



Sinead Power, MSc, BSc, RGN, PGCertTLHE,
PGDipTLHE

Josephine Hegarty, PhD, MSc, RNT, BSc, RGN

Facilitated Peer Support in Breast Cancer

A Pre- and Post-Program Evaluation of Women's Expectations and Experiences of a Facilitated Peer Support Program

KEY WORDS

Breast cancer

Facilitated face-to-face
peer support programs

Peer support

Preprogram and
postprogram evaluation

Background: Peer support programs are associated with the provision of emotional, informational, and appraisal support. The benefits of peer support for women with breast cancer include reduced social isolation, enhanced coping, and access to information. **Objective:** The aim of this study was to conduct a pre- and post-program evaluation of a 7-week facilitated breast cancer peer support program in a cancer support house. **Methods:** Women with primary breast cancer (n = 8) participated in pre- and post-program focus groups. The interviews were recorded and were transcribed verbatim by the researcher. The data were analyzed using content analysis. Eight themes were identified. **Results:** The key themes emerging from the pre and post programme focus groups included: The need for mutual identification; Post-treatment isolation; Help with moving on; The impact of hair loss; Consolidation of information; Enablement/empowerment; The importance of the cancer survivor; Mutual sharing. **Conclusion:** It is essential that facilitated peer support programs are tailored to meet the support needs of women with breast cancer. There is a particular need to facilitate mutual sharing and support for hair loss within these programs. **Implications for Practice:** Implications for practice emerging from this study include the importance of pre- and post-program evaluations in identifying whether peer support programs meet the expectations of women with breast cancer, the need for peer/professional programs to support women with treatment-induced hair loss, the importance of including cancer survivors in support programs, and the need to allow more informal sharing to occur in facilitated peer support programs.

Authors' Affiliation: Catherine McCauley School of Nursing and Midwifery University College, Cork, Ireland.

Corresponding author: Sinead Power, MSc, BSc, RGN, PGCertTLHE, PGDipTLHE, Catherine McCauley School of Nursing and Midwifery University College Cork, Brookfield Health Sciences Complex, College Road Cork, Republic of Ireland (sinead.power@ucc.ie).

Accepted for publication August 2, 2009.

Breast cancer now affects 1 in 16 women in Europe.¹ Patients with breast cancer experience physical, psychological, and social effects. These include nausea and vomiting, fatigue, altered body image, social isolation, depression, and disruption to family relationships.²⁻⁶ Since their inception in the 1940s,⁷ peer support programs in cancer have been effective in alleviating many of the physical and psychosocial effects of breast cancer.^{8,9} In an effort to identify the support needs of patients with cancer, national and international cancer agencies and those involved in the day-to-day care of individuals with cancer have identified research into the psychosocial well-being and supports for patients with cancer as priority areas.¹⁰⁻¹⁵ The purpose of this study was to explore women's expectations, motivations, and experiences of participating in a facilitated face-to-face breast cancer peer support program.

■ Review of the Literature

Peer support programs constitute the provision of emotional, informational, and appraisal support to individuals.^{16,17} Findings from empirical studies within the literature suggest that women who have a strong support network cope better with a diagnosis of breast cancer and have better psychological adjustment.¹⁸⁻²⁰ In the context of breast cancer, peer support programs have inherent benefits for patients. These benefits include enhanced emotional well-being, self-efficacy, feelings of empowerment, and enhanced knowledge.²¹⁻²³ Peer support programs in breast cancer may be delivered in numerous different formats. These may be one-to-one or facilitated face-to-face group programs.^{9,21} Furthermore, these programs may be delivered online or via the telephone and may be facilitated by peers and/or healthcare professionals.²⁰⁻²⁴ The provision of peer support to individuals by cancer survivors in group or one-to-one format is of particular benefit to patients with breast cancer.^{21,25-28} The literature demonstrates the positive benefits of peer support programs for women with breast cancer regardless of how they are delivered. Despite the positive benefits of peer support programs for women with breast cancer, more formal evaluations of community-based peer support programs are required to assess their effectiveness in meeting the support needs of those who avail of them.⁹ While numerous studies have verified the positive benefits of peer support for women with breast cancer, relatively few researchers have conducted pre-evaluation and postevaluation of such programs to assess whether these programs are effective in meeting the support needs of participants.²⁸

■ Methods

This study used a qualitative descriptive design. The data were collected through focus groups. Focus groups involve a discussion between a small group of people under the guidance of a facilitator.^{29,30} This method of data collection was chosen as the most effective, efficient, and nonintrusive way of allowing and encouraging participants to express their

views on the facilitated peer support program. This method of data collection was also similar in format to the facilitated peer support program. The preprogram focus group in particular also allowed participants to get to know each other prior to attending the first day of the peer support program.

