Suggestions for Providing Nonclinical Peer Support and Debriefing to Frontline Healthcare Providers and Other Personnel Working with COVID-19 Patients

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Introduction

This is a modified version of materials used by the University of Southern California Department of Psychiatry's *COVID-19 Peer Support Line*. It is made available as a service to the broader community of clinicians who provide emotional support for front-line workers and others affected by workplace exposure to the COVID-19 pandemic. It discusses possible parameters for brief, stand-alone phone sessions that, importantly, *are not intended to represent mental health services, per se, but rather to offer immediately accessible, peer-level, validation and support.* This document offers suggestions, not specific procedures, that can be freely adapted to different contexts and circumstances. This may include, in some instances, defined clinical contexts, in which case some suggestions presented here may no longer be relevant.

Front-line callers often have experienced major stress -- and sometimes trauma exposure -- in the course of their work with patients who are at risk of severe illness and sometimes death. Further, given the virulence of COVID-19 and the current absence of a vaccine, callers may be at significant risk of infection themselves, and may fear spreading the virus to family members, partners, and friends. Especially affected callers may require triage and referral for more intensive mental health services, although that eventuality is location-specific and not addressed by the current approach, which is limited to support and debriefing.

The parameters of the call should be introduced to the caller in some version of the following, paraphrased as needed:

Hello, this is [clinician name], and this is the ___ peer support line. What is your name, please?

[caller responds]

Hi ___. I'm glad you called. What can I do for you?

[caller answers, typically with a brief summary of the reasons for his or her call. Ideally this will be a brief synopsis. After the caller has answered, the clinician responds. If the answer is extended, the clinician waits until there is a point in time when he or she can interrupt gently. If such a point is not obvious, the clinician waits until the caller finishes his or her statement].

{That sounds very upsetting} {I'm sorry you had to go through that} {That's a bad situation} {some other acknowledgement of this caller's difficulties, stress, trauma, loss, etc.}. Would you like to spend a little time talking about that?

[Caller typically answers in the affirmative]

Before we start, I'd like to mention how this peer support call line works. Is that ok with you?

[Caller typically answers in the affirmative]

[Paraphrase the following]: Ok, good. So, first of all, this is a peer support conversation. It's important that I stress that this isn't therapy, or a clinical contact. This is just a chance for you to talk to someone who understands something about what you are going through, who is here to support you. No notes are taken, there's no clinical record. Also, because a lot of people are calling in, we have to keep the call relatively short, in any case no more than __ *[we suggest 30]* minutes. You can call more than once, but you'll probably get a different peer each time. OK?

[Caller agrees, or does not. If he or she does not, the clinician responds nonjudgmentally and in a caring way, and briefly discusses with the caller other options, such as a crisis line, 911, a support group, an outpatient clinic, the caller's current or previous psychotherapist, the caller's Employee Assistance Program, or other options, and the call is terminated as soon as is compassionately possible].

Assuming the caller agrees with the nonclinical frame, the clinician signals the beginning of the session. For example:

Great. OK, so, tell me what's going on. It sounds like things have been pretty rough.

In the course of the phone session, it is possible that certain issues will arise. Presented below are a number of these issues or problems, in each case followed by suggestions of ways to "work around," address, or lessen their impacts so that the call can be maximally helpful.

Issue: **The caller is especially emotionally distraught and overwhelmed, and this does not lessen over the course of the phone session.**

Suggested approach: This typically occurs when the caller has either experienced extreme adversity or, for whatever reason, has significant difficulty modulating his or her emotions. In addition to providing visible support, the clinician is advised to do one or more of three things: divert the caller to a less upsetting aspect of the topic (e.g., ask a concrete question), distract (e.g., carefully move on to another topic), or provide a brief grounding or breathing exercise.

Qualifying comment: Emotionality is normal for stressed or traumatized people, and the goal is not for the caller to suppress emotional expression, but rather to gain sufficient control that he or she can gain from the call.

