

ORIGINAL ARTICLE

Subjective evaluation of a peer support program by women with breast cancer: A qualitative study

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Abstract

Aim: The aim of this study was to determine the subjective evaluation of a breast cancer peer support program based on a survey of the participants who completed the program.

Methods: Semistructured interviews were held with 10 women with breast cancer. The responses were subject to a qualitative inductive analysis.

Results: Women with breast cancer who participated in the breast cancer peer support program evaluated the features of the program and cited benefits, such as “Receiving individual peer support tailored to your needs,” “Easily consulted trained peer supporters,” and “Excellent coordination.” Also indicated were benefits of the peer support that was received, such as “Receiving peer-specific emotional support,” “Obtaining specific experimental information,” “Re-examining yourself,” and “Making preparations to move forward.” The women also spoke of disadvantages, such as “Strict management of personal information” and “Matching limitations.”

Conclusions: In this study, the subjective evaluation of a peer support program by women with breast cancer was clarified. The women with breast cancer felt that the program had many benefits and some disadvantages. These results suggest that there is potential for peer support-based patient-support programs in medical services that are complementary to the current support that is provided by professionals.

Key words: breast cancer, peer support, peer support program, qualitative research.

INTRODUCTION

Peer support, and the integration of peer relationships into the provision of health care, is a concept of substantial significance to health scientists and practitioners (Dennis, 2003). Peer support is an intervention that leverages shared experience in order to foster trust, decrease stigma, and create a sustainable forum for seeking help and sharing information about support resources and positive coping strategies (Money *et al.*, 2011). Peer interventions are used in diverse settings

throughout the world and across different age groups to target a broad range of physical health outcomes (Simoni, Franks, Lehavot, & Yard, 2011). Peer support programs have been found to improve satisfaction with medical care (Hoey, Ieropoli, White, & Jefford, 2008).

In the field of psychiatric disorders, the emergence of Medicaid funding for peer support services that are provided by “certified peer specialists” in the state of Georgia, USA, in 2001 generated great interest among people in recovery, providers, administrators, and funders in discovering the types of roles and responsibilities that peers can play as part of the system (Schwenk, Brusilovskiy, & Salzer, 2009). Certified peer specialists frequently provide peer support and focus on self-determination, health and wellness, hope, communication with providers, illness management, and stigma (Salzer, Schwenk, & Brusilovskiy, 2010).

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In the field of kidney disease, peer support before dialysis provides patients with access to practical information about kidney disease, empathy and understanding, and hope for the future and has helped them to reach decisions about treatment and to cope with treatment for their disease (Hughes, Wood, & Smith, 2009). In the field of diabetes, peer support programs are a promising approach to enhancing social and emotional support, assisting patients in daily management and living with diabetes, as well as promoting linkage to clinical care (Heisler, 2009).

Peer support is a widely used form of social support in the field of oncology (Macvean, White, & Sanson-Fisher, 2008). A number of models have been advanced to explain how peer support programs help individuals to cope with cancer (Dunn, Steginga, Occhipinti, & Wilson, 1999). Studies have been conducted on peer support programs for patients with many types of cancer, including prostate cancer (McGovern, Heyman, & Resnick, 2002; Weber *et al.*, 2004), melanoma (Rudy, Rosenfield, Galassi, Parker, & Schanberg, 2001), urological cancer (Skea, MacLennan, Entwistle, & N'Dow, 2011), and colorectal cancer (Klemm, Reppert, & Visich, 1998). In particular, many studies have focused on breast cancer. One of the benefits of peer support programs for patients with breast cancer is that of survivors offering suggestions for managing the side-effects that women with breast cancer experience, mostly by sharing information from their own past experiences with cancer and treatment (Sutton & Erlen, 2006). Significant improvements also have been observed in trauma symptoms, emotional well-being, cancer self-efficacy, and the desire for information on breast cancer resources among newly diagnosed women (Giese-Davis *et al.*, 2006).

Reach to Recovery is a program of the American Cancer Society, through which survivors of breast cancer provide support, either face-to-face or by telephone, to women with concerns about breast cancer or in whom breast cancer has been diagnosed (Rinehate, 1994; Rossiter, Thompson, Hollander, & Matthews, 2001). Reach to Recovery has a decades-long history and the benefits of peer support in this program have been listed as providing informational, emotional, and practical support, as well as understanding, empathy, hope, encouragement, and reassurance. Additional benefits that have been identified by the volunteers as peer supporters include being an understanding and sensitive listener and being able to talk with someone who is a “nonjudgemental, nonthreatening, nonmedical and emotionally uninvolved person” (Cameron, Ashbury, &

Iverson, 1997, p. 105). Reach to Recovery participants are generally satisfied with the support that they receive and the program has incremental benefits for the quality of life of patients with breast cancer (Ashbury, Cameron, Mercer, Fitch, & Nielsen, 1998). In studies on the relationship with medical care, those patients who participated in Reach to Recovery had a significantly better relationship with their primary physician than those who did not participate (Ashbury *et al.*).

