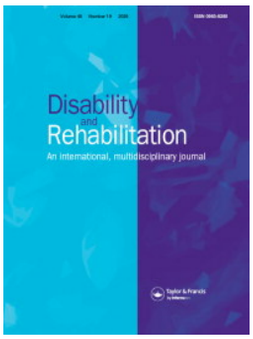

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RESEARCH ARTICLE

Patient's perspectives on the value of peer support after acquired brain injury: an exploratory study

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ABSTRACT

Purpose: Studies have shown positive socio-psychological effects of peer support for patients with acquired brain injury. However, little is known of what patients themselves understand and mean by peer support: what do they consider the added value?

Materials and methods: Semi-structured interviews were conducted with inductive thematic analysis.

Results: Four key-values were identified. Patients valued: 1) gaining perspective on a meaningful life, 2) receiving advice based on lived experience, 3) being with one another without having to explain everything and 4) having space to tell your story to someone with a similar story. Peer support increased their motivation for rehabilitation, protected them from pitfalls and decreased feelings of loneliness.

Conclusion: Findings show the potential of optimizing regular rehabilitation services by the addition of peer supporters. This requires a reconsideration of existing organizational and cultural structures. Genuine integration of peer support within rehabilitation services can only occur when structural inequalities and power asymmetries are explicitly acknowledged and addressed.

➤ IMPLICATIONS FOR REHABILITATION

- Patients with acquired brain injury perceive peer support as a valuable component of inpatient rehabilitation, as it can foster motivation, provide a sense of comradeship, and help individuals avoid common pitfalls during recovery.
- Patients perceive peer support as a distinct and complementary form of assistance that differs from the support offered by professional caregivers, family members, or friends.
- Rehabilitation organizations should recognize peer support as a legitimate and integral element of rehabilitation care.
- Genuine integration of peer support within rehabilitation services can only occur when structural inequalities and power asymmetries are explicitly acknowledged and addressed.

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Peer support; rehabilitation; acquired brain injury; value; qualitative research; Netherlands

Introduction

Peer support has become increasingly integrated into healthcare services. Evidence suggests that patients' needs are more effectively addressed when the professional expertise of healthcare providers is complemented by the experiential knowledge of peer supporters [1–5]. A peer supporter is typically someone with lived experience of a disability or chronic condition, who provides guidance to another individual facing a similar condition but with less experience. This form of support aims to promote outcomes

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related to health, participation, and quality of life [1,2,6]. Peer support is commonly described in terms of emotional support, appraisal support, and informational support [2,7].

The underlying principle is that individuals who have critically reflected on their own health journey are well positioned to support others [8–12]. This aligns closely with the recovery approach, which emphasizes regaining control over one's life—not necessarily by returning to pre-disability levels of functioning, but by developing a renewed sense of identity and purpose [8,9,11]. Within this approach, the emphasis is placed on fostering resilience rather than solely on managing symptoms of illness or disability [8,11,12].

In the field of Acquired Brain Injury (ABI), peer support has been associated with strengthened social relationships [13,14] improved behavioral self-regulation [15], increased experiences of validation and hope [16], improvement of the ability to handle stress as a caregiver [17], and the provision of positive role models that encourage participation in meaningful activities following discharge from rehabilitation [4]. Despite these reported benefits, the literature frequently lacks conceptual clarity regarding the definition and theoretical foundations of peer support, as well as transparency in relation to the selection, training, and organizational positioning of peer supporters [1,6,18]. Such conceptual and methodological inconsistencies hinder efforts to delineate the essential components of peer support and to robustly evaluate its contribution to recovery, community integration, and overall well-being among individuals with ABI.

A recently developed framework seeks to address this gap by delineating the components and contextual factors of peer support interventions in rehabilitation, including the timing, dosage, and characteristics of peer supporters, as well as their training [6]. This framework provides a structured approach to documenting interventions and enhances transparency, making it a valuable resource for researchers. However, by framing peer support primarily as a technical construct, it risks overlooking its relational and experiential essence. Peer support is not merely an intervention to be standardized; it is rooted in mutual understanding and the sharing of lived experiences of recovery. Even more important, the perspectives of patients with ABI are underrepresented, particularly regarding what they value in peer support and how this is related to their personal journeys [18].