■ Participants and Procedure

Permission to conduct the study was granted by the local ethics committee. Women with breast cancer ($n = 8$) who had agreed to take part in a face-to-face peer support program in a local cancer support house were invited to participate in preprogram and postprogram focus group interviews. Written and verbal information on the study was provided by the researcher and the breast nurse counselor in a local cancer support house. Recruitment of participants took place in the first 2 weeks of January 2009. Having agreed to participate in the study, participants signed a consent form. Participants were assured that their anonymity would be maintained throughout the course of the study and for subsequent publications by the use of code numbers. All of those invited agreed to participate in the study. Participants ranged in age from 30 to 60 years. We considered participant's age to be important, as women of different ages may have had different support needs to each other. All participants had completed active treatment for primary breast cancer. The length of time that treatment had been completed ranged from 1 week to 14 months. We acknowledge that women may have different support needs at different stages posttreatment. However, the sample for this study was obtained using convenience sampling. Eight women who had agreed to participate in a facilitated peer support program were invited to participate in the study. Therefore, we had no control over the length of time that participants had finished treatment. The preprogram interview took place 2 weeks prior to the commencement of the facilitated peer support program. The postprogram interview took place 2 weeks following completion of the program.

Peer Support Program Details

The facilitated peer support program in this study was of 7-week duration. The program is run in a local cancer support house, which has been in operation since 2001. The day-to-day running of the house is dependent on voluntary contributions and fund-raising activities. The breast cancer support program is run 3 times per year and is offered to women with primary breast cancer who have completed active treatment. The overall aim of the program is to help women adjust to living with the physical and psychological effects associated with a diagnosis of breast cancer. The program in question was led by a breast cancer nurse counselor, a volunteer retired counselor, a trainee counselor, and a Reach to Recovery volunteer (a breast cancer survivor who has received training in providing peer support to individuals from the Irish Cancer Society). Two of the participants missed 1 week of the program, each due to family commitments. The objectives

of the program are to provide information on the effects of surgery, radiotherapy, and hormone treatment; to dispel the myths and misconceptions associated with breast cancer; and to offer a forum for women to recheck the information they have already received in hospital. Program participants met once weekly over the 7-week period for a 2.5-hour session. The program involved a combination of information sessions on practical issues such as hormone therapy and lymphedema. Informal sharing of experiences between participants was encouraged by the lead facilitator. There was also an opportunity for informal sharing between participants. This allowed them the opportunity to share their experiences of breast cancer with other participants. All of these sessions were facilitated by the breast cancer nurse counselor.

Data Collection

Preprogram and postprogram focus groups were the chosen method of data collection for this study. Each focus group meeting was recorded and was of 1-hour duration. The questions used in the preprogram and postprogram interviews are detailed in Table 1. A flip chart and field notes were used to assist in summarizing key points and to recap on key themes from participants. The flip chart and field notes were particularly useful in helping the researcher to validate the responses and key themes with participants on completion of each focus group.

Data Analysis

The focus group data were analyzed through the use of content analysis. Content analysis is concerned with the analysis of narratives and the identification of prominent themes.³¹ There is evidence within the literature to suggest that opinions vary in relation to the meaning, procedure, and interpretation of qualitative data through the use of content analysis.³¹ The interviews were transcribed verbatim by the researcher (S.P.). The transcribed interviews were read and reread by the researcher (S.P.) and the coresearcher (J.H.) to gain an understanding of the content. Second, the text was divided into codes, that is, a collection of words or statements relating to

the same central meaning.³² Third, the codes were then divided into subcategories and categories. The formation of categories is a core feature of qualitative content analysis.³⁰ Finally, the categories emerging from the analysis of the data were developed into themes. Eight themes emerged following the analysis of the preprogram and postprogram interviews.

