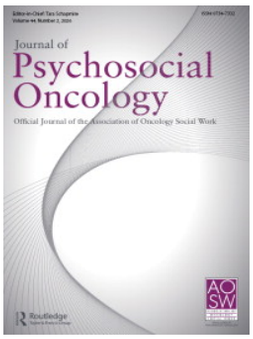

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RESEARCH ARTICLE

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Feasibility of a peer-to-peer parent mentoring program for parents of children recently diagnosed with cancer

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ABSTRACT

Aims: A childhood cancer diagnosis can be one of the most distressing experiences for parents and poor social support is linked to higher distress levels. This study aimed to test the feasibility of a parent-to-parent mentoring program, pairing parents of newly diagnosed children with parents of survivors.

Methods: Parent mentors were trained using self-guided materials and a virtual workshop. Each mentoring relationship lasted three months and was conducted *via* phone, text, and/or videoconference.

Findings: In total, 10 parent mentors were trained, and 16 mentees enrolled (50% of those invited). Of the enrolled participants, nine (56%) mentor-mentee dyads completed the intervention. One hundred percent of mentors rated the training as acceptable. Of those mentees that completed the intervention, 89% found it beneficial overall, 100% reported increased feeling of support and reduced feeling of isolation, and 77% reported reduction in distress.

Conclusion: While the intervention was helpful to those that took part, the low participation rate suggests future implementation may be better suited to larger organizations with access to a larger patient population.

KEYWORDS

Parental distress; parent mentoring; pediatric cancer; peer mentoring; peer support

Childhood cancer can take a serious emotional toll on parents or guardians in addition to impacting the child undergoing treatment. Emotional stress reactions often begin around the time of diagnosis but may persist throughout treatment and into survivorship.[1,2] While parents as a whole demonstrate resiliency, a subset of parents will continue to experience distress throughout treatment and into survivorship.[1,3] For example, one study found that 44% of caregivers showed depressive symptoms one year after diagnosis and 13% showed moderate PTSD symptoms.[2] Another found that mothers had a 40% increase in utilization of outpatient mental health services during and after treatment compared to the average population,[4]

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demonstrating an increased demand for supportive care and services. In addition to impacting the parent's individual coping and quality of life, caregiver mental health also influences how well their children cope with cancer-related stress.[5,6]

Higher levels of social support have shown to be a protective factor related to better parent coping.[7] Similarly, poor social support[8] and greater social stress[9] are related to increased distress symptoms. Unfortunately, not all parents have access to psychosocial support during the critical period of adjustment following their child's diagnosis.[10] Finding ways to increase the level and quality of social support that parents receive during this difficult time may improve overall coping. During the early phases of diagnosis and treatment, caregivers may feel isolated and alone as they face a situation in which few of their peers have experience.[11] They may feel that others in their support network cannot comprehend what they are dealing with, as most will not know another family with a child with cancer. While a family's support network often offers logistical and tangible supports that are useful (e.g. cooking meals, taking care of other children in the home), parents may experience a significant gap in emotional support due to the lack of connection with another person with shared experience.[11] Providing an opportunity for increased social support, especially from a parent that has been through a similar experience, could increase overall coping and potentially lower distress.

Lazarus and Folkman[12] consider social support to be a coping resource that positively affects mood. Seeking social support, especially from a social network tie who has direct personal experience with a life event or "experiential similarity,"[13] can tap into both problem-focused and emotion-focused strategies[14] through informational support (e.g. symptom management tips or anticipatory guidance) and emotional support (e.g. empathy). Because of their experiential similarity, parents of survivors can offer emotional support, serve as role models, and provide comfort as someone who has been through it.[15] Thus, training parent mentors to provide empathic social support may increase parents' perceived social support and reduce symptoms of distress.

Parent-to-parent mentoring has not been systematically studied in childhood cancer despite a number of informal programs in hospitals and cancer centers. Parent-to-parent mentoring in other contexts has shown mentoring to be rewarding and helpful for both mentors and mentees.[16] Parents supporting other parents whose children have addiction issues described significant improvement in happiness and hopefulness[16] and parents of children with chronic illness, both newly diagnosed and long-standing, reported benefiting from peer support programs.[11,17]

The benefits of peer mentoring can also be seen in a larger body of research with adults undergoing treatment for cancer. A wide range of qualitative studies found peer-to-peer mentoring in the cancer community improved coping skills, provided reassurance and a sense of normalcy, contributed to a reduction in isolation and information sharing, gave a better understanding of the experience and future, and in some cases, increased confidence in talking to physicians.[18,19] Adult patients report that talking with a former patient reduced loneliness; further, it was easier to exchange emotional thoughts with someone who has been through it.[20] While the experience of being an adult patient is distinct from being a parent of a child undergoing cancer treatment, the perceived benefit of peer mentoring may translate across situations.