Advancing the field requires a shift in perspective—moving beyond technical definitions to center the experiences of those who receive peer support. Patients' beliefs, motivations, and expectations offer essential insights into how peer support becomes meaningful and how it may influence recovery (cf [18]). Accordingly, this study explores how patients experience peer support during inpatient rehabilitation, what they value, and how these perspectives can inform the design and delivery of peer support programs in practice. By foregrounding patients' voices, we aim to address a critical gap: clarifying what patients themselves understand and mean by peer support.

Materials and methods

Study design

This exploratory qualitative study investigated patients' perspectives on the perceived value of peer support during inpatient rehabilitation using semi-structured interviews. Written informed consent was obtained from all participants prior to participation.

Phenomenology was employed as the primary theoretical lens to understand peer support through patients' subjective experiences. By examining experiences as they are lived, this approach facilitates the development of new meanings and insights that can inform or reorient their interpretation [19]. The study protocol was reviewed and approved by the Medical Ethics Review Committee of the Amsterdam UMC (reference number 2021.0253). Reporting followed the Consolidated Criteria for Reporting Qualitative Research (COREQ) guidelines [20].

Setting

Participants were recruited from the inpatient ward of a rehabilitation center in Amsterdam, the Netherlands. During the study period, five individuals with Acquired Brain Injury (ABI) provided peer

Table 1. Demographic and clinical characteristics of peer supporters.

Characteristics		N
Sex	Female	4
	Male	1
Age, years	40–44	1
	45–49	2
	50–54	2
Type of ABI	Non-TBI	4
	TBI	1
Time after onset of ABI in yrs	0–4	1
	5–9	1
	10–14	3
	>14	0
mRS*	1	0
	2	4
	3	1
	4	0
	5	0

ABI, Acquired Brain Injury, mRS, Modified Rankin Scale.
*Modified Rankin Scale (mRS).
0 No symptoms.
1 No significant disability. Able to carry out all usual activities, despite some symptoms.
2 Slight disability. Able to look after own affairs without assistance, but unable to carry out all previous activities.
3 Moderate disability. Requires some help, but able to walk unassisted.
4 Moderately severe disability. Unable to attend to own bodily needs without assistance, and unable to walk unassisted.
5 Severe disability. Requires constant nursing care and attention, bedridden, incontinent.
6 Dead.

support (see Table 1). All peer supporters were salaried employees who had completed the rehabilitation center's training program. The training is provided in 5 sessions of 4 h. The first sessions facilitate participants to engage in critical reflection on personal and shared experiences while acquiring skills in non-judgmental listening, motivational interviewing, and the psychology of grief and loss. Two-thirds of the sessions is dedicated to simulation-based learning, utilizing role-plays to practice boundary setting, (perceived) communication proximity, and navigating complex scenarios. In the final session trainees are trained to recognize the heterogeneity of ABI.

All inpatients were invited to attend an introductory meeting with a peer supporter during the third week of their admission. Matches between patients and peer supporters were made by the rehabilitation physician, primarily based on the patient's main impairment following ABI. For example, a patient experiencing mobility limitations was paired with a peer supporter who had similar functional limitations. During the introductory meeting, the peer supporter presented themselves by sharing an overview of their rehabilitation journey and describing the types of support they could provide. Patients were encouraged to speak openly about any concerns or topics of personal relevance. If a patient expressed no further interest in peer support, the contact was concluded. When patients wished to continue, the frequency and format of subsequent meetings were mutually agreed upon, and contact could be maintained throughout outpatient rehabilitation. Information about the frequency and duration of contact, as well as subjects of conversation were reported in an earlier study [21].