Trustworthiness of the Study

Three criteria were used to ensure the trustworthiness of the qualitative data analysis procedure and resultant findings. These were credibility, dependability, and trustworthiness.^{33,34} Methods to ensure credibility, dependability, and trustworthiness in this study included the selection of a homogenous group of patients, that is, women with primary breast cancer; an interview guide was designed by the researcher for both preprogram and postprogram interviews to ensure consistency and the stability of data over time; a flip chart was used to verify participant's responses during and on completion of both focus group meetings; the process of data collection, data analysis, and a detailed presentation of the findings supported by exemplars from the participants were provided. The researcher (S.P.) who collected the preprogram and postprogram data was an independent person and did not take part in the peer support program.

Findings

Eight themes and 5 subthemes emerged following analysis of the preprogram and postprogram data. These themes and subthemes are provided in Table 2.

Preprogram Interview: Main Themes

THE NEED FOR MUTUAL IDENTIFICATION

When asked about their motivation for taking part in the program, all participants identified the need to identify with others in a similar situation.

 **Table 1 • Preprogram and Postprogram Focus Group Questions**

Preprogram	Postprogram
How did you find out about the support program?	Was the support group what you expected it to be?
What was your motivation for taking part in the support program?	How did the support group affect your life/lifestyle?
What are your expectations of the program?	Did you feel that the program was long enough?
How do you think the support program will help you?	The format of the program (meeting on set dates and facilitation by a professional)—did this suit your needs?
Why did you choose face-to-face group support?	Is there anything you would like more of/less of in the program?
	Did you find that that the content of the program was appropriate for your needs?
	Would you recommend participation in the support group to other women with breast cancer?
	What does the word "peer support" mean to you having been through the program?
	Some of you mentioned in the previous interview the need for support around hair loss. What are your views on this? That is, when, how, and by whom should this be delivered?

Table 2 • Main Themes Identified in Preprogram and Postprogram Evaluation

Preprogram Evaluation	Postprogram Evaluation
The need for mutual identification	Consolidation of information
Posttreatment isolation	Empowerment
Help with moving on	The importance of the cancer survivor
Support for hair loss	Mutual sharing

To meet people that would have been exactly the same as myself... and to see what they felt about it... I don't think I've met anybody my age yet who has had breast cancer or anything like that... so I just want to know that their experiences were, so that I can put my own experiences into some sort of order and to find out if they were different or the same... how they felt. (P.3)

This participant hoped that her attendance at the program would help her to reinterpret her breast cancer experience based on listening to the voices of other women with breast cancer in the group.

I think there's no one really who completely understands what you're going through better than someone who has been through it and to get together with other people who have been through the same experience... although I've got really good friends who have been very supportive... I think it will be really good... (P.5)

For this participant, meeting women who had been through the same experience as herself was important, despite the fact that her friends had been very supportive of her.

POSTTREATMENT ISOLATION

Participants identified the feelings of isolation associated with the completion of treatment. All of the participants stated that support from healthcare professionals and family members diminished as soon as treatment was completed. Participants felt that they continued to need support even following completion of treatment. They felt that the peer support program would help to address this void in the posttreatment phase.

I just felt that while I was having the chemo, I was in contact with people in the hospital then I had radiotherapy and then suddenly... you're on your own. You know. I just felt... there was no one there. People were saying to me, "Oh you're looking great, you're grand now, it's all over," but I'd say, "Oh yeah it is." I'd drive myself crazy then saying... is it meant to be all over? ...I feel like it's only starting... 'cos all the drama is over! You know, so that's why... (P.5)

The exemplars above demonstrate the fact that participants received ample support from healthcare professionals, family, and friends during the active treatment phase. However, it is clear that this support abates once treatment is completed. This suggests that patients need support in the posttreatment phase.

HELP WITH MOVING ON AND GETTING BACK TO NORMAL

All of the participants in this study had completed active treatment for primary breast cancer. The treatment was identified by all participants as a particular phase of their cancer journey. Now that the treatment was completed, participants were concerned with moving onto the next stage and getting back to normal life again. All participants expressed their hopes that the peer support program would in some way assist them in moving on and returning to normality.

I am hoping that it will give me strength to just get back, I was good up to now, up until the mammogram I am back now to square one, I want to just get back... to where I was. (P.4)

Just to be normal again... yeah, I suppose to feel the way I was before I got the breast cancer. (P.7)

It is apparent from the exemplars above that now that treatment was completed, participants were hoping to return to their normal lives. They were hopeful that participating in the peer support program would help them to achieve this return to normality.