In Japan, a national basic plan for promoting measures to cope with cancer was finally established in 2012; this plan promoted cooperation between cancer patients and cancer survivors, aiming to further enhance peer support (Ministry of Health, Labour and Welfare, 2012). Recently, the number of peer support programs has been increasing around the country (Ohno, 2011; Osaka *et al.*, 2011), but there are few studies on the topic as these programs have only just begun. Dennis (2003) stated that nursing professionals should effectively incorporate peer relationships into their support-enhancing interventions in order to improve the quality of care and health outcomes. In Japan, nursing professionals also are expected to cooperate with patients in order to incorporate their experiences as a resource for patient support in the future (Ono, Takayama, Kusano, & Kawata, 2007).

Hospital A commenced a peer support program in 2009, prior to the launch of the national plan. This program was introduced in order to respond to the needs of patients who want to meet others with the same disease and who are unable to participate in patient groups within the hospital. In this program, survivors of breast cancer are trained as peer supporters and nurses act as coordinators to facilitate cooperation between the medical staff and the peer supporters in order to provide peer support to women with breast cancer who request it. The evaluation of this peer support program in Japan could prove useful in pursuing peer support in the future.

Therefore, as one step in verifying the peer support program, the present study aimed to clarify the subjective evaluation of the peer support program at Hospital A, as perceived by women with breast cancer who participated in the program.

METHODS

Study design

In this study, women with breast cancer openly described their experience of receiving peer support in

Hospital A's breast cancer peer support program. A qualitative inductive study design was used in order to explore the subjective evaluations of the program by women with breast cancer, in accordance with the methodological procedure and while valuing the content of the women's narratives.

Overview of the breast cancer peer support program

When the patient with breast cancer herself requests peer support or when she requests peer support after it is recommended by a medical professional, the coordinator explains the program details to her and confirms her request for a peer supporter. The coordinator selects a peer supporter that matches the patient's request and arranges the date, time, and a private room for them to meet. The coordinator then introduces the patient and peer supporter to each other on the meeting day. The provision of peer support takes about 1 h. After the meeting, the coordinator asks the patient and peer supporter for their feedback on the meeting. The peer supporter then reports the details of the meeting to the coordinator.

The breast cancer peer supporter training course (three half-days) consists of lectures and training on "Basic medical knowledge about breast cancer necessary for peer support," "Roles of peer supporters," "Cancer patient psychology," "Communication skills," and "Role playing: Scenarios in which peer support is provided and where ethical considerations are required." At the end of the training, the students' level of understanding and their suitability as a peer supporter are assessed in individual interviews with medical professionals.

Participants and setting

The participants in this study were 10 women with breast cancer who had completed the program before July 2011, who had completed the surgery or chemotherapy that they were about to undergo at the time of taking the program, and whose condition had settled. Each primary physician was asked if a survey request could be made. After verifying that the women were suitable to participate in the study, the women were contacted by the outpatient nurse and a researcher explained the purpose of the research and obtained their consent during one of their hospital visits. After obtaining informed consent, a semistructured interview was conducted and the content was recorded. The researcher had no involvement in the treatment, had no

vested interest in the women, and met them for the first time in the interviews. On the basis of these proceedings, requests were made to a total of 10 women with breast cancer and all agreed to participate.

It was possible to ensure the privacy of the study's participants by holding the interviews in a quiet, private room. Every effort was made to pay attention to the physical condition of the participants during the interviews. One of the 10 participants did not give permission to be recorded, but she did consent to the interview. For this participant, the researcher took notes and was given permission to use those data. The data were collected between May 2011 and June 2012. The interviews lasted between 34 min, 19 s and 64 min, 17 s per person, with an average of 50 min, 38 s.

The content of the semistructured interviews was as follows:

- 1 Why did you decide to participate in the peer support program?
- 2 What did you discuss with your peer supporter during your meeting?
- 3 How did you feel after receiving peer support?
- 4 What do you think was good or bad about receiving peer support and what could be improved?
- 5 Do you have any other remarks about the peer support program? If so, please elaborate.