Participants

All patients who gave permission to their rehabilitation physician to be contacted for scientific research, were screened for eligibility for this exploratory study. Inclusion criteria were: 1) a first diagnosis of ABI; 2) 18 years or older; 3) contact with peer support with a minimum of 30 min, 4) contact was less than 1 year ago, and 5) Dutch or English speaking. ABI was defined as a collective term for Traumatic Brain Injury (TBI), where an external traumatic event causes injury to the brain, and for Non-Traumatic Brain Injury (Non-TBI) which occurs when brain tissue is damaged by an internal disease process [22]. We aimed at contacting patients with a maximum variety with regard to sex, age, cultural background, marital status, diagnosis, and peer supporter.

Data collection

The setting for the interview was chosen by the respondent: at their home or in the rehabilitation center. Interviews lasted on average 1-1.5 h and were conducted in Dutch or English. The interview guide comprised questions exploring patients' initial expectations prior to meeting the peer supporter, their overall experiences of peer support, the topics discussed during interactions, their perceptions of the appropriateness of the patient–peer supporter match, and the perceived impact of peer support on their well-being and rehabilitation process. All interviews were audio-recorded and transcribed verbatim.

The researcher who conducted the interviews (RW) was involved in setting up the peer support program. After discussing this in the research team, we decided to be critical on a possible influence during data analysis. The respondents were only informed about her role as a researcher.

Data analysis

Following Braun and Clarke [23,24], inductive thematic analysis was performed to interpret data. In the first round, the researchers (RW, MD and RN) independently applied open coding for each interview and wrote a memo of the most important aspects that the respondent brought forward. In an iterative process the researchers reached consensus on the main themes. The themes were then discussed with three patients (other than the respondents) to validate and deepen the findings [25] and to ensure that the interpretation and the formulation stayed close to the patients' perspectives. Pseudonyms were assigned to the respondents to ensure anonymity.

The authors brought diverse perspectives to the interpretation and description of the results, drawing on their extensive backgrounds in clinical rehabilitation (JV, RW), peer support (KJ, CD, RW), and qualitative research (CD, MD, KJ).

Results

Ten patients were interviewed with an age ranging from 25 to 69 years. The degree of disability varied from a slight to a moderately severe disability (based on the Modified Rankin Scale) and the length of inpatient rehabilitation ranged from 1 to 6 months. Nine participants were interviewed between 1.5 and 12 months after their contact with a peer supporter, one participant was interviewed 18 months after the contact with the peer supporter due to the Covid-19 pandemic. Participants' first contact with a peer supporter ranged from 4 to 13.5 weeks after the onset of ABI. Patient characteristics are shown in Table 2. Due to the Covid-19 pandemic two interviews were conducted via Microsoft Teams. The other interviews were situated at patients' homes or in the rehabilitation center.

Respondents mentioned that they hardly knew what to expect from the contact with a peer supporter, as they had never heard of peer support before, but they wanted to give it a chance. It was mainly during the first conversation that they realized what the contact could mean to them. One respondent expressed that he had no need for peer support, as he could not identify with the peer supporter he met. He found more understanding among his fellow-patients on the inpatient ward.

> Thomas: It was not someone I could very much identify with. It was a woman of, well… sort of, of my mother's age. So I think it was because of that. The conversation was fine but I did not feel that it was of more use for me. I think it was because… how should I say this? Because we did not have much in common.

From the interviews with the other participants we identified four key-values: 1) gaining perspective on a meaningful life, 2) receiving advice based on lived experience, 3) being with one another without having to explain everything, and 4) having space to tell your story to someone with a similar story. Each patient tended toward an emphasis on one particular value, however, often other values came up in conversation. Below we describe the values. Interestingly, we found two aspects that shed more light on the means through which patients perceived the value of peer support. These are described as the modality and temporality of the values.

Table 2. Demographic and clinical characteristics of respondents.

