

The Use of Motivational Interviewing to Promote Peer-to-Peer Support for Cancer Survivors

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Motivational interviewing (MI) as a counseling approach has gained empirical support for its use in a number of settings and for a variety of behaviors. However, the majority of practitioners trained to use MI have been professionals rather than laypeople. This article presents the rationale, design, and evaluation of an MI-based training for cancer survivors and caregivers to deliver peer support. The training and evaluation of the peers ("guides") to encourage practice and increase research knowledge for using MI-based peer support models for cancer care are discussed. Thirteen cancer survivors and two caregivers received two-day DVD-based MI training, as well as supplemental monthly sessions for six months. The guides demonstrated MI proficiency as assessed by the MI Treatment Integrity scale and other process evaluation assessments. MI can be adapted to train laypeople to provide support for groups such as cancer survivors.

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With continued improvements in early detection and treatment of cancer, an increasing number of patients survive cancer. More than 12 million cancer survivors are living five or more years beyond initial diagnosis in the United States (Horner et al., 2009), creating unanswered questions about long-term psychological well-being, as well as impact on families and support systems.

Psychosocial problems related to cancer from diagnosis to post-treatment have been well documented. Studies have reported negative stressors to physical (Hewitt, Greenfield, & Stovall, 2006), psychological (Carlsen, Jensen, Jacobsen, Krasnik, & Johansen, 2005; Hegel et al., 2006; Hewitt et al., 2006; Spiegel & Giese-Davis, 2003), social, emotional, and spiritual or existential well-being (National Cancer Institute, 2004), as well as concerns about body image. In addition, management of treatment-associated long-term issues and late effects is required, along with ongoing surveillance and health promotion strategies (Hewitt et al., 2006).

In contrast to the escalating number of cancer survivors, projected limits in the medical and healthcare oncology workforce will affect the industry's ability to serve the sheer number of survivors (Oeffinger & McCabe, 2006; Shulman et al., 2009). Therefore, innovative solutions such as training laypeople to provide support should be explored.

Peer support in this study is provided by survivors who have experienced cancer personally or have been caregivers. Lay support has been used with breast cancer survivors (Ashbury, Cameron, Mercer, Fitch, & Nielsen, 1998; Curran & Church, 1999; Dunn, Steginga, Occhipinti, & Wilson, 1999; Dunn, Steginga, Rosoman, & Millichap, 2003; Edgar, Remmer, Rosberger, & Rapkin, 2003; Gray, Fitch, Davis, & Phillips, 1997) and has been found to improve satisfaction with medical care, personal relationships, and social support (Ashbury et al., 1998); increase a sense of belonging (Fernsler & Manchester, 1997; Gray et al., 1997); and improve mood (Dennis, 2003; Dunn et al., 1999). Peer support can provide survivors with information, coping skills, a sense of normalcy, and diminished social

isolation (Barlow, Burlingame, Nebeker, & Anderson, 2000; Campbell, Phaneuf, & Deane, 2004). Overall, studies report that patients appreciate experiential information, and former patients enjoy providing it (Rini et al., 2007). However, Rini et al. (2007) found that learning about experiences from fellow patients can be unhelpful or even harmful. Better outcomes might result from emphasizing the experience and needs of the person seeking support. Peer support techniques using motivational interviewing (MI) establish and maintain this focus (Miller & Rollnick, 1991).

MI is an interpersonal counseling approach that has been applied to a variety of chronic disease management and health promotion behaviors, such as healthy eating, smoking cessation, and HIV prevention (Miller & Rollnick, 1991, 2009). In MI, the role of the counselor is to establish a safe, nonconfrontational, and supportive climate to explore potential resources for coping. MI counselors rely heavily on reflective listening and positive affirmations, rather than on persuasion or advice giving.

The majority of applications of MI in clinical and other settings have been conducted by clinical professionals (Rubak, Sandbaek, Lauritzen, & Christensen, 2005). Few studies have used this approach with laypeople. This article reports on the development and implementation of an MI-based training program for cancer survivors and caregivers to provide support to other cancer survivors and caregivers.