Data analysis

The authors used inductive content analysis (Elo & Kyngäs, 2008). The first step of the analysis was reviewing the transcripts. Two analysts who were experienced in qualitative research first carefully read the transcripts repeatedly to achieve immersion. The text then was divided into the minimum meaningful number of clauses or sentences while paying attention to the context. Next, the parts representing a subjective evaluation by women with breast cancer who had completed the program were extracted as meaning units. The meaning within the description of each extracted unit was interpreted and the units were summarized and coded so that the meaning of each was faithfully represented. Once this work was finished, the researchers examined the data and codes several times among themselves and then grouped similar codes with reference to the surrounding context in order to create subcategories. The subcategories were created by keeping in mind the faithful representation of the semantic content of the codes. The relationships between the subcategories also were examined in order to create abstracted categories that were based on similarities. The association of categories

and subcategories with each code was investigated while this work was underway, modifications were made repeatedly, and the participants' evaluations of the breast cancer peer support program were categorized until the researchers reached a consensus. An effort was made to describe the nature of the subjectively perceived evaluation by the participants as precisely as possible in the category name, resulting in layer upon layer of revisions and modifications. In addition, several researchers checked for repeated appearances of similar data before proceeding with the analysis. The interviews with the 10 participants were completed when no new category was expected to be extracted.

In order to ensure the trustworthiness of the results (Lincoln & Guba, 1985), four participants who provided a lot of meaningful feedback during the interviews were chosen to confirm the categories and subcategories. The analytic process involved repeated discussions among the researchers regarding data interpretation, category distortion, and the presence or absence of bias. Certified breast cancer nurses also gave their opinions on the results of the analysis. Researchers with over 10 years' experience and with achievements in qualitative research supervised the entire process. The validity of the translation also was examined with the cooperation of a bilingual researcher.

Ethical considerations

The study was approved by the authors' institutional ethics committees. The researcher gave the study's participants an oral and written explanation that stated the intent of the study, that participation in, and discontinuation of, the study were voluntary, that they could

withdraw from the study at any time without penalty, that personal information would be kept confidential, that data would be stored properly and disposed, that data would not be used for purposes outside of the present study, and that the study's results would be published; the participating women with breast cancer agreed to participate in the study by signing a consent form.

RESULTS

Backgrounds of the participating women with breast cancer

The backgrounds of the women with breast cancer leading up to participation in the program are shown in Table 1. The participants were 10 women with breast cancer in their thirties to sixties, with an average age of 48.2 years. Three requested and received peer support before chemotherapy treatment and seven requested and received it before surgery. In other words, all the participating women requested and received peer support before treatment. Five participants were married and nine were employed. The scenarios leading to the introduction of peer support were requests by women with breast cancer themselves in three cases and requests by women with breast cancer who had been recommended peer support by a medical professional who considered support to be necessary in seven cases. Of these seven women, two were patients for whom emotional support was considered to be particularly important after they cried during their interview with a nurse.

Table 1 Background of the participating women with breast cancer

Code	Age (years)	Marital status	Employment status	When peer support was provided	Background leading to the introduction of peer support
A	59	Married	Employed	Before chemotherapy	Request after a nurse's recommendation when she became teary during the chemotherapy explanation
B	51	Single	Employed	Before chemotherapy	Request from the woman by phone
C	40	Single	Employed	Before surgery	Request after a doctor's recommendation
D	63	Married	Unemployed	Before surgery	Request from the woman by phone
E	36	Married	Employed	Before surgery	Request after a doctor's recommendation
F	50	Single	Employed	Before chemotherapy	Request after a doctor's recommendation
G	48	Single	Employed	Before surgery	Request after a nurse's recommendation when she cried during an interview
H	45	Divorced	Employed	Before surgery	Request after a doctor's recommendation
I	42	Married	Employed	Before surgery	Request by the woman
J	48	Married	Employed	Before surgery	Request after a nurse's recommendation

Participants' subjective evaluation of the breast cancer peer support program

The analysis resulted in the creation of 97 codes, 21 subcategories, and 9 categories. The categories, subcategories, and some examples of the content that was related by the participants are shown in Table 2. The nine categories were broadly classified by the nature of their content into the benefits of the program, the benefits of the peer support that was received, and the disadvantages of the program. The following section discusses the categories and subcategories in detail, according to these category groups.