Name	Sex	Age range	Type of ABI	mRS*	Marital status	Length of inpatient rehabilitation in months	Number of contacts with PS	Time after onset ABI and first contact PS in weeks	Time between Interview and contact with PS in months	Peer supporter
Ben	M	55–60	Non-TBI	3	In a relationship/ married	<3	2	0–4	3	1
Carlos	M	65–69	Non-TBI	2	Single	<3	3	9–12	12	2
Miranda	F	50–54	Non-TBI	4	In a relationship/ married	3–6	3	9–12	9	1
Betty	F	60–64	Non-TBI	4	Single	>6	>4	9–12	12	3
Jelle	M	40–44	TBI	2	In a relationship/ married	<3	2	>12	18	2
Nadia	F	50–54	Non-TBI	3	In a relationship/ married	3–6	4	0–4	3	4
Thomas	M	25–29	Non-TBI	2	Single	<3	1	0–4	2,5	5
Suzan	F	65–69	Non-TBI	3	In a relationship/ married	<3	1	0–4	1,5	4
Precious	F	45–49	Non-TBI	2	Single	<3	3	5–8	5	5
Amira	F	35–39	Non-TBI	3	In a relationship/ married	<3	2	0–4	1	4

ABI, Acquired Brain Injury, mRS, Modified Rankin Scale.
*Modified Rankin Scale (mRS).
0 No symptoms.
1 No significant disability. Able to carry out all usual activities, despite some symptoms.
2 Slight disability. Able to look after own affairs without assistance, but unable to carry out all previous activities.
3 Moderate disability. Requires some help, but able to walk unassisted.
4 Moderately severe disability. Unable to attend to own bodily needs without assistance, and unable to walk unassisted.
5 Severe disability. Requires constant nursing care and attention, bedridden, incontinent.
6 Dead.

Gaining perspective on a meaningful life

Respondents talked about how they had valued seeing "light at the end of the tunnel" through their contact with the peer supporter. Some explained that they were in a mentally bad state at the time of the contact. By meeting the peer supporter they realized that their situation was not as hopeless as they had thought.

> Miranda: He showed me what I can do instead of what I cannot do. That is what you see at first, I cannot do this, I cannot do that. He asked me about it and he said I can do this. I can still drive, those were positive things. […] In fact the peer supporter, like, fully functions again. That is positive and he has a job.

The "recovered" peer supporter offered them a perspective on a meaningful life after brain injury.

> Ben: At that moment I was in a wheelchair, I think I had just wiped my own behind for the first time. Well, and then he talks about how he is doing. The fact that he had a girlfriend and that he was buying a new house […], what I got from that was okay, so there is life.

In order for patients to gain perspective from the contact with the peer supporter it was not necessary to exchange a lot of words; it was enough to see how well the peer supporter was doing: "*So it is really important to see, because you can say everything will be all right, or there is a future and you can do this and you can do it but if you cannot see it…" (Ben)*.

As stated by one of the respondents: "*you have to see that there is hope*" *(Amira)*.

> Suzan: It is actually surprising to sit in front of someone and think oh? This person went through the same thing and looks normal? You know, like that.

Respondents explained that it motivated them to fully engage in the rehabilitation services.

> Suzan: Maybe I will be all right. Like with her. You know, that's what I thought then. I thought… who knows. I'll just work really hard for it. It gave me a lot, yes it actually gave me the power to do something.

With the hope of recovery, they could find the courage to give everything – even though things might never be the same again: "*Just because I have seen that it can be all right. That motivates me to also just, I just give the best I can you know, I do that and I work really hard to get better. But it motivates me even more because I see that it's actually possible" (Amira).*

Receiving advice based on lived experience

The respondents appreciated the advice they received from the peer supporter; information based on lived experience of someone still living with ABI every day. While the value of gaining perspective was about seeing a spot on the horizon, this aspect was about the road or process toward it; about the "how" of recovery and living with the consequences of a brain injury. Some respondents had internalized the voice of the peer supporter in daily confrontations.

> Suzan: So about resting. Taking your own rest. Also, at home. […] That is what she said, just tell them because they don't know how it feels. That is what I encounter a lot, my husband often says just do this and that. Then I think no [laughs], it doesn't work that way, one thing at a time. And then I often remember her and I think, oh yes. The same thing happened to her. Yes.

Respondents explained how the suggestions protected them from threats or pitfalls such as wanting to go home too soon, using too much energy at once, having arguments at home over small things, or caring too much about what others think of you.