SUPPORT FOR HAIR LOSS

While the questions in the preprogram interview did not focus on the effect of treatment-induced hair loss, the impact of hair loss and the need for support for treatment-induced hair loss emerged as a significant theme within the preprogram focus group. Six of the 8 participants in the preprogram focus group had experienced chemotherapy-induced hair loss. It is evident from the following exemplars that treatment-induced hair loss had a significant impact on participants and their loved ones:

I can't say that losing the breast affected me... because there were other issues going on at the time. I think my hair was worse. I think that's more visible you know... it's more in your face, and you're just like "Oh my God...YEUCH!" (laughs) (pause) ...It's like, oh here comes the cancer patient! (P.3)

...the children. I'd say to them, "If you're friends are coming up, let me know in advance..." I don't want a house full of teenagers and me with no hair on! ...They're very good like that... they'd say, "Get your hair on; my friends are outside." I could have the dressing gown on me, but I'd have to have the hair.... So for them as much as you to have it? (P.8)

A discussion then ensued regarding the way in which hair loss was addressed by healthcare professionals. It is apparent from the following exemplars that hair loss was addressed briefly by healthcare professionals and with little awareness of the potential impact of treatment-induced hair loss on women with breast cancer:

Just a little bit more thought about it, I mean [referring to healthcare professional] said to me, "You'll have to have chemo, and you'll lose your hair." That was that...

there was no more about it... until it started falling out. I asked him when, and he just said, "Just after your second session. (P.3)

There was a suggestion from the group that more support is needed around the issue of treatment-induced hair loss. Participants suggested that a hospital-based support intervention combining support on hair loss from peers and health-care professionals would be beneficial. It was also suggested that this intervention would be most effective prior to the onset of hair loss.

I think with the hair. Yes... I think there is really a need for somebody to be involved when you lose your hair... It [is] growing back... and just dealing with it. At the hospital maybe, because at the time I feel. You know, you're in shock... you don't feel up to going places... It should be something that's brought to you in the hospital... I feel that there is a big gap there you know... for hair loss. (P.8)

A volunteer would do... I'd do it myself... If a nutritionist can come to you while you are on your chemo... I can't see why they can't have someone to come and talk to you about how traumatic hair loss is for a woman... (P.7)

As "support for hair loss" emerged as a significant theme within the preprogram interview, participants were again asked to clarify issues around this area in the postprogram interview. It is apparent from their responses that the practical and emotional support provided for hair loss is minimal and that there is an immediate need for a hospital-based peer/professional support intervention prior to the onset of hair loss.

One of the first thing I would love to do is go to the hospital... talk to the women who are having treatment... talk to them about hair loss... You know... just do what we did in the group... They gave you the leaflet and that was it. (P.4)

As well as the emotional side, there are practical things... like how to tie the scarf on your head... there is nothing... (P.2)

There are lots of people in the hospital who come and talk to you—chaplains, pastoral care, etc... There needs to be someone who knows what you are going through... from the first time the drip goes into you... that's when it needs to start... for women... the hair it's everything... you are stripped without your hair. (P.3)

The exemplar above from participant 3 demonstrates the significance of treatment-induced hair loss for women. The statement, "You are stripped without your hair," suggests that the loss of hair is in some way associated with an assault on one's person.

Postprogram Interview: Main Themes

CONSOLIDATION OF INFORMATION

For all of the participants, the peer support program allowed them to consolidate the information that they had been given

on their cancer since diagnosis. The following exemplars demonstrate the fact that participants felt that the information they received on their cancer was fragmented:

You know I found by being in the group that there were major gaps in the information people were given... you know I was told one thing, and XXX would be told another... yeah... gaps in information. The group... it filled in a lot of the gaps. (P.2)

It's like a jigsaw... you know you go to the support group and everything comes together... the penny drops! (P.4)

While the structured format of the group served to fulfill participants' need to consolidate the information they had received regarding their cancer, the informal sharing of information between participants was also highly valued by all participants.

A lot of things came together for me... and a lot of it happened when we were just having the coffee. (P.1)

It is clear from the previous exemplars that participants valued the structured component of the program in helping them to consolidate the information they had received on their breast cancer. However, the previous exemplar demonstrates the fact that the informal sharing of information was also valued by participants.

