

Helping, mutual sharing, committing, and benefiting described the peer advisor experience of providing social support

Whittemore R, Rankin SH, Callahan CD, et al. *The peer advisor experience providing social support*. *Qual Health Res* 2000 Mar;10:260–76.

QUESTION: What are the experiences of peer advisors with previous myocardial infarctions (MI) who provide social support to unpartnered, post-MI elders?

Design

Qualitative study.

Setting

A northeastern city in the US.

Participants

10 actively involved peer advisors (mean age 69 y, 60% women) who had had an MI in the previous 1–3 years were recruited from a cardiac rehabilitation maintenance programme. Inclusion criteria were age ≥ 62 years, ≥ 12 months since MI, ability to speak and read English, access to a telephone, and ability to communicate effectively. These peer advisors had received 4 hours of training and provided social support for a group of post-MI unpartnered elders (n=45) in a large randomised clinical trial.

Methods

Data collection consisted of peer advisor logs (26 peer-elder dyads), a focus group interview (5 peer advisors), and individual telephone interviews (3 expert peer advisors). The process of data reduction, data display, conclusion drawing, and verification identified by Miles and Huberman* was used.

Main findings

A synthesis of all data sources revealed 4 themes: helping, mutual sharing, committing, and benefiting. Peer advisors identified *helping* as the most important aspect of their role, and this contributed to their role satisfaction. Helping was described as giving advice and assisting with problem solving, being advocates, and alleviating fear. They recognised their unique ability to be supportive because of their own experiences of recovery. Peer advisors needed to know that the elder required their support for the helping relationship to develop. They felt that accessibility to an advanced practice nurse was essential for managing the complex situations that sometimes arose. The second theme that emerged was *mutual sharing*. Peer advisors felt this was necessary to facilitate the helping role. The common bond of a shared illness experience was enough to establish rapport with someone they had never met. Mutual sharing fostered reciprocity of their cardiac recovery experience and was the central aspect of most relationships. There were some risks with mutual sharing, such as, emotional issues associated with severing relationships, vulnerability, or entanglement. The third theme was *committing* to the peer experience. Many

peer advisors approached this role with a work ethic, a feeling of dedication and responsibility, and with a personal desire to be successful. The fourth and final theme was *benefiting*. Reciprocity was a benefit expressed by peer advisors. Another important benefit was an increased awareness of their own health behaviours.

Conclusion

Helping, mutual sharing, committing, and benefiting were the common themes that described the experience of peer advisors who provided social support to unpartnered, post-myocardial infarction elders.

*Miles MB, Huberman AM. *Qualitative data analysis*, second edition. Thousand Oaks, CA: Sage, 1994.

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COMMENTARY

The findings of this excellent study by Whittemore *et al* (Rankin, principal investigator [PI]; Carroll, co-PI) help to confirm the benefit of social support in illness. Triangulation of methods (logs, focus groups, and interviews) strengthens the reliability and validity of the findings, and provides a rich tapestry of data for analysis. The results are consistent with the connections and sharing that are characteristic of non-hierarchical relationships. The themes that contribute to the success of the dyads are similar to the feminist values of connection, reciprocity, mutual sharing, and commitment. The themes are also consistent with dimensions of caring, raising the issue of whether caring is unique to nursing.¹ Both the post-MI elder and the peer advisor benefited from the programme.

The findings help to clarify further why previous studies on social support have reported inconsistent findings.^{2–4} The type and structure of the social support intervention is critical to improving patient and client outcomes. The unique contribution of this research is that the intervention was tested in a dyad in which the peer advisor experienced the same illness as the post-MI elders and could identify with their experiences.

The beauty of this model for an intervention is that it can be applied in many illness situations where the individuals who need assistance are alone and feel isolated. It is suggested, however, that additional studies with other groups of patients be done to assess the extent to which the model can produce the same or similar results. It is recommended that, in the future, someone other than the principal investigators, especially when they have established relationships with peer advisors as was the case in this study, run the focus groups to reduce the introduction of bias. Despite the value of the model, not all participants felt the need for social support. This is a true reflection of what occurs in practice.

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