> Jelle, reading from his diary: Let's see what I have here: things that cost energy, social expectations, concerns about how to move on, that is what I wrote down. Explaining to the children, those kind of things. It was more, they were actually conversations about what can happen to you if things are not going so well. How can you deal with that, if you have less energy and you are used to going full throttle.

> Ben: What I found really scary in the beginning here, was that I went home and my partner and I kept getting into quarrels over really trivial stuff, but the psychologist says, fifty percent of relationships will end in the next two years, take that into account. And I was like, I do not want that at all and the peer supporter gave me tools for that. […] And that was good for our relationship.

While respondents gained perspective primarily by looking at the peer supporter and seeing that things can change for the better, respondents who valued advice asked the peer supporter many questions. One respondent described herself as insatiable: *"I had too many questions" (Precious)*. Another respondent started off by asking the peer supporter what was the biggest mistake she had made:

> Nadia: Then she said: 'Well, if I am really honest, it is that I left too early [from the rehabilitation unit]. Actually I took good note of this because I also only wanted to go home …. and that gave a kind of … mind-set change.

Respondents reported the importance of lived experience as the foundation of receiving advice from the peer supporter. This could be in contrast with how it felt when coming from a healthcare professional.

> Suzan: I would prefer to hear the person talking who has gone through the same experience. Because the doctor… that is their (doctors') hope, that is how they assume things will happen. […] It's a technical plan: if we give you this paracetamol your body will do this. But she (peer supporter) says ok I got all the medicine and I did everything and I am now able to do something by myself. To go to work and… I would rather hear it from her, how it really feels.

Advice from professionals is more technical, based on assumptions and working experience, whereas advice from peer support is based on lived experience and personal.

> Nadia: No offence, but look, I think that if you are with the psychologist, mainly to ventilate, to express what you feel… Not exactly because this person has really felt what it is to…, you know? (explains that it can depend on the person). It can be a plus because they know very many different cases but it can also be that at some point, something I can imagine, they become a little blind for it. Because it is a similar story, you understand?

Being together without having to explain everything

Respondents reported the value of being among people with a similar experience, who have been confronted with similar problems. The respondent and peer supporter together were seen as "we," as opposed to "they": the outside world that doesn't understand what it is like to experience the consequences of brain injury. "We" had been through or are going through a similar experience and did not need a lot of words for explanation of the situation.

> Amira: If you have brain injury, nobody understands it from the outside. Do you get it? Everything you experience, even now for example I might look normal but that is not the case. But someone who has brain injury like me, understands exactly why I am really not normal [laughs]. […] Without me having to explain anything.

"They" observe "us" with pity, which made respondents feel like the only one dealing with such a situation and they explained that this can lead to "loneliness" (Nadia). In contrast, the "we" could bring "camaraderie" (Nadia) and recognition.

> Betty: It is, it sometimes makes me think it is like deaf people. Once in a while they have a meeting with only deaf people. And then it's dead quiet. When they are having fun [laughs]. Look when somebody else meets someone who is deaf it's like oh that one is deaf. Well that's how it is with me and with [name peer supporter] as well.

> Thomas: That you don't, sort of, well… sort of feel an idiot because of things that don't really go well or that you have difficulty with. That you feel some recognition sort of. If someone says yes, that is very normal, I had that too…

Having gone through a similar experience, together with feelings of equality and connection, made it possible to let the other person come closer, tolerate more from each other, even criticism. This way, the painful contrast with the outer world was temporarily absent. Confrontations were easier to handle coming from a peer supporter than from the outside world as Nadia explained:

> Nadia: And there I was, in the beginning I wore my husband's t-shirt and sweatpants (explains that this is practical clothing when you can only use one arm) and every time you see yourself in the mirror you scare yourself and think oh, my god who is this woman, you know. […] And then it isn't nice to sit and talk with someone who looks all pretty, all charming and you are a sort of… But the knowledge that she also… has been in that situation makes it possible to… have a little more relaxed reaction to that.