EMPOWERMENT

All participants felt that having attended the group, they felt more capable of making definite decisions for themselves in relation to issues such as returning to work, choosing what they wanted, and discussing their needs around breast reconstruction. These feelings of empowerment are demonstrated in the following exemplars:

Well, it took me 11 months to get there! ...It took a lot of thought, but once I got there... just talking to the others... I felt like a wimp... You know 12 months on and not being with others... But now... it's given me the courage... Now I am going back in June... It's done that for me help me get back to where I felt normal again. (P.5)

I have got great encouragement and I have changed... certain things that I wanted to do and now I am going to do them. I hate my scar... I really want to get something done with it... up to now I felt I couldn't go about it... but now, after the group... and by talking to others, I feel that I will go and get it [it] sorted. I have an appointment with (plastic surgeon) on the 14th April. (P.2)

It is clear from the previous exemplars that taking part in the program had a powerful effect on participants' ability to make important decisions in their lives.

THE IMPORTANCE OF THE CANCER SURVIVOR

One of the facilitators in the program was a Reach to Recovery volunteer (a breast cancer survivor who had the first diagnosis of breast cancer 18 years ago). It is apparent from

the following exemplars that this individual had a significant impact on participants. Her involvement in the group helped participants to cope better with their diagnosis on a daily basis:

It was important that she was there... you know... even what she said about keeping the bit of mystery there about yourself... that for me was important... You know she wasn't the ordinary Joe Soap... she just knew what we had been through... I often think of her you know... even when I meet someone in town... I'll tell them only what I want to tell them... keep my business to myself you know. (P.7)

The previous exemplar demonstrates that the presence of the Reach to Recovery volunteer in the group had a significant impact on participant 7.

When I get these thoughts about it coming back, I think of her... you know I think of her. (P.6)

Participants felt that the cancer survivor provided them with a sense of hope regarding the future.

The examples provided previously demonstrate the benefits of including a cancer survivor in the program. Not only did this individual enable participants to cope with their diagnosis on a daily basis, but she also provided them with hope regarding the future.

MUTUAL SHARING

The program in question was a 7-week facilitated peer support program. All participants felt that they would have benefited if the program was of a longer duration (approximately 10 weeks). When questioned on their reasons for wanting a program of longer duration, all participants identified the fact that they would have liked more opportunities for mutual sharing of experiences between each other.

I would have liked a session where we could just chat... just chat... you know, over our coffee, we learnt a lot... We really learnt an awful lot. (P.8)

Definitely 1 or 2 classes of nonstructured stuff... We wanted more time together. (P.5)

The previous exemplars demonstrate the fact that mutual sharing and identification were highly valued by all participants. While the participants considered the facilitation of the program important, all expressed the feeling that the provision of more opportunities for mutual sharing and "chatting" would have benefited them greatly, particularly as they got to know each other better.

■ Discussion

In a concept analysis of peer support within a healthcare context,¹⁶ 3 key attributes of peer support were identified. These were emotional, informational, and appraisal support.

The findings of this study support the presence of these 3 attributes in facilitated face-to-face peer support programs

for women with breast cancer. In relation to emotional and appraisal support, all of the participants in this study benefited from the mutual sharing of experiences, mutual identification, and understanding that occurred within the program. All participants would have welcomed more time to engage in "informal chatting" with each other. To further support this finding, the values of mutual sharing, mutual identification, and understanding have been identified as key findings within previous studies on peer support programs in breast cancer.^{24,35}

In relation to informational support, the informational component of the program was highly valued by all participants and played an important role consolidating the information participants had received since diagnosis. This finding is supported within the findings of previous studies.^{9,36} It is also apparent that participation in the program enabled women to make definite decisions regarding important issues in their lives. This finding concurs with the findings of previous studies where participation in peer support programs instilled confidence in individuals with cancer.^{23,24}

This study also demonstrates the importance of including a cancer survivor (Reach to Recovery volunteer) in facilitated peer support programs for women with breast cancer. The Reach to Recovery Program is an international one-to-one peer support program that was initiated in the United States in the 1950s by Teresa Lasser.³⁷ There is evidence in the literature to support the value of including an individual who has survived a diagnosis of breast cancer in facilitated peer support programs for women with breast cancer.^{21,25-27} The inclusion of the Reach to Recovery volunteer in the facilitated peer support program in this study was instrumental in providing participants with the necessary skills needed to cope with the day-to-day problems associated with a diagnosis of breast cancer. The volunteer also provided participants with hope for the future.