Methods

Peer Connect is a patient-centered program developed as part of the University of North Carolina at Chapel Hill's LIVESTRONG® Survivorship Center of Excellence to help survivors cope with their cancer diagnosis, treatment, and life after treatment (Shapiro et al., 2009). The program connects post-treatment volunteer cancer survivors and caregivers ("guides") with those currently experiencing cancer-related issues and requesting support ("partners"). Cancer survivors and caregivers who wish to be guides to other survivors or caregivers are trained using a DVD and manual-based training program and matched to partners. The focus is patient centered: listening, reflecting, and avoiding unsolicited advice. Peer Connect trains volunteer guides in MI communication skills: asking open-ended questions, reflective listening, building motivation (e.g., importance, confidence, values clarification), moving toward change (e.g., overcoming barriers and matching resources with participant interests), summarizing, and goal setting. The program includes several modules specific to the needs of cancer survivors identified in LIVESTRONG's 2010 survey results (e.g., dealing with fear of recurrence) (Campbell et al., 2011). Guide and partner pairings are based on participant type (survivor or caregiver), gender, and race when possible. All conversations between guides and partners are initiated over the telephone, but may be extended to in-person conversations, depending on feasibility and desirability. Telephone communication allows access for survivors living in outlying areas, undergoing treatment, or with other medical problems that make travel difficult. The number and length of conversations is determined by each pair, but guides are encouraged to provide a minimum of two conversations. Support continues for as long as the partner

feels it is beneficial. For the current study, the program collaborated with Cornucopia Cancer Support Center, a nonprofit organization, to match guides in the Peer Connect program with partners coming to their facility to seek support services.

Setting and Participants

Guide recruitment took place from July 2010 to December 2010 through Cornucopia Cancer Support Center; flyers posted at area hospitals, clinics, libraries, and community organizations; and local cancer support group electronic mailing lists. Eligibility criteria for guides stipulated that participants be older than 18 years, English-speaking, and either at least one year post-treatment or experienced in caregiving for someone touched by cancer. The goal of the study was to assess whether guides could be trained to use MI-based communication skills successfully and maintain these skills with high MI fidelity during the intervention period of six months. All study procedures were approved by the University of North Carolina at Chapel Hill's institutional review board.

Training

Guides completed a two-day training (day 1 = six hours; day 2 = four hours) that included MI practice and feedback, as well as monthly 90-minute face-to-face supplemental sessions (Guide Gatherings) for six months. Guide Gatherings began one month after the initial two-day training to reinforce MI skills, provide additional practice, problem-solve issues with partners, receive feedback from guides about specific content needed in the trainings, and offer overall support. Training tools included a DVD and supplemental manuals based on previous research (e.g., National Cancer Institute Body and Soul [Campbell, Resnicow, Carr, Wang, & Williams, 2007], and MOVE Buddy! [Weiner, Haynes-Maslow, Kahwati, Kinsinger, & Campbell, 2012], developed for the United States Veterans Administration), as well as needs assessments completed by cancer survivors and caregivers and earlier peer counseling interventions the authors developed for health behavior change. All training sessions were conducted by the same research staff member. Table 1 shows MI skills taught and Table 2 shows training session topics.

Assessment Criteria

Training evaluation: A pre- and post-test and a debriefing session immediately after the training evaluated the guides' perceptions of the training and skills learned (confidence in using MI skills, scale ranged from 0 [not at all] to 10 [very confident]; usefulness of skills, scale ranged from 0 [not at all] to 10 [very useful]; quality of the training in techniques, four-point Likert-type scale ranging from strongly agree to strongly disagree). At pre- and post-test, guides were prompted to provide responses to two fictitious scenarios intended to gauge short-term learning and application of MI skills. For example, "You ask your partner: 'On a scale of 0-10, with 10 being very important and 0 not at all important, how important is it for you to manage your stress?' The partner's response: 'I would say around a 6.' What do you say next?" The debriefing session was designed to obtain feedback about the DVD training tool, format of the