Having space to tell your story to someone with a similar story

A fourth value that arose from the interviews was that of being able to tell your story to someone with a similar story. Respondents for whom this was an important aspect especially valued that there was a space where they could tell their story in their own pace.

> Carlos: she wanted to hear my story and was sensitive. (Explains how he can see this from someone's body language). How was I doing, how did I get here, what had happened to me. Yes, these things. Yes, that still comes very clear to mind, that she really took her time with me. […] I loved that. Yes, because you feel understood, approached and also pampered.

Instead of indulging in the experiential knowledge of the peer supporter (as with "receiving advice"), here the respondent wants a listening ear from the peer supporter. The tables have turned: now it is not the patient who asks questions, but the peer supporter, and it is not the peer supporter who does the talking, but the patient.

> Nadia: then you shouldn't be judging. You should only listen, you understand? That is really important. That is the most important for the whole of (name rehabilitation center). I really think so. And not try to silver-plate this or that but just listen well.

Being a good listener for the patient implies a genuine interest in what they have experienced. Carlos described how he had tested the peer supporter's authenticity by checking if her body language and

facial expressions matched her words. Then he opened up to her. Another important quality of a peer supporter was to be sensitive, as Precious expressed:

> Precious: Because I really want to know, I don't want somebody to play around with my feelings because when I come to talk to you about something that is painful, I want you to be in there with me. Yes, I want you to be in there with me. And understand oh what is she trying to get at. That is the kind of… That is the kind of skill that I want.

Time was mentioned as an important condition for being able to tell one's story. In the above quote of Carlos it becomes clear how he valued the fact that the peer supporter took the time for him. Betty mentioned it as a shortcoming of the system that the peer supporter had the same standard amount of time available as the therapeutic consultations.

> Betty: I didn't like it when she left again [laughs]. Oh is it that late already? […] Look the time that you have with a therapist to… well, to talk, or for example physical therapy that is half an hour, occupational therapy is also half an hour. Most of it is half an hour. I think with her it was also half an hour, I don't know.

Modality and temporality of the benefits

We found two aspects that gave a more in depth understanding of the means through which patients perceived the value of peer support. The first aspect is the modality through which the value was put across: physical or verbal. The themes "gaining perspective on a meaningful life" and "being with one another without having to explain everything" were more about physical presence than about talking together. In contrast, the other two values depended more on verbal communication with the peer supporter. In the case of "receiving advice based on lived experience," the patient asked many questions and the peer supporter answered those. The presumed roles were reversed when patients talked about the value of "having space to tell your story to someone with a similar story": the peer supporter asked questions and the patient told the story of what he or she had been through.

In addition to the verbal or physical modality, we came across the aspect of temporality in the conversations. With "gaining perspective on a meaningful live," the emphasis was on the future, whereas with "having space to tell your story to someone with a similar story," the patient seemed to prefer to review the past. "Being with one another without having to explain everything" suggested being together at that moment, in the present time. "Receiving advice based on lived experience" seemed to have different temporalities: advice for the present (for instance on how to deal with decreased energy) and advice for the future (e.g. what to expect after the rehabilitation process).

Discussion

The aim of the current study was to explore the perspectives of patients with ABI on the value of peer support during inpatient rehabilitation and to discuss practical implications for rehabilitation services. We identified four values: 1) gaining perspective on a meaningful life, 2) receiving advice based on lived experience, 3) being together without having to explain everything and 4) having space to tell your story to someone with a similar story. By trying to stay close to the patients' perspectives we were able to describe some of the unique contribution of peer support to patients in a rehabilitation center.

The values identified in our study are broadly consistent with previous research on peer support for patients with ABI after discharge and when living in the community. Kersten et al. [4] reported that peer support gave hope for the future and a sense of "comradeship" through the sharing of experiences and stories. Also, Kessler et al. [16] found that peer support enhanced patients' hope and motivation. Stiekema et al. [5] further noted that peers were perceived as more capable of understanding patient's difficulties and more accepting of "odd behavior." The identified values also align with Dennis' [2] conceptualization of the types of support provided by peers. For example, "being with one another without having to explain everything" and "having space to tell your story to someone with a similar story" reflect emotional support. "Receiving advice based on lived experience" corresponds to informational support, while

"gaining perspective on a meaningful life" encompasses elements of both emotional and appraisal support.