Following analysis of the preprogram and postprogram data, the need for support in relation to treatment-induced hair loss was identified and has emerged as a major theme within the findings of this study. While chemotherapy-induced alopecia is a significant concern for women with breast cancer,^{6,38} we are unaware of the presence of this finding within previous studies on peer support programs for women with breast cancer. This finding suggests that support for treatment-induced hair loss is an unmet need for women with breast cancer. The findings from our study also demonstrate that little attention and sensitivity were paid to addressing the practical and emotional aspects of treatment-induced hair loss by healthcare professionals. This finding concurs with the findings of previous studies.^{6,39,40} Participants believed that support for hair loss would be most appropriate if provided in the hospital setting prior to the onset of hair loss by both professionals and peers.

A search of the Internet demonstrated that there are numerous informal systems of support available for all types of hair loss.⁴¹⁻⁴⁴ The majority of these are locally run groups facilitated by volunteers, and there is also evidence of some online support groups.^{43,44} We are aware of a program facilitated

by cancer survivors that provides practical and informational support to women who have been affected by chemotherapy-induced hair loss.⁴⁵ While this program is commendable, the findings from our study demonstrate that programs focusing on the provision of practical and emotional support need to be made widely available to women in an effort to address their unmet support needs pertaining to treatment-induced hair loss. Cancer survivors and professionals already involved in the provision of services to individuals with treatment-induced hair loss may be ideally positioned to become involved in providing the necessary support for treatment-induced hair loss within the hospital setting.

Implications for Research and Practice

The findings of this study have many implications for health-care professionals and those involved in the planning and implementation of peer support programs.

This study was concerned with the pre-evaluation and post-evaluation of a face-to-face peer support program for women with breast cancer. The preprogram and postprogram evaluation component of this study was important, as it helped to identify the needs of women prior to their participation in the program. It also served to assess whether the needs of participants identified in the preprogram focus group interview were met by their participation in the 7-week peer support program. In recent years, numerous studies have been carried out exploring the benefits of participating in peer support programs for women with breast cancer. Few of these studies have focused on the pre-evaluation and postevaluation of these programs. For example, in a systematic review of 43 peer support programs,²⁸ only 11 of the studies included involved a preprogram and postprogram evaluation. There is a need for future preprogram and postprogram evaluations to identify whether peer support programs are adequate in meeting the specific needs of women with breast cancer.

The mutual sharing and identification that naturally occurred within the group were highly valued by all participants. This finding suggests that those involved in the planning and implementation of peer support programs need to structure programs so that there is adequate time for mutual sharing to occur between participants.

All participants valued the informational aspect of the program. This finding suggests that program developers cannot underestimate the value of the informational components of facilitated peer support programs in addressing the gaps that exist in health-related information for women with breast cancer.

It is evident from the findings of this study that participants believed that support for hair loss would be most effective if provided prior to the onset of hair loss. This finding has implications for healthcare professionals and suggests that interventions to address the practical and emotional aspects of hair loss need to be implemented in the hospital setting prior to the onset of hair loss.

In the postprogram focus group, all of the participants spoke of the importance of the cancer survivor (Reach to Recovery

volunteer) within the facilitated peer support program. Given the positive impact of the cancer survivor on participants in this study, those involved in the planning of facilitated peer support programs should consider the inclusion of a cancer survivor in such programs where possible.

Limitations of the Study

This study involved the collection of data by means of preprogram and postprogram focus groups. The focus groups were confined to women with breast cancer who had agreed to take part in a face-to-face facilitated peer support program in a local cancer support house. Because of the relatively small number of participants ($n = 8$) and the fact that the study was confined to 1 cancer support house, the findings may not be transferable to other settings or programs. The fact that participants had completed their treatment at different stages (1 week to 14 months) is a limitation of this study. We acknowledge that women with breast cancer may have different support needs at different stages following treatment.