TABLE 1. Core Skills of the Motivational Interviewing Technique

| Skills and Purpose | Example Responses | Goals of the Conversation: Intended Effect on the Partner |
|---|---|--|
| Open-ended questions encourage partners to <ul style="list-style-type: none"> • Think broadly and deeply about their situation. • Tell their story. • Elaborate on their own hopes, goals, desires, and motivation. • Develop their own plan for changes desired, support needed, and process for monitoring. • State their motivations explicitly. | What made you sign up for this program? What concerns you the most about your cancer diagnosis? What is your first step in talking to your coworkers about your diagnosis? What thoughts do you have about how things might be less stressful at this point? | Elaborate on their own personal reasons for seeking help. Articulate their strengths and confidence. Develop a plan that will be their own and is likely to succeed. State their intention to change. |
| Reflective listening allows guides to <ul style="list-style-type: none"> • Respond in an empathic, nonjudgmental, and supportive manner. • Reflect back to the partner what was heard and understood <ul style="list-style-type: none"> – Reflective responses can (a) validate their struggle, emotions, and concerns; (b) affirm their strengths, hope, and goals; and (c) reinforce their reasons, plans, and intentions for change and support. | Now that your treatment is completed, you're having a hard time adjusting to your new job. You're relieved that your treatment is completed but you're still worried each time you feel under the weather that the cancer has come back. You've already made changes since your diagnosis and you feel ready to think about other ways to help stay healthy. It's important to you to talk to your family and coworkers about your diagnosis so that you're less anxious about them being worried all the time and you plan to start making a list of how and who can help you at home and work. | Experience being heard and understood by the guide. Use the created safe environment to explore the change. See themselves from another perspective. Tap into their inner motivation for making changes and getting support. |
| Building motivation (importance, confidence, and values clarification) encourages partners to <ul style="list-style-type: none"> • Elaborate on their own hopes, goals, desires, and motivation. • Develop their own plan for changes desired, support needed, and process for monitoring. • State their motivations explicitly. | You mentioned that your family, being independent, and being a good mother are important to you. How might those things relate to continuing to stay healthy? How have you dealt with a difficult situation in the past? On the one hand, you say it is important to talk to your kids about your diagnosis, but on the other hand, you are not sure you are ready to do so. You seem fairly sure that this is the right time to join a support group; what has made you decide? | Articulate their strengths and confidence. Develop a plan that will be their own and is likely to succeed. State their intention to change. |
| Providing information, suggestions, and advice to the partner involves guides <ul style="list-style-type: none"> • Asking permission to share their opinion. • Offering information in a neutral tone; avoid using words like "you should" or "you must." • Prioritizing the information and giving only the most important. • Avoiding telling the partner what they already know. • Asking the partner about their thoughts on the information, suggestions, or advice. • Affirming the partner's choice to act or not to act on that information. | Would you mind if I share my thoughts about some things that might be appropriate in this case? Can I tell you what some other survivors have found helpful to them? As your provider, I think the most important thing in terms of managing your blood pressure is to find a way for you to take the medication regularly. What do think about that? What do you already know about cancer support groups? It seems like you have a pretty good idea about treatment options but you're unsure about which surgeons have a good reputation. Would you like some information about that? We've discussed three different options to help you manage your stress; what do you think might work for you? It is really up to you what you choose to start with. You are the only one who can know what will work in your life. | Not respond with resistance, which is normal when being told what to do. Willingly hear the information. Actively process information. Ask for more details, specifics, and follow-up. Determine the relevance of the information to their own life. Begin the process of choosing to act on the information. |

Note. Based on information from Miller & Rollnick, 1991.

training, and ease or difficulty of learning the content in the current format.