A salient finding from our study is the motivation patients derive from meeting another person with ABI who physically demonstrates the possibility of living a meaningful life. Inpatient rehabilitation is often experienced as demanding and frustrating due to dependency on others, fear of permanent limitations, and a perceived loss of control [26]. Participants in our study described being in a poor mental state during this phase. The physical presence of a peer supporter, however, provided a tangible "light at the end of the tunnel," encouraging patients to engage more actively in rehabilitation. This corresponds with the idea that motivation in rehabilitation is not a fixed trait but can be "nurtured" through hope, encouragement, and support [27]. In addition, patients described that advice from someone with lived experience helped them confront daily challenges—such as reduced energy levels or tension in personal relationships. Being better prepared can foster a sense of control and competence, which further supports motivation in people with ABI [28].

Importantly, the findings highlight the role of physical presence as a possible source of motivation. A scoping review by Shaw et al. [29] examined the role of interaction modalities in peer mentorship and their potential influence on outcomes, identifying face-to-face contact as one such modality. Our results suggest that this modality is more complex than commonly assumed. While face-to-face contact allows for verbal exchange of information and encouragement, patients in our study emphasized the significance of the physical presence of a peer supporter. Simply seeing and being with someone who embodies recovery and resilience appeared to instill hope and strengthen motivation to persevere with rehabilitation—an effect that extends beyond what verbal communication alone can achieve.

Perhaps the most evident—yet still noteworthy—finding is that peer support offers a distinct and complementary form of support in the rehabilitation process. Patients emphasized the importance of feeling truly understood. While family and friends can provide valuable support, they often lack firsthand knowledge of what it means to live with ABI, which can leave patients feeling lonely despite their presence [30]. As patients expressed, a peer supporter may serve as a temporary "comrade." Rehabilitation professionals, by contrast, play a crucial role in helping patients manage the consequences of ABI in daily life, but they cannot provide advice grounded in lived experience. Within the structured schedules and limited capacity of rehabilitation programs, peer support creates a more "off-grid" space where patients can reflect, articulate their experiences, and voice their fears. Patients further explained that peer supporters needed to be good listeners and sensitive to their emotions. Although these qualities are also cultivated in rehabilitation professionals, the combination with lived experience provides a qualitatively different form of support.

From the patient perspective, peer support can exert a positive—and potentially catalyzing—influence on rehabilitation by nurturing motivation, reducing loneliness, and helping to prevent pitfalls. Yet despite these benefits, peer support remains precariously positioned within rehabilitation services. While healthcare professionals worry that peer supporters may replace or undermine professional roles [31], patients clearly distinguish between the two: peer supporters do not replace professionals but instead meet needs that professional care cannot. However, precisely because peer support is valued in a different way, it risks being marginalized, instrumentalized, or absorbed into professional frameworks, thereby losing its distinctiveness.

Balancing two conditions—acknowledging peer support as a unique form of rehabilitation care, while at the same time preventing it from being absorbed into rigid institutional structures—is especially challenging. The first condition exposes deep-seated hierarchies in healthcare. Experiential knowledge continues to be systematically undervalued when compared to scientific or professional knowledge [9,32,33]. Rehabilitation centers often reinforce these hierarchies, granting legitimacy and authority primarily to those with higher levels of formal education. Within such a culture, peer supporters risk being tolerated rather than truly recognized. As Leemeijer [33] argues, genuine equality is more likely to be found in teams practicing "connective professionalism," where collaboration actively challenges professional and organizational boundaries. Without such conditions, peer supporters remain structurally disadvantaged.

The second condition—ensuring peer support has space within rehabilitation—faces similar structural resistance. Rehabilitation services in the Netherlands typically operate through fixed schedules, designated spaces, and tightly regulated interventions. In case of peer support programs, regulation extends

to controlling conversation topics and the selection and matching of peers. This however, undermines what patients describe as the distinctive value of peer support: its flexibility, informality, and authenticity. If peer support is forced into these professionalized molds, it risks losing precisely what makes it effective. Worse still, such assimilation may produce a tokenistic form of peer support—present in name, but stripped of its autonomy, informality, and patient-centered character.