Benefits of the peer support program

Receiving individual peer support tailored to your needs

The participants spoke about being easily swayed by unexpected bad news or expectations and being overwhelmed with group support. Despite these vulnerabilities, the participants wanted to meet with others who were dealing with the same disease and understood that they were seeking peers with no conflict of interest. On the basis of these points, the participants evaluated the program positively because they could individually ask peers what they wanted.

Easily consulted trained peer supporters

The participants spoke of feeling safe with the trained peer supporters within the framework of the hospital program and rated the peer supporters as easier to consult than medical professionals.

Excellent coordination

The participants spoke of feeling grateful for the coordination by nurses in regard to the arrangements in the run-up to meetings and peer supporter selection.

Benefits of the peer support that was received

Receiving peer-specific emotional support

The participants received peer-specific emotional support, such as deep empathy from someone who was suffering from the same disease, release from the isolation of no longer feeling alone after meeting the peer, seeing someone doing their best while suffering from the same disease, feeling relieved, and receiving encouragement.

Obtaining specific experimental information

The participants gained realizations from touching on actual experiences as a result of obtaining the information they wanted by asking the peer how they overcame their illness and inquiring about specific concerns.

Re-examining yourself

To the participants, talking with peer supporters provided a chance to calmly accept their current situation and re-examine themselves by imagining themselves as the peer supporter who was a little further ahead.

Making preparations to move forward

The participants felt that they received encouragement from the peer supporters to move forward and spoke of being able to plan the next step by specifically asking the peer supporters, who were a few steps ahead, about their own experiences. Many of the participants also spoke of making decisions about the issues that they had been worrying about and making preparations to move forward in dealing with their disease.

Disadvantages of the peer support program

Strict management of personal information

The participants cited the strictness of the regulations regarding the protection of personal information, such as not having the personal contact details of the peer supporters, as a disadvantage.

Matching limitations

The participants also wished for more similarities with their peer supporter, such as the same disease stage, age group, and lifestyle, implying that this should be a requirement.

DISCUSSION

In this study, the subjective benefits and disadvantages of a peer support program, as perceived by women with breast cancer who participated in a breast cancer peer support program at Hospital A, were clarified.

Benefits of the peer support program

All the participating women with breast cancer in the present study were in the pretreatment phase, before starting chemotherapy and/or surgery. These women with breast cancer suffered various anxieties and distress over their treatment that was soon to begin. They

Table 2 Participants' subjective evaluation of the peer support program for women with breast cancer

Category group	Category	Subcategory	Examples of the content related by the participants
Benefits of the program	Receiving individual peer support tailored to your needs	Overwhelmed in group support	“At the self-help group, I was overwhelmed. I felt a huge gap between myself and the others who had been there longer. Oh, I felt I was somehow different, like being left behind.” (B) “I cannot participate in patient groups when I am feeling down.” (J)
		Easily swayed by unexpected bad news or expectations	“I only want to hear specific information. Even when I look on the Internet, I don't have to see what I don't want to see. Because it's a place that allows me to make that choice, what I require is not a patient group, but something more like this program.” (I)
		Wanting to meet with others dealing with the same disease	“I wanted to start by meeting people currently dealing with this disease. I have no one who I can talk to and I haven't even heard of anyone to talk to.” (B)
		Seeking peers with no conflict of interest	“Because they are a stranger, you can ask questions because you don't know them or say things because you don't know them. I can say things to them because I do not know them at all and they have no involvement with me whatsoever. You can't say things to people you have some sort of involvement with ... though that is the opposite of what it should be.” (G)
	Easily consulted trained peer supporters	Feeling safe with trained peer supporters	“I suppose I feel peace of mind simply from the fact that these people have received that kind of training and that you can meet them alone face-to-face. I think it's good that there's that kind of system.” (F)
		Peer supporters are easier to consult than medical professionals	“I find it somewhat difficult to ask my doctor questions because I keep wondering whether it's really okay to do so ... I felt a sense of freedom in being able to ask an ordinary person [peer supporter] anything.” (I) “I obviously don't use that kind of difficult technical jargon in everyday speech, so I am happy.” (J) “I felt they demonstrated their strength in their role as individuals different from medical professionals who understand pain.” (F)
	Excellent coordination	Feeling grateful for coordination by nurses	“I think that nurses probably select peer supporters really carefully and for that I am the most grateful. It's likely that their choice is strongly influenced by the medical condition and whether the grouping of patient and peer supporter, or something of the like, is compatible.” (I)
Benefits of the peer support that was received	Receiving peer-specific emotional support	Feeling empathy	“They became a little teary together with me, as if remembering [their own rough experiences], and they said they knew what it was like. I