Motivational interviewing fidelity: To assess learning of MI skills by guides, the MI Treatment Integrity (MITI) scale (version 3.1.1) was used (Moyers, Martin, Manuel, Hendrickson, & Miller, 2005). Guides did a practice call with a research team member two to three weeks after the follow-up training, knowing the conversation would be a 10-minute realistic scenario on their own cancer type or, for caregivers, the cancer type of the person for which they cared. All practice calls were recorded and guides received written and verbal feedback. Two staff members coded the tapes using the MITI scale. The MITI scale is relevant for capturing practitioner (guide) attributes such as empathy and use of microskills (e.g., open questions, reflections). The MITI was an appropriate tool for this program because it is not intended to capture the overall practitioner competence and fidelity in using the more complex MI skills. The MITI consists of two components: global ratings and behavioral counts. Global ratings of the rater's judgment are measured on a seven-point Likert-type scale ranging from 1 (low) to 7 (high) for two items, empathy/understanding and spirit of MI, which are important MI components (Moyers, Martin, et al., 2005). Behavioral counts are tallies of interviewer behaviors (giving information, MI adherent, MI nonadherent, questions [closed and open], and reflection [simple and complex]).

Demographic variables: Information was collected on age, race or ethnicity, gender, cancer type, caregiving status, marital or partner status, and current occupation.

Results

Of the initial 20 volunteer guides who completed training, five dropped out (relocated [$n = 1$], no longer could afford the time commitment [$n = 3$], or lost interest [$n = 1$]). Participant characteristics for the remaining 15 guides are provided in Table 3.

Training Evaluation

Guides increased confidence (10-point scale) in using MI skills from 6.8 at pretest to 7.6 at post-test. Training was rated as highly useful by 97% of the guides (7 or higher on a 10-point scale). All agreed or strongly agreed that the training provided skills needed for peer support, and they evaluated the training and DVD positively. At post-test, 80% of guides were able to provide MI-appropriate responses for the two brief scenarios (i.e., using reflections and/or open questions). Responses provided at pretest included giving advice and/or making incorrect assumptions about the situation. Participants liked the diversity in race, gender, and

TABLE 2. Peer Connect Guides' Training Topics by Session

| Session | Topics ^a |
|---------------------------------|--|
| Day 1 | <ul style="list-style-type: none"> • Introduction and program overview • How Peer Connect works • Providing support and maintaining confidentiality • DVD part I: Communication skills <ul style="list-style-type: none"> – Open questions – Reflective listening and use of affirmations – Building motivation: Values, importance, and confidence – Summarizing |
| Day 2 | <ul style="list-style-type: none"> • Review of day 1 • Using the skills in a full conversation • DVD part II: A first conversation with partners <ul style="list-style-type: none"> – Sharing resources and other information – Making a referral for counseling – Handling requests for medical or other advice – Setting up the next call and continuing the partnership |
| 1–2 weeks post initial training | <ul style="list-style-type: none"> • Practice phone conversation and role play between guide and research assistant (tape-recorded) |
| Guide Gathering 1 | <p>The Nuts and Bolts of Making Calls: Building the Partnership <i>Setting up the next call and checking back in—DVD clip</i></p> <ul style="list-style-type: none"> • Exercise 1: Coding of bonus conversation—DVD clip <ul style="list-style-type: none"> – Guides code for open and closed questions, reflective listening, summary, giving advice, and other observations. • Exercise 2: Coding of guide's practice tape <ul style="list-style-type: none"> – Guides code for open and closed questions, reflective listening, summary, giving advice, and other observations. |
| Guide Gathering 2 | <p>How to Keep the Focus on Your Partner</p> <ul style="list-style-type: none"> • Follow-up conversation—DVD clip • Discussion of do's and don'ts when talking to your partner • Exercise: Guides pair up and practice a follow-up phone call. |
| Guide Gathering 3 | <p>How to Keep the Focus on Your Partner: Medical Decisions, Sexuality, and Religion</p> <ul style="list-style-type: none"> • Bonus conversation—DVD clip • Importance of understanding partner's values and needs • Exercise: Guides use values clarification exercise to understand how values influence the decisions and actions of partners. |
| Guide Gathering 4 | <p>Differences Between Palliative Care, Recurrence, and Metastatic Disease</p> <ul style="list-style-type: none"> • Palliative care presentation: Guest speaker • Information regarding palliative care and end of life • Exercise: Guides share concerns and problem-solve palliative care issues faced with current partners. |
| Guide Gathering 5 | <p>Dealing With Resistance and Denial</p> <ul style="list-style-type: none"> • Exercise 1: Rolling with resistance: How to work with partners who are ambivalent, unable to move forward, or having trouble making a decision • Exercise 2: Participants provide responses to possible scenarios of a partner resisting treatment. • Discussion of concerns dealing with resistance expressed by their partners |
| Guide Gathering 6 | <p>Dealing With Fear</p> <ul style="list-style-type: none"> • Group discussion and problem-solving session about addressing fears, vulnerabilities, and feeling alone from partner and guide points of view • Exercise: Responding to partner's fears <ul style="list-style-type: none"> – Guides provide mock responses to scenarios regarding what fearful partners might say during their cancer experience. |