In this sense, integrating peer support without altering existing organizational and cultural structures is not merely ineffective but potentially counterproductive. Rather than enhancing rehabilitation, it risks reinforcing the very hierarchies that peer support is meant to challenge [34]. Genuine integration would therefore require not only trust in patients' autonomy and the legitimacy of experiential knowledge, but also a willingness to confront the structural inequalities and power asymmetries embedded in rehabilitation services. Without such changes, peer support may remain an add-on at the margins—recognized rhetorically, but neutralized in practice.

Future research

The findings of this study highlight several avenues for future research aimed at strengthening the role and influence of peer support in rehabilitation while addressing the structural and cultural challenges identified.

First, research is needed to develop and evaluate flexible models of peer support that maintain its patient-driven character. This includes exploring alternatives to rigid scheduling, standardized meeting spaces, and prescribed patient–peer matching, as well as evaluating how such models influence patient values, including motivation, engagement, and feelings of autonomy. Additionally, age should be explicitly considered, as the study population in this research was relatively older. Younger adults experience unique challenges related to employment, identity formation, and social participation, yet these experiences remain insufficiently explored [35,36]. Second, there is a need to explore how professional hierarchies influence collaboration between rehabilitation professionals and peer supporters, and under what conditions "connective professionalism" [33] emerges to foster more equitable teamwork. Third, research should examine the risks associated with the institutionalization of peer support. While formal integration into rehabilitation services may offer practical advantages, it may also unintentionally neutralize the distinct qualities that make peer support effective. Finally, cross-cultural and system-level comparisons could provide valuable insights into contextual factors that facilitate or hinder the sustainable integration of peer support. By examining different healthcare systems and organizational models, researchers can identify best practices for supporting the unique role of peer supporters while navigating institutional constraints. One relevant field is mental health care, which has longstanding experience with implementing strategies to integrate peer support within healthcare organizations [37,38].

Together, these research directions can contribute to a more nuanced understanding of peer support in rehabilitation and inform strategies to preserve its distinct value while enhancing its integration into care systems.

Strengths and limitations

The results give a more in depth understanding of the value of peer support for patients with ABI during inpatient rehabilitation along with the modalities and temporalities. This is useful for future research on the delivery of peer support and gives guidance for the working mechanisms of peer support. In contrast to other studies that describe patient experiences but focus on feasibility or intervention characteristics of peer support programs [1,39], this study specifically reported from a patient perspective. By validating the themes and wording for the presented results we stayed close to the patients' perspective.

This study has some limitations. First, within a relatively small sample of patients with ABI in rehabilitation, the respondents might mainly be patients with a positive attitude toward peer support and therefore present a one-sided perspective. Second, due to the method of semi-structured interviews, we were unable to include patients with severe cognitive and communication difficulties, although these patients do receive peer support during rehabilitation. In future, observational research could be useful to understand more of their experiences with peer support. Due to the Covid-19 pandemic one

interview was conducted 18 months after the contact with the peer supporter instead of the intended maximum of 12 months and therefore a potential recall bias. Luckily, the patient was able to support his memory by reading from his diary.

Conclusion

Patients with ABI regard peer support as a valuable component of inpatient rehabilitation, as it can foster motivation, provide a sense of comradeship, and help individuals avoid common pitfalls during recovery. While the verbal exchange of advice and personal experiences is appreciated, the mere presence of a peer supporter often instills hope for the future. Patients perceive peer support as a distinct and complementary form of assistance that differs from the support offered by professional caregivers, family members, or friends. Rehabilitation organizations should therefore recognize peer support as a legitimate and integral element of rehabilitation care—one that requires the validation of experiential knowledge and a reconsideration of existing organizational and cultural structures. Genuine integration of peer support within rehabilitation services can only occur when structural inequalities and power asymmetries are explicitly acknowledged and addressed.

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