Table 2 Continued

Category group	Category	Subcategory	Examples of the content related by the participants
	Obtaining specific experimental information	Release from isolation	was most grateful that someone truly understood my feelings.” (H) “I think I was probably content just feeling that I was not alone.” (B)
		Feeling relief	“I became able to brush off the things that I was most worried about.” (B) “I felt relieved hearing ‘It’s okay’ from the peer supporter who has overcome hardship.” (F)
		Receiving encouragement	“As I listened to their stories, I understood that there are many others with the same disease who are moving much further ahead and that everyone is doing their best and that somehow cheered me up.” (F) “I asked if they were working and was somehow amazed [that they had a job.] I started to think that I too must do my best. So, I felt that I should try a little harder.” (A)
		Asking how to overcome the illness	“I was somewhat worried about things like the side-effects of chemotherapy. What I wanted to ask them the most was what they did to overcome that.” (F)
		Inquiring about specific concerns	“I asked them who had helped them, and other such things, because I had not told my parents of my condition.” (I) “I only remember asking whether it was possible to hold a job.” (A) “Up until then, I hadn’t really thought about the implications for my breasts. But eventually, I wondered how a man, my husband, would perceive my breasts after surgery. So, I asked the peer supporter how her husband had been after her surgery.” (B)
		Gaining realizations from touching on actual experiences	“I asked the doctors many things, but I started realizing things from listening to their [peer supporters’] actual experiences.” (D) “They showed me their reconstructed breasts.” (B)
		Re-examining yourself	Calmly accepting the current situation “I think that only my feelings were really invigorated. So, I was probably hearing about many things, but in my head I was not really understanding them properly ... [After meeting the peer supporter,] I realized that I needed to accept my situation properly and calmly.” (B)
		Imagining yourself as the peer supporter	“I think I started feeling that, ‘I want to be like this person’ and return to a normal life in 1 year, not 10 or 20 years.” (I)
		Making preparations to move forward	Receiving encouragement to move forward “They let me feel that it is alright, that I can move forward. They encouraged me to take another step forward.” (F)

Table 2 Continued

Category group	Category	Subcategory	Examples of the content related by the participants
Disadvantages of the program	Strict management of personal information	Planning the next step	“We start thinking about the next steps. For example, about how many days I take off work.” (A)
		Making decisions	“In my case, I was agonizing over whether or not to have reconstruction surgery and I decided I would. That is what I felt while listening to the peer supporter, and when I left, I had made the decision to have the surgery.” (E)
		Not having the personal contact details of the peer supporters	“The hospital won’t tell you their contact details or anything, so it’s a bit lonely when you can’t contact them afterwards. It’s probably because any personal information that is in the hospital’s system has to be protected in that way.” (B)
		Wishing for more similarities	“I wondered whether I would have met this person at my stage of breast cancer ... I thought about whether their thoughts were similar to mine, considering I was in the early stage ...” (I) “Despite the similar experience, it was the fact that they weren’t in the same age group as me ... What are the concerns of someone around the same age as me? Also, I was a bit of a special case. My illness was discovered while I was pregnant, so I gave birth, then had surgery ...” (B)

were easily swayed by unexpected bad news or expectations. As a result of their vulnerable condition, it is possible that women with breast cancer are overwhelmed by the gap between themselves and people with the same illness in support groups and are not yet strong enough to participate in patient groups. In the peer support program, the women with breast cancer meet directly with a trained peer supporter, receive support that is tailored to their needs, and they can feel assured because the peer supporter is trained and acts within the framework of a program. In such a peer-support-provision framework, it is less likely that women with breast cancer will become confused by an unspecified large amount of information or be burdened with excess anxiety, making it particularly well-suited to women with breast cancer in a vulnerable condition. Peer supporters “speak the same language” as those that they are helping as a result of shared experience(s), which fosters an environment of credibility and trust (Money *et al.*, 2011). Compared to the medical staff, the participating women with breast cancer found that it was easy

to ask questions and talk to peer supporters because they used familiar terms, not jargon. This signifies that women with breast cancer have issues that they hold back from medical staff, but which they are able to express clearly to peer supporters. A peer supporter’s potential as a mediator in medical care is thought to have great benefits for both women with breast cancer and medical staff. Actively repositioning persons to provide assistance as aid resources and restructuring human-related services have the benefit of extending aid resources (Kubo & Ishikawa, 2001). The peer support program actually positions the peer supporter, who is also a patient, as an aid resource, thereby offering the benefit of extending aid resources. The fact that women with breast cancer are grateful for and appreciate the nurse coordinator signifies that the coordinators are successfully fulfilling their role. In this program, nurses as a coordinator understand the participating patient’s pathology, are aware of her needs, and have a sufficient understanding of the peer support coordinators. The main coordinators tend to be veteran nurses with at

least 25 years of clinical experience, are familiar with breast cancer, and have worked as the deputy director of a breast cancer treatment and reconstruction center. The role of the coordinator is important because matching a patient with a peer supporter could impact the quality of the peer support that is provided.