Issue: **The caller is preoccupied with -- or reliving -- a specific traumatic event (e.g., a COVID-related death or a difficult clinical decision), and has difficulty interacting with the clinician in the here-and-now.**

Suggested approach: The goal is for the caller to briefly focus his or her attention away from intrusive internal experiences, such as flashbacks or upsetting memories, so that he or she can attend to, and gain from, the session. Typically, the clinician asks the caller if he or she would like to manage these intrusions and, if the caller agrees, briefly focuses on grounding (e.g., describing the room around him or her) or carefully redirecting attention (e.g., discussing his or her work environment or job description). In some cases, if the clinician can find an acceptable

way to transition, the caller can be asked to describe a safe, soothing, peaceful event that occurred in the past, as a way to remember that good things happen too and to "take the edge off" his or her current distress.

Qualifying comment: Intrusive reexperiencing is a hallmark of posttraumatic stress, and thus it is unlikely to remit just because the caller (or the clinician) wants it to. Rather, this approach accepts the reality of posttraumatic intrusion, but helps the caller focus, as much as possible, on the here-and-now, so that he or she can gain from the phone session.

Issue: **The caller seeks therapeutic interventions during the call, when the goal of the interaction is nonclinical support.**

Suggested approach: The clinician should remind the caller that the call is not a mental health service, but rather an opportunity to debrief and gain peer support around work-related COVID events. The clinician may note (if it is true) that the caller is experiencing an entirely normal psychological reaction to recent stressful experiences. If the caller's difficulties appear to be more severe than typical, the clinician can refer him or her to clinical services in the community.

Qualifying comment: A desire for extended, clinical interventions is entirely reasonable when someone is in great emotional pain, and should be responded to in a nonjudgmental way. If the caller points out that the clinician is, in fact, a mental health worker, the clinician can agree but note that this is why he or she is a peer (another helping professional) and can hopefully understand what the caller is up against.

Issue: **The caller perseverates on a single theme (e.g., helplessness, anger, or feelings of inadequacy) and is unable to see a "bigger picture" that is less catastrophic for him or her**

Suggested approach: The clinician acknowledges and validates the caller's concerns, but then attempts to redirect the caller to some level of problem solving (e.g., "What do you think you might be able to do about that?") or acceptance (e.g., "Of course you feel bad about that, anyone would"). Arguing with the caller's strongly held preoccupation or belief is rarely helpful. Instead, the goal is to note the caller's perception, and then discuss what he or she thinks would be most helpful, given his or her belief.

Qualifying comment: The caller's belief may be entirely accurate. COVID-19 *is* frightening, and our options are, in fact, limited.

Issue: **The caller seeks to extend the phone session beyond 30 minutes (or whatever time-limit has been established).**

Suggested approach: Gently and empathically remind the caller of the parameters of the call, noting that a longer conversation cannot happen given the constraints forced on the clinician by the demands of the COVID-19 pandemic. This should in no way be a guilt- or shame-inducing response, but merely a statement of our limited options. If the caller continues to request a longer session, extended advice, or detailed information, the clinician may refer him or her to relevant websites developed by organizations such as the CDC (*https://www.cdc.gov/coronavirus/2019-ncov/index.html*), the National Center for PTSD (*https://www.ptsd.va.gov/covid*), or the Substance Abuse and Mental Health Administration (*https://www.samhsa.gov/coronavirus*) for additional resources, and/or support groups, crisis services, and clinics in the community. If correct, the caller also can be reminded that he or she

can call the support line again, as needed, although the responding clinician may be a different person.

Qualifying comment: Why wouldn't someone who is distressed want to prolong a conversation that is helpful and/or validating? Thus, the clinician's response acknowledges and reflects agreement with the desire, but also the constraints of the system.

Issue: **The caller wants to have multiple phone sessions with the same clinician.**

Suggested approach: Note the parameters of the peer support approach, including that each call is self-contained, that records are not being kept (i.e., there is no continuity between contacts), and that there are multiple clinicians taking calls. Again, be careful not to shame the caller about wanting continued conversation at such a stressful time.

Qualifying comment: If the phone session is going well, both the clinician and the caller may experience connection, warmth, and other positive feelings. For this reason, even the clinician may want to continue the contact over multiple sessions. This is an entirely benign response, albeit one that must be resisted given the goals of peer support.

Issue: **The caller feels discounted by the clinician because the clinician stays within a time-limited, nonclinical, supportive frame.**

Suggested approach: Again, it is important that the clinician explain at the outset of the call the parameters of the call. In general, the clinician should refrain from expressing any desire to have more time or a more clinical conversation, since there is a risk that the caller may feel that the clinician has a special alliance with the caller and thus that the "rules" can be broken given the specialness of the relationship.