^a Teaching materials provided in manuals, handouts, and role plays were included in each session.

TABLE 3. Sample Characteristics

| Characteristic | \bar{X} | SD |
|---|-----------|------|
| Age (years) | 57 | 12.3 |
| Characteristic | n | |
| Race | | |
| Caucasian | 11 | |
| African American | 3 | |
| Other | 1 | |
| Gender | | |
| Female | 10 | |
| Male | 5 | |
| Cancer type^a (N = 13) | | |
| Breast | 5 | |
| Prostate | 1 | |
| Colon | 1 | |
| Other | 6 | |
| Marital status | | |
| Married | 8 | |
| Divorced | 1 | |
| Single or never married | 3 | |
| Widowed | 2 | |
| Missing | 1 | |
| Employment status | | |
| Retired or semiretired | 8 | |
| Employed | 7 | |
| N = 15, unless otherwise noted | | |
| ^a Refers to the cancer survivors' status (excludes two caregivers) | | |

cancer type of the actors in the DVD, the progression of the skills taught, and that the actors in the DVD seemed like real people, yet professional. The DVD also was rated as easy to follow and user-friendly. Guides preferred the two-day training format, as it allowed them to feel more at ease and better prepared to be a guide. However, guides responded that reflective listening and affirmations were challenging to grasp and they would need more practice to master these skills.

Motivational Interviewing Treatment Integrity Scale Coding

To assess fidelity to MI principles, average scores for each of the dimensions of MITI coding (Moyers, Martin, Manuel, Miller, & Ernst, 2010) were calculated for the 15 guide interviews (see Table 4). The tapes were coded by two research team members and their scores were averaged. The range of possible scores for the MI dimensions of empathy (i.e., the extent to which the interviewer understands and/or makes an effort to grasp the client's perspective) and spirit (i.e., the overall competence of the interviewer in using MI, explicitly focusing on the three characteristics of evocation, collaboration, and autonomy) (Moyers, Miller, & Hendrickson, 2005) was 1–5, with higher scores indicating higher success. Guides' scores ranged from 3.5–4.7, with an average empathy score of 4.2 and an average spirit score of 4.1, indicating that their skills generally were high in MI integrity. Percent of questions that were open ranged from 23%–75%. Beginning proficiency is indicated by 50% or more, and 7 of the 15 guides achieved this level. Percent MI-adherent ranged from 44%–100%, where 90% is considered to be beginning proficiency. Percent com-

plex reflections are not reported here, as the training focused on the use of simple reflections.

Discussion

Because of advances in detection and treatment, more people are living longer after cancer diagnosis and treatment. Coping with the emotional and psychological impact of the disease is a critical part of survivorship. The current study describes the training of cancer survivors and caregivers to serve in a peer support program. Peer support is not a new approach, and has been used to help patients dealing with many chronic illnesses, as well as for health behavior promotion. Unique to the Peer Connect program is the training of layperson volunteers in using MI-based communication skills, a patient-centered approach that emphasizes problem-solving with partners rather than giving advice or focusing on the guide's own cancer journey. Although most MI-oriented programs are designed around changing a specific behavior (e.g., substance abuse), this program taught MI skills that were applicable to whatever issue the cancer survivor or caregiver wanted to discuss. In some ways, this nonspecific behavior focus allowed the investigators to teach the skills in the true spirit of MI, which is empathic and patient-centered.