Benefits of the peer support that was received

Sakiyama (1996, p. 52) stated, “It is not possible for a person who has received a serious shock to obediently accept words like ‘It’s okay’ or ‘Be strong’ from doctors and nurses who are healthy; to varying degrees, it is easy for people with the same illness who have experienced the same suffering and agonized over the same things to understand the patient’s psychological condition and empathize with them.” The empathy that develops from being a peer is an extremely deep emotion and may be considered as a unique type of support that is not attainable elsewhere. The participants also might recognize that there are people like them right in front of them, which causes them to feel empathy, releases them from feelings of isolation, and gives them feelings of relief and encouragement. By receiving high-quality emotional peer support, women with breast cancer can gain the strength that is needed to live their life well with their disease over the long term, which could, in turn, promote psychological recovery.

Peer supporters have acquired experiential knowledge (Borkman, 1976) through the process of surviving their illness and that knowledge can be passed on to women with breast cancer as concrete, empirical informational support. Women with breast cancer ask how the peer supporter overcame their illness, which can lead them to understand their current situation and create an image of what is to come; thus, women with breast cancer gain a realization of their illness from touching on actual experiences. In addition, women with breast cancer ask specifics about what they are currently interested in, meaning that they are obtaining pragmatically based here-and-now information, which is a feature of experiential knowledge (Borkman). In this way, women with breast cancer obtain the specific information they need in a timely manner. Social comparison theory posits that being able to compare one’s own experience with others in a similar situation might normalize the experience, provide positive role modeling, encourage health-promoting behaviors, and enhance self-esteem (Campbell, Phaneuf, & Deane, 2004). By perceiving peer supporters as role models and identifying with

them, women with breast cancer are able to both calmly accept the current situation and their future, like peer supporters have done. Peer supporters allow women with breast cancer in turbulent situations to look at themselves objectively and to provide them with positive strength. Peer supporters have been shown to encourage the planning of the next step. Decision-making assistance (i.e. help in selecting a treatment and treatment strategy) has been proposed as one benefit of peer support (Hughes *et al.*, 2009; Komatsu, 2009). In addition, in the peer support program in the present study, the women with breast cancer indicated that they were able to make a decision about issues that they had agonized over or were indecisive about. For patients to mentally prepare themselves before surgery to face reconstruction and post-surgery life, as well as the accompanying psychological distress, they must make their own decisions, which entails self-responsibility (Sato, 2001). Support to help patients make their own decisions is indispensable for enabling them to be convinced to receive treatment and to live their future life with their illness. Therefore, peer support is suggested as a method of providing decision-making support for women with breast cancer.

Disadvantages of the peer support program

The peer support in this program was provided as part of medical services; thus, no personal contact was made after the meetings. This was done in order to avoid placing an excessive burden on the peer supporters and for data management reasons. If any woman wished to receive peer support again, her request was placed once again by the coordinator. Some of the participants wished to personally make contact with their peer supporter after the meeting and felt lonely as a result of not being able to do so. This was unavoidable, considering that a hospital support system was used. Similarities with peer supporters, such as the same disease stage, same lifestyle, and same employment status, greatly influenced the effects of peer support. Currently, there are only eight peer supporters at Hospital A. Peer supporters need to be recruited from a wide range of backgrounds and matched to the patients who are most similar to them in terms of lifestyle (Dunn *et al.*, 1999). Going forward, as much effort as possible will need to be put into training peer supporters and providing the conditions that are necessary in order to address the diversity of potential participants.