Qualifying comment: It is very easy to feel discounted when one's desires for help or emotional connection are seemingly rebuffed. Although some callers may have preexisting beliefs or experiences that heighten their susceptibility to feelings of rejection or invalidation, the issue is not the clinician's intent to withhold, but rather the boundaries of the call.

Issue: **The caller expresses fear, anger, or helplessness at the national or institutional response to COVID-19, and it activates thoughts or feelings in the clinician who has the same thoughts or feelings.**

Suggested approach: When this occurs, the clinician should nonjudgmentally recognize his or her personal reactions (which may easily be accurate) as reasonable, and yet manage his or her reactions so that the session doesn't focus on the clinician's own issues rather than the caller's. This is especially relevant when the clinician finds himself or herself in unspoken agreement with the caller's sense of helplessness or hopelessness, which may interfere with the clinician's ability to be objective, supportive, and even hopeful.

Qualifying comment: The caller is correct about the scariness of the COVID-19 pandemic, the potential failures of the politicians or organizations involved, and the unfairness of bad things happening to innocent people. The issue is whether the clinician can put aside these responses during the call, so that he or she can be as objective as possible in supporting the caller and acknowledging his or her concerns.

Issue: **The caller insists on advice from the clinician, when such advice would exceed the nonclinical frame of peer support.**

Suggested approach: Although simple advice can be helpful, especially if it addresses caller behaviors that may be risky or otherwise problematic (e.g., nonjudgmentally suggesting avoiding alcohol or drugs, or risky behavior), or provides access to available resources (e.g., relevant websites or community resources), excessive advice-giving has not been shown to be especially helpful in psychotherapy, let alone when the focus is nonclinical support. Among other things, the clinician's advice may be wrong, or may inadvertently imply that he or she is wiser or otherwise more "special" than the caller. The fact that the caller solicits excessive advice does not, in and of itself, make it appropriate.

Qualifying comment: Advice can be helpful when it facilitates the caller's access to needed information or resources. And it is entirely reasonable that the caller might want concrete answers and guidance when feeling overwhelmed. Excessive advice, however, may arise from the clinician's countertransferential needs to be competent and wise, and may inadvertently undercut the caller's sense of competence and, ultimately, empowerment.

Issue: **The caller describes fears of spreading the virus to family members, partners, friends, or coworkers**.

Suggested approach: The clinician should validate the caller's concern, which is entirely appropriate. Although some especially high-risk health care providers are now isolating themselves from family and friends, in many cases this is not possible. It may be helpful to refer the caller to websites developed by the CDC and others describing measures that may reduce the spread of COVID-19. At the same time, it is important to stress that this is a pandemic and we all can do only what we can do, and that some risk is typically unavoidable for parents and other familial caretakers. Allow the caller to explore his or her feelings around this issue, without either catastrophizing or underappreciating his or her concerns.

Qualifying comment: Because the caller's worries are grounded in reality, there is no simple answer to his or her fears. Although the clinician cannot fully alleviate the caller's anxiety, he or she can provide a caring, nonjudgmental context within which the caller can explore his or her thoughts and feelings.

Issue: **The caller expresses grief regarding the loss of loved ones or patients due to COVID-19.**

Suggested approach: Grief is widely prevalent in the COVID pandemic -- given current estimates, well over a million people will have experienced the death of a family member before COVID can be prevented or treated, and many more will have lost a friend or colleague. In other cases, the grief may arise from the death of a patient to whom the clinician has become attached. The clinician should communicate that all COVID-related impacts are worthy of discussion, not just those that arise directly from work, and validate the caller's "right" to grieve. Grief counselors stress the importance of normalizing grief, and of providing the opportunity to explore and express grief in a safe, nonjudgmental environment. In keeping with the nonclinical focus of the call, the clinician should avoid labeling grief as a symptom or disorder, frame it as a normal response to extreme loss, and help the caller to explore and express his or her distress.

Qualifying comment: In most cases, the most painful aspects of grief are time-limited, and generally respond to continued normalization, emotional expression, and support. The clinician is unlikely to "fix" grief, which obviously may persist in some form for years, but he or she can support and validate the caller as he or she begins the recovery process.