Conclusion

In conclusion, the findings from this study demonstrate the value of preprogram and postprogram evaluations in identifying whether facilitated peer support programs are effective in meeting the needs of women with breast cancer. The findings demonstrate that facilitated face-to-face peer support programs incorporating cancer survivors are effective in helping patients adjust to a diagnosis of breast cancer. There is also a need for more informal sharing between participants in facilitated peer support programs. The findings also demonstrate the fact that women with breast cancer have unmet needs in relation to treatment-induced hair loss. There is clearly a need for practical and emotional support for women with breast cancer prior to the onset of hair loss.

ACKNOWLEDGMENTS

The authors thank the following people without whom this study would not have been possible: the 8 women who gave freely of their time to take part in the pre- and post-focus group interviews; the staff and volunteers ARC House Cork, Ireland, particularly, Ellen, Fiona, Marie, and Ann; Prof Joyce Fitzpatrick (Fulbright professor) at the Catherine McCauley School of Nursing and Midwifery, Brookfield Health Sciences Complex, College Road, Cork, for her expert advice; and fellow colleagues and members of the Irish Cancer Society (Steering Group Committee on building effective cancer support groups for Ireland) for their encouragement to date.

References

1. World Health Organization Regional Office for Europe Reproductive Health and Research 2008. http://www.euro.who.int/reproductivehealth/areas/20071101_6. Accessed May 7, 2009.