The results of this program point out that, with supplemental training and ongoing supervision, volunteers can effectively be prepared to provide support to other cancer survivors. In this study, 15 guides (survivors and caregivers) representing a range of cancer types were trained, suggesting that the training was applicable and useful for multiple types of cancer. Post-test assessments and recorded practice sessions showed that guides were able to learn the MI skills. When compared to the recommended proficiency and competency thresholds (Glynn & Moyers, 2010), guides demonstrated MI proficiency in all categories (competency in some categories), with the exception of the percentage of MI adherence. Because of the brief nature of the practice calls, enough data may not have been captured to demonstrate that proficiency. However, variation in skill level would be expected at this point in training, particularly with a lay population.

After the initial two-day training, guides reported reflective listening as most challenging. Practice sessions during the monthly Guide Gatherings provided opportunities for guides to practice and receive feedback to improve competency. Although the training focused on teaching simple reflections, the use of complex reflections emerged during the training sessions. MI is not a simple counseling approach to master (Miller & Rollnick, 2009), and systematic post-training support and supervision can build MI competency and prevent decay of skills (Walters, Matson, Baer, & Ziedonis, 2005). Training using MI-based skills has been conducted primarily with professionals (e.g., physicians, nurses, dietitians), with few programs using lay peers (Crane-Okada, Freeman, Ross, Kiger, & Giuliano,

Exploration on the Go



For more information about the Peer Connect program discussed in this article, open a barcode scanner on your smartphone, take a photo of the code at left, and your phone will link automatically. Or, visit <http://carolinawell.org/connecting.do>.

TABLE 4. Motivational Interviewing (MI) Fidelity: Summary Scores for Guides

| Guide | Global Spirit Rating | Global Empathy Rating | Reflections-to-Questions Ratio | % Open Questions | % MI-Adherent |
|-------|----------------------|-----------------------|--------------------------------|------------------|---------------|
| 1 | 3.5 | 4 | 1:3 | 50 | 50 |
| 2 | 4.33 | 4 | 5:9 | 23 | 47 |
| 3 | 3.67 | 4.5 | 3:2 | 0 | 51 |
| 4 | 3.67 | 4.5 | 1:2 | 63 | 90 |
| 5 | 3.5 | 4 | 6:7 | 38 | 57 |
| 6 | 4.165 | 4.5 | 6:17 | 39 | 71 |
| 7 | 4.665 | 4 | 7:26 | 53 | 79 |
| 8 | 3.67 | 4 | 1:2 | 75 | 100 |
| 9 | 4.67 | 4.5 | 4:9 | 41 | 75 |
| 10 | 4.335 | 4.5 | 2:17 | 52 | 71 |
| 11 | 3.835 | 4.5 | 5:7 | 29 | 44 |
| 12 | 3.835 | 4.5 | 5:9 | 50 | 72 |
| 13 | 4.335 | 4 | 3:16 | 59 | 88 |
| 14 | 4.33 | 4 | 1:13 | 27 | 63 |
| 15 | 4.5 | 4 | 1:2 | 44 | 100 |

Note. Global spirit ratings range from 1–5, with higher scores indicating greater spirit of MI. Global empathy ratings range from 1–5, with higher scores indicating greater empathy and understanding.

2010; Dale, Caramlau, Lindenmeyer, & Williams, 2008). Park et al. (2006) found that survivors of childhood cancers could be effectively trained as peer counselors for other adult survivors of childhood cancers who were smokers.

A key focus of the Peer Connect training was teaching guides to focus on their partner's issues, needs, and reasons for seeking support, rather than telling about their own cancer journey. Although experiential information from peer cancer support providers may appear to be powerful, personal stories of the support-giver's cancer journey could be unhelpful and harmful (Rini et al., 2007). Unhelpful information was reported as information provided from others about their experiences that differed from the patient's own experience and thus was uninformative. Harmful effects were communications patients thought were distressing (e.g., talking about adverse treatment effects) or harmful information (e.g., encouraging nonadherence to treatment). MI-based communication techniques keep the focus on the partner's needs and concerns.