Issue: **The caller expresses guilt because he or she is not working on the front-lines with COVID patients and thus fears he or she is placing additional hardship or risk on his or her colleagues**

Suggested approach: The social distancing requirements associated with COVID-19 mean that some clinicians no longer have as much, or any, face-to-face contact with patients. Others, for example, clinical researchers, teachers, and administration staff, have been forced to "shelter in place" at home, and work via the internet. When hearing of the challenges faced by their front-line colleagues, some feel guilt that they are in safer and sometimes less stressful jobs. They may also fear that they are making it harder on their colleagues because they are not sharing the direct burdens and dangers of work on the front lines. Call clinicians should note that all of us are directly or indirectly addressing the COVID crisis, whether through research, teaching, supervision of trainees, administrative support, or "just" attempting to reduce the spread of the virus. The clinician should not talk callers out of their feelings of concern and responsibility, but rather should validate the understandable nature of the caller's responses, and the fact that such feelings signal goodness and caring for others.

Qualifying comment: This issue can be understood as a form of "survivor guilt" that often arises from trauma. The COVID pandemic has traumatized us all, leading to responses that can be seen as a form of PTSD. We must be compassionate with ourselves and others under such conditions.

Issue: **The caller has COVID-related financial concerns (e.g., loss of retirement funds), or worries about impending unemployment**.

Suggested approach: This is also a common worry in the coronavirus pandemic, given the ongoing deterioration of our economic system. Like fears of spreading the virus, often the best thing the clinician can do is to listen to employment or financial concerns in an empathic, supportive way, and serve as a sounding board for the caller's concerns. In some cases, the clinician can help the client explore next steps if job loss is likely, such as filing for unemployment, or seeking government relief from immediate foreclosure or eviction. However, this should typically be done only if the caller requests it, should not involve overly detailed advice, and should not replace the central function of the call, which is to support and validate the caller's immediate and ongoing experience.

Qualifying comment: Many people are undergoing, or will experience in the near future, major financial and occupational stress and disruption. The clinician's role is not to try to somehow fix this reality, but rather to be supportive and empathic as the caller shares his or her worries and concerns.

Issue: **The caller requests current information on COVID-19, its prevalence, its symptoms, or currently recommended safety procedures.**

Suggested approach: Although it is appropriate for the clinician to convey obvious information, such as the value of social distancing, he or she is unlikely to also be a virologist or public health specialist, and the facts on the ground are rapidly evolving. As a result, the clinician should refrain from providing detailed, specific information or recommendations, and instead refer the caller to websites created by the CDC and others, as described earlier.

Qualifying comment: Providing information is an important aspect of crisis intervention, and can sometimes relieve anxiety for those struggling with inaccurate understanding. In general,

however, the clinician's role is to provide support, validation, and a "listening ear," rather than serving primarily as an information outlet.

Issue: **The caller discloses credible suicidal or homicidal ideation, or appears to be struggling with severe depression, a debilitating anxiety disorder, or psychotic symptoms.**

Suggested approach: When danger to self, other(s), or severe functional disability is verbalized or exhibited in the session (an unlikely scenario given the high-functioning characteristics of most callers in this context), the clinician must shift from a supportive, listening stance to a more active, clinical role. If there is no immediate risk, but major psychological impairment, the clinician may make a referral to a clinical agency. If the clinician believes the danger is imminent, he or she should perform a "warm-handoff" to emergency personnel or a 911 operator -- it will usually be insufficient for the clinician to just refer the caller to emergency resources. In some cases, it may be possible to enlist the assistance of family members or friends who are present in the caller's immediate environment. The specific procedure whereby hand-offs to crisis or emergency personnel occurs varies according to setting and/or organization, and is beyond the scope of this guide.

Qualifying comment: Stressed people sometimes verbalize suicidal or other-harming thoughts that they are actually unlikely to act upon, and some severely impacted callers may experience temporary looseness of thoughts or associations, or verbalize impaired reality testing, in the absence of a formal psychotic disorder. Thus, it is important that the clinician balance his or her duty to protect and warn with the possibility that some verbalizations or behaviors are not, in fact, harbingers of immediate danger and may not require urgent intervention. When there is some reason to be worried about the caller's wellbeing, or the wellbeing of others, however, it is generally better to respond conservatively and initiate emergency procedures.

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