilner & Alvarez, 1979) that measures PTSD symptoms. Measures more specifically focused on grief reactions that were used in several of the studies reviewed here include the Hogan Grief Reaction Checklist (Hogan et al., 2001) with scales for despair, anger and detachment as well as personal growth, and a shortened version of the Grief Experience Questionnaire (Bailey, Dunham & Kral, 2000; Feigelman et al., 2009).

Another potential barrier to research with bereaved individuals is the worry that answering research questions may be painful or reawaken disturbing memories. This is a reasonable concern. However, Feigelman and colleagues (2012) argue that the traumatically bereaved are usually quite willing to participate in research about their experiences, if handled properly. They suggest that research can be done with the bereaved as long as they are approached with respect, sensitivity and compassion. For example, participants should be fully informed they can skip any questions they find disturbing (Feigelman et al, 2012, p. 296). There remains the issue of timing, however. When bereaved survivors first appear seeking support services, this is not a good time to request they complete survey instruments or other forms. For one thing, this runs the risk of damaging the trust that is essential for success, and even possibly driving clients away by adding to their fears about evaluation and loss of confidentiality. According to Brandi (2010), part of the reason for the success of the Vietnam era peer support centers for veterans was their easy accessibility, and the fact that veterans were not asked to complete any paperwork for the first five or six visits. This was believed to be essential for establishing a relationship of trust and confidentiality with veterans. Only after some basic level of trust was established with the veteran was there any mention of paperwork or forms to fill out. With bereaved survivors, it should thus be possible to collect brief questionnaire or interview data later in time, after the peer support relationship is firmly established.

In sum, while there is a clear need for additional research, the present report finds compelling evidence that peer support brings multiple benefits for those dealing with sudden loss, as well as for the peer supporters themselves. In addition, by identifying current best practices in this area, we have hopefully provided some evidence-based guideposts for those engaged in the design and management of peer support programs for bereaved survivors.

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APPENDIX: Subject Matter Experts Interviewed

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14. ABSTRACT

The number and variety of peer support programs has grown dramatically in the last 15-20 years. These programs aim to help people cope with problems ranging from severe mental and physical illness and disabilities, to the more common challenges of everyday life such as maintaining a healthy diet and exercise. A particular area of growth has been in peer support programs which aim to assist those affected by sudden or traumatic loss, such as death of a loved one or coworker. As peer support programs and applications have advanced, there has also been an increase in research aimed at assessing the effectiveness of peer support, and identifying standards of care and best practices. Unfortunately, much of this work is scattered across different disciplines and is often unavailable to practitioners and policy makers who could use it. The present study helps to address this problem by providing an up-to-date review and assessment of the evidence for efficacy and best practices in peer support programs, with a special focus on programs to assist survivors of traumatic loss. Results should be of value to anyone interested in peer support programs, but especially those engaged in designing and implementing peer support programs for survivors.

15. SUBJECT TERMS

peer support, death, loss, suicide, military, grief, bereaved, recovery, best practices, evidence, systematic review

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