2. Boehmke MM, Dickerson SS. Symptom, symptom experiences and symptom distress encountered by women with breast cancer undergoing current treatment modalities. *Cancer Nurs*. 2005;28(5):382–389.
3. Hoga L, Mello D, Dias A. Psychosocial perspectives of the partners of breast cancer patients treated with a mastectomy: an analysis of personal narratives. *Cancer Nurs*. 2008;31(4):318–325.
4. Harrow A, Wells M, Barbour RS, Cable S. Ambiguity and uncertainty: the ongoing concerns of male partners of women treated for breast cancer. *Eur J Oncol Nurs*. 2008;12(4):349–356.
5. Von A, Kang D. Correlates of mood disturbance in women with breast cancer: patterns over time. *J Adv Nurs*. 2008;61(6):676–689.
6. Power S, Condon C. Chemotherapy-induced alopecia: a phenomenological study. *Cancer Nurs Pract*. 2008;7(7):44–47.
7. Holland J, Rowland J. *Handbook of Psycho-oncology*. Oxford, UK: Oxford University Press; 1990.
8. Rankin N, Williams P, Davis C, Girgis A. The use and acceptability of a one to one peer support program for Australian women with early breast cancer. *Patient Educ Counsel*. 2004;53:141–146.
9. Zeigler L, Smith PA, Fawcett J. Breast cancer: evaluation of the Common Journey Breast Cancer Support Group. *J Clin Nurs*. 2004;13:467–478.
10. Ropka ME, Guterbock TM, Krebs LU, et al. Oncology nursing society research priority survey year 2000. *Oncol Nurs Forum*. 2002;29(3):481–491.
11. Lee E-H, Kim J-S, Chung BY, et al. Research priorities of Korean oncology nurses. *Cancer Nurs*. 2003;26(5):387–391.
12. McIlfatrick S, Keeney S. Identifying cancer nursing research priorities using the Delphi technique. *J Adv Nurs*. 2003;42(6):629–636.
13. Cancer Research UK grants and research. <http://science.cancerresearchuk.org>. Accessed May 1, 2009.
14. A Strategy for cancer control in Ireland. *Government of Ireland: The Stationery Office Dublin*. Dublin: The Stationery Office; 2006.
15. Murphy A, Cowman S. Research priorities of oncology nurses in the Republic of Ireland. *Cancer Nurs*. 2006;29(4):283–290.
16. Dennis C-L. Peer support within a healthcare context: a concept analysis. *Int J Nurs Stud*. 2003;40:321–332.
17. Zeigler L, Smith P, Fawcett J. Breast cancer: evaluation of the Common Journey Breast Cancer Support Group. *J Clin Nurs*. 2004;13:467–478.
18. Lewis J, Manne S, DuHamel K, et al. Social support, intrusive thoughts and quality of life in breast cancer survivors. *J Behav Med*. 2001;24(3):231–245.
19. Koopman C, Angeil K, Turner-Cobb J, et al. Psychosocial intervention for rural women with breast cancer. *Breast J*. 2001;7(1):25–33.
20. Kornblith A, Herndon J, Zuckerman E, et al. Social support as a buffer to the psychological impact of stressful life events in women with breast cancer. *Cancer*. 2001;91(2):443–454.
21. Giese-Davis J, Bliss-Isberg C, Carson K, et al. The effect of peer counseling on quality of life following diagnosis of breast cancer: an observational study. *Psychooncology*. 2006;15:1014–1022.
22. Rankin N, Williams P, Davis C, Girgis A. the use and acceptability of a one-on one peer support programme for Australian women with early breast cancer. *Patient Educ Counsel*. 2004;53:141–146.
23. Solberg S, Church J, Curran V. Experiences of rural women with breast cancer receiving social support via audio teleconferencing. *J Telemed Telecare*. 2003;9:282–287.
24. Reed L. A lifeline for women with breast cancer? *Eur J Palliat Care*. 2004;11:246–247.
25. Wilson PM. The UK expert patients program: lessons learned and implications for cancer survivors' self care support programs. *J Cancer Survivorship*. 2008;2:45–52.
26. Rini C. Peer mentoring and survivors' stories for cancer patients: positive effects and some cautionary notes. *J Clin Oncol*. 2007;25(1):163–166.
27. Sutton LB, Erlen JA. Effects of mutual support on quality of life in women with breast cancer. *Cancer Nurs*. 2006;29:488–498.
28. Hoey L, Ieropoli S, White V, Jefford M. Systematic review of peer-support programs for people with cancer. *Patient Educ Counsel*. 2008;70:315–337. doi:10.1016/j.pec.2007.11.016.
29. Clark J, Maben S, Jones K. The use of focus group interviews in nursing research: issues and challenges. *J Res Nurs*. 1996;1:143–155.
30. Polit D, Hungler B. *Nursing Research: Principles and Methods*. London, UK: Lippincott; 2006.
31. Graneheim U, Lundman B. Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Educ Today*. 2004;24:105–112.
32. Krippendorff K. *Content Analysis. An introduction to Its Methodology*. London, UK: Sage Commtext Series, Sage Publications; 1980.
33. Guba E. Annual review paper; criteria for assessing the trustworthiness of naturalistic inquiries. *Educ Commun Technol J Theory Res Dev*. 1981;29(2):75–91.
34. Lincoln YS, Guba EG. *Naturalistic Inquiry*. Newbury Park, London: Sage Publications; 1985.
35. Hoybye MT, Johansen T, Tjornhoj-Thomsen T. On-line interaction. Effects of story telling in an Internet breast cancer support group. *Psychooncology*. 2005;14:211–220.
36. Rudy RR, Rosenfeld LB, Galassi JP, Parker J, Schanberg R. Participants' perceptions of peer-helper telephone based social support interventions for melanoma patients. *Health Commun*. 2001;13:285–305.
37. American Cancer Society: Reach to Recovery http://www.cancer.org/docroot/ESN/content/ESN_3_1x_Reach_to_Recovery_5.asp?s. Accessed May 7, 2009.
38. Lemieux J, Maunsell E, Provencher L. Chemotherapy-induced alopecia and effects on quality of life among women with breast cancer: a literature review. *Psychooncology*. 2008;17:317–328.
39. Mulders M, Vingerhoets AD, Breed W. The impact of cancer and chemotherapy: perceptual similarities and differences between cancer patients, nurses and physicians. *Eur J Oncol Nurs*. 2008;12:97–102.
40. Hesketh P, Batchelor D, Golant M, Lyman G, Rhodes N, Yardley D. Chemotherapy induced alopecia: psychosocial impact and therapeutic approaches. *Support Care Cancer*. 2004;12:543–549.
41. Alopecia awareness: support groups. <http://www.alopeciaawareness.org.uk/support/>. Accessed May 8, 2009.
42. Alopecia and cancer support group. Hair loss. <http://orangecounty.craigslis.org/bts/1139740511.html>. Accessed May 8, 2009.
43. Alopecia and women's hair loss information and support. What really works? <http://www.heralopecia.com/>. Accessed May 8, 2009.
44. Hair loss—Alopecia Areata Support Forums. <http://www.mdjunction.com/forums/alopecia-areata-discussions/general-support/3116>. Accessed May 8, 2009.
45. Headstrong: breast cancer care—support and information for anyone affected by breast cancer. <http://www.breastcancercare.org.uk/server/show/nav.524>. Accessed June 15, 2009.