Limitations of the study and future directions

The initial plan was to conduct a survey of women before and after they received peer support, together with an evaluation that compared the answers before and after peer support. However, because women with breast cancer are extremely nervous around the time that they require peer support, this plan was abandoned for ethical reasons. Nonetheless, in order to evaluate the program more strictly, it is necessary to investigate simple survey methods that do not place a burden on the women in order to compare the data both qualitatively and quantitatively and to evaluate the data multilaterally. These are challenges to be addressed in the future. In addition, the present study only surveyed patients with breast cancer who had received peer support. The authors are in the process of analyzing the results of surveys that were conducted at the same time in order to investigate the peer supporters, doctors, and nurses who were the support providers. The aim is to carry out the analysis separately for each of the positions involved in the program in order to achieve a comprehensive evaluation.

Although these results provide little insight when applied to actual settings, they serve to encourage the provision of effective support by contributing to the improvement of the program. Furthermore, the role of the coordinator, taken on by nurses in this program, was found to require advanced coordination skills and nursing abilities. The future spread of this kind of peer support program should test the abilities of nurses and lead to the improvement of nursing care services.

CONCLUSIONS

The subjective evaluations of women with breast cancer who participated in a peer support program at Hospital A were identified. The participants cited the following benefits from the program: “Receiving individual peer support tailored to your needs,” “Easily consulted trained peer supporters,” and “Excellent coordination.” The benefits of the peer support that was received also were described, such as “Receiving peer-specific emotional support,” “Obtaining specific experimental information,” “Re-examining yourself,” and “Making preparations to move forward.” In addition, disadvantages, such as “Strict management of personal information” and “Matching limitations,” were revealed. By combining expert support from medical professionals and peer support in medical settings, both the survivors of cancer and the medical professionals found many

benefits, despite the challenges that were faced. Using the experiences of the survivors of cancer in medical services not only brings these services closer to serving the true needs of patients, but also offers possibilities for the realization of team medicine that counts patients as members.

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CONFLICT OF INTEREST

The authors have no conflict of interest to declare.

AUTHOR CONTRIBUTIONS

M. O. and Y. T. contributed to the conception and design of this study; M. O. contributed to the acquisition of the data; M. O. and H. O. carried out the analysis and interpreted the data; M. O. drafted the manuscript; R. O. critically reviewed the manuscript and supervised the whole study process. All the authors read and approved the final manuscript.

REFERENCES

- Ashbury, D. F., Cameron, C., Mercer, L. S., Fitch, M. & Nielsen, E. (1998). One-on-one peer support and quality of life for breast cancer patients. *Patient Education and Counseling*, 35, 89–100.
- Borkman, T. (1976). Experiential knowledge: A new concept for the analysis of self-help groups. *Social Service Review*, 50, 445–456.
- Cameron, C., Ashbury, D. F. & Iverson, C. D. (1997). Perspectives on Reach to Recovery and Can Surmount: Informing the evaluation model. *Cancer Prevention & Control*, 1, 102–107.
- Campbell, H. S., Phaneuf, M. R. & Deane, K. (2004). Cancer peer support programs—do they work? *Patient Education and Counseling*, 55, 3–15.
- Dennis, L. C. (2003). Peer support within a health care context: A concept analysis. *International Journal of Nursing Studies*, 40, 321–332.