The strengths of the Peer Connect training program include the use of evidence-based training tools, ongoing training and supervision of guides, and support delivered by survivors and caregivers rather than medical personnel. However, a few limitations should be noted. First, 20 guides were trained but, because of a variety of reasons, only 15 completed the program (25% dropout rate). Although this sample size may seem small, it was ample to serve the needs of the cancer survivors seeking support in the program. Guides indicated that they would be comfortable being matched up with three partners at a

given time. Cancer organizations seeking to replicate or conduct similar programs must determine the number of guides needed based on their clientele volume. Attrition in any program should be expected and planned for, particularly given the voluntary nature of the guide role. Second, this program does not focus on a specific cancer. Therefore, guides whose partners have rare cancers may not feel as prepared for the issues that may arise specific to these types of cancer. The development of the training module was an iterative process that tried to anticipate this issue by including topics that guides could encounter in talking with their partners (e.g., palliative care, how to talk about issues of religion). The Guide Gatherings served as an additional way to problem-solve cancer-specific issues that emerged.

Conclusion

The data suggest that cancer survivors and caregivers trained to be peer guides to support others touched by cancer highly valued the training program and were able to maintain their newly learned skills. Guides stated that their time in the program was satisfying, and that they enjoyed being able to give back and serve as a support for someone else. In addition, they gained valuable skills to fulfill

the role. For example, one guide said, "This program was wonderful. I learned about listening and how effective it could be." The current study demonstrated that MI can be adapted for training lay (i.e., nonprofessional) volunteers to work with survivor populations. Preliminary data from partners show that guides provided a listening ear and were supportive and nonjudgmental, and that partners valued the opportunity to engage with a cancer survivor. Limited time availability of some volunteer guides was a reported challenge for partners.

Providing support programs and services to cancer survivors and those touched by cancer is a critical need at all levels of the cancer continuum. Several other programs exist that train volunteers to offer one-on-one support and information to those

Implications for Practice

- ▶ Motivational interviewing (MI) is collaborative, patient-centered, and designed to draw out a patient's primary concerns and ways to address these concerns that fit within the patient's life and resources. This is particularly helpful in dealing with the many stressors that cancer adds to a patient's life.
- ▶ MI can be used to address a broad range of health-related concerns.
- ▶ MI tools are accessible and can be learned regardless of professional background to enhance patient relationships by changing one's style of communication.

touched by specific cancers. For example, the Patti Robinson Kaufmann First Connection Program (www.lls.org/#/diseaseinformation/getinformation/support/supportgroups/peersupport) links newly diagnosed patients and their families with trained volunteers who have been touched firsthand by a blood cancer and have shared similar experiences. The American Cancer Society's (ACS's) Reach to Recovery program trains volunteer breast cancer survivors to provide face-to-face or telephone support, giving patients and family members an opportunity to express their feelings, talk about fears and concerns, and ask questions (www.cancer.org/Treatment/SupportProgramsServices/reach-to-recovery). ACS also provides a similar program for prostate cancer survivors (www.cancer.org/Treatment/SupportProgramsServices/MantoMan/index). To the authors' knowledge, the current study's program is the first peer support program for cancer survivors that uses MI as a primary communication tool to guide the peer-to-peer interaction. As the number of cancer survivors continues to grow, the need to research and encourage best practices, including peer support models, will continue and grow.

MI can be a useful resource for oncology nurses to improve patient health. MI helps participants to develop a relationship based on trust and respect. It allows increased sharing of underlying concerns and fears by patients, leading to better understanding of the patients' behavior and needs. MI allows patients to express their own commitments and motivations for initiating and maintaining health-promoting behaviors or reducing or ceasing harmful behaviors. Nurses can learn more about MI in several ways.

- Read *Motivational Interviewing in Health Care: Helping patients change behavior* (Rollnick, Miller, & Butler, 2007). Practice the skills and strategies detailed in this book.
- Take part in training, feedback, and coaching in MI. The Web site www.motivationalinterviewing.org provides a list of trainings by country and state.
- If formal training is not accessible, the strategies and skills in Table 1 can be used to help practitioners (a) develop a list of good open-ended questions that encourage the patient to give more information, and (b) practice listening skills and develop and expand capacity to convey empathy to patients.

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