- Dunn, J., Steginga, S. K., Occhipinti, S. & Wilson, K. (1999). Evaluation of a peer support program for women with breast cancer – lessons for practitioners. *Journal of Community and Applied Social Psychology*, 9, 13–22.
- Elo, S. & Kyngäs, H. (2008). The qualitative content analysis process. *Journal of Advanced Nursing*, 62, 107–115.
- Giese-Davis, J., Bliss-Isberg, C., Carson, C., Star, P., Donaahy, J., Cordova, M. J. *et al.* (2006). The effect of peer counseling on quality of life following diagnosis of breast cancer: An observational study. *Psychooncology*, 15, 1014–1022.
- Heisler, M. (2009). Different models to mobilize peer support to improve diabetes self-management and clinical outcomes: Evidence, logistics, evaluation considerations and needs for future research. *Family Practice*, 27, i23–i32.
- Hoey, M. L., Ieropoli, C. S., White, M. V. & Jefford, M. (2008). Systematic review of peer support program for people with cancer. *Patient Education and Counseling*, 70, 315–337.
- Hughes, J., Wood, E. & Smith, G. (2009). Exploring kidney patients' experiences of receiving individual peer support. *Health Expectations*, 12, 396–406.
- Klemm, P., Reppert, K. & Visich, L. (1998). A nontraditional cancer support group: The internet. *Computers in Nursing*, 16, 31–39.
- Komatsu, Y. (2009). The role of patients as peer supporters. *The Japanese Journal of Clinical Dialysis*, 25, 69–74 (in Japanese).
- Kubo, H. & Ishikawa, T. (2001). *The theory and development of the self-help group*. Tokyo: Chuohoki Publishing Co. Ltd (in Japanese).
- Lincoln, Y. S. & Guba, E. G. (1985). *Naturalistic inquiry*. Newbury Park, CA: Sage.
- McGovern, R. J., Heyman, E. N. & Resnick, M. I. (2002). An examination of coping style and quality of life of cancer patients who attend a prostate cancer support group. *Journal of Psychosocial Oncology*, 20, 57–68.
- Macvean, M. L., White, V. M. & Sanson-Fisher, R. (2008). One-to-one volunteer support programs for people with cancer: A review of the literature. *Patient Education and Counseling*, 70, 10–24.
- Ministry of Health, Labour and Welfare. (2012). National basic plan for promoting measures to cope with cancer. [Cited 8 Dec 2014.] Available from URL: http://www.mhlw.go.jp/bunya/kenkou/dl/gan_keikaku02.pdf (in Japanese).
- Money, N., Moore, M., Brown, D., Kasper, K., Roeder, J., Bartone, P. *et al.* (2011). Best practices identified for peer support programs. [Cited 30 Apr 2015.] Available from URL: <http://www.dcoe.mil/content/Navigation/Documents/>
- Ohno, H. (2011). Interpretation of the current status and issues in cancer peer support. *The Japanese Journal of Clinical Nursing*, 37, 1246–1249 (in Japanese).
- Ono, M., Takayama, T., Kusano, E. & Kawata, C. (2007). Peer support among patients and its relationship with mental health—survey on the ostomates. *Journal of Japan Academy of Nursing Science*, 27, 23–32 (in Japanese with English abstract).
- Osaka, W., Yagasaki, K., Kanamori, A., Tamahashi, Y., Kanai, H., Wagatsuma, S. *et al.* (2011). Report of peer support service “St. Luke’s Smile Community” for breast cancer patients: Implementation through a collaborative partnership with breast cancer survivor volunteers and medical professionals. *The Bulletin of St. Luke’s International University*, 37, 36–41 (in Japanese with English abstract).
- Rinehate, M. R. (1994). The Reach to Recovery program. *Cancer Supplement*, 74, 372–375.
- Rossiter, S., Thompson, N. J., Hollander, M. & Matthews, B. (2001). Investigation of healthcare providers’ patterns of referring breast cancer patients to Reach to Recovery. *Cancer Practice*, 9, S49–S55.
- Rudy, R. R., Rosenfield, L. B., Galassi, J. P., Parker, J. & Schanberg, R. (2001). Participants’ perceptions of peer-helper, telephone-based social support intervention for melanoma patients. *Health Community*, 13, 285–305.
- Sakiyama, M. (1996). About the ostomy visitor – Why the ostomy visitor promotes one’s social reintegration. *Journal of Digestive Organ Care*, 1, 49–57 (in Japanese).
- Salzer, M. S., Schwenk, E. & Brusilovskiy, E. (2010). Certified peer specialist roles and activities: Results from a national survey. *Psychiatric Services*, 61, 520–523.
- Sato, F. (2001). Influence of patients suffering from breast cancer on the preoperative decision-making of other patients with breast cancer. *Journal of the Japan Academy for Health Behavioral Science*, 16, 191–210 (in Japanese).
- Schwenk, E. B., Brusilovskiy, E. & Salzer, M. S. (2009). *Results from a national survey of certified peer specialist job titles and job descriptions: Evidence of a versatile behavioral health workforce*. Philadelphia, PA: The University of Pennsylvania Collaborative on Community Integration.
- Simoni, J. M., Franks, J. C., Lehavot, K. & Yard, S. S. (2011). Peer interventions to promote health: conceptual consideration. *American Journal of Orthopsychiatry*, 81, 351–359.
- Skea, Z. C., MacLennan, S. J., Entwistle, V. A. & N’Dow, J. (2011). Enabling mutual helping? Examining variable needs for facilitated peer support. *Patient Education and Counseling*, 85, e120–e125.
- Sutton, B. L. & Erlen, A. J. (2006). Effect of mutual dyad support on quality of life in women with breast cancer. *Cancer Nursing*, 29, 488–498.
- Weber, B. A., Roberts, B. L., Resnick, M., Deimling, G., Zauszniewski, J. A., Musil, C. *et al.* (2004). The effect of dyadic intervention on self-efficacy, social support, and depression for men with prostate cancer. *Psychooncology*, 13, 47–60.