The primary aim of this study was to determine the initial feasibility and acceptability of a parent-to-parent mentoring program, with an emphasis on the feasibility of mentor training and whether training is effective in preparing parents to be peer mentors. Feasibility and acceptability of the program was examined through enrollment rates, retention rates, mentor satisfaction with the training, and mentor/mentee satisfaction with the mentoring intervention program.

Methods

Design

This study was a single-arm pre-post study evaluating the feasibility of a virtual parent-to-parent mentoring program. Qualitative interviews and quantitative questionnaires were used to assess effectiveness of outcomes.

Mentor recruitment

Parent mentors were eligible if they were (1) a parent or guardian of a child, age < 18 at time of diagnosis, who underwent treatment for a pediatric cancer, (2) age 18 years or above, and (3) at least one year from child's completion of treatment. Exclusion criteria included (1) physician- or self-reported cognitive delay or impairment that would interfere with learning mentoring skills, (2) patients with cancer diagnoses that are not typically considered pediatric cancer, including basal and squamous cell skin cancer, breast, colorectal, lung, melanoma, Merkel cell skin cancer, ovarian, and testicular cancer, and (3) non-English speaker. Mentors were recruited by referral from the clinical team and through advertisements in the local survivorship clinic of an NCI-designated Comprehensive Cancer Center on the East Coast.

Mentee recruitment

Parent participants were eligible if they were (1) a parent or guardian of a child diagnosed with a pediatric cancer prior to age 18 and currently undergoing treatment, (2) age 18 years or above, and (3) the child with cancer was within the first three months of treatment. Exclusion criteria included (1) patients with cancer diagnoses that were not typically considered pediatric cancer, including basal and squamous cell skin cancer, breast, colorectal, lung, melanoma, Merkel cell skin cancer, ovarian, and testicular cancer, and (2) non-English or Spanish speaker. Mentees were recruited by referral from the clinical team and through advertisements in their treatment or survivorship clinic.

Procedures

Parent mentors attended a four-hour virtual training workshop conducted by the Principal Investigator (PI) and study staff. Prior to attending the workshop, parent mentors were asked to read and complete the self-guided Parent Mentor Handbook, which detailed mentor roles and expectations, active listening skills, establishing boundaries, and noticing and reporting "red flags" to the study team. Red flags were concerns that required immediate action such as suicidal thoughts or actions, child or domestic abuse, and/or significant complaints against clinical providers or staff. During the workshop, the workbook was reviewed in detail, and the mentors were engaged in training exercises including presentations, interactive discussions, and role plays. Ethical issues, including confidentiality and setting boundaries with peers, were discussed. Parent mentors had weekly telephone supervision with the PI available to them to review their mentoring calls and discuss any challenges experienced.

Each mentoring intervention was expected to last three months. To the extent possible, mentees were matched with a parent mentor whose child was a similar age at the time of treatment to the mentee's child and had a similar expected duration of treatment. Mentors were asked to reach out to mentees *via* voice or video call or text message once per week for a period of three months. If the mentee was not available during the time of contact, the mentor made efforts to arrange for better time in the week to connect. The method of contact was to be decided upon between the mentor and mentee based on what was more desirable to the mentee. The purpose was to provide emotional support; the calls were not scripted or directive.

Parent mentors completed measures prior to receiving the parent training workbook and attending the parent mentor workshop (pre-training), at

the completion of the virtual workshop (post-training), and at completion of the mentoring intervention (post-intervention). Mentees completed measures prior to first contact with the parent mentor (baseline) and at the completion of the mentoring intervention (follow-up). Measures were given to mentees in their preferred language (i.e. English or Spanish). Mentors and mentees received a $50 gift card upon completion of the three-month mentoring intervention.

Measures

Acceptability and feasibility outcomes

Feasibility

Enrollment and retention rates were measured with descriptive statistics, using a priori set benchmarks of >50% enrollment, >75% retention, and frequency of engagement during the intervention.[21]

Mentor training evaluation

At the end of the training workshop, mentors were asked to complete a 6-item training evaluation form in which they rated how well the training helped them understand what was expected of them in their role as mentor and how prepared they felt to be a mentor using a 4-point Likert scale.

Multi-dimensional treatment satisfaction

Parent mentors' and mentees' satisfaction with the program was assessed using an adapted 10-item Multi-Dimensional Treatment Satisfaction Measure[22] to assess utility of intervention specific components (e.g. the user manual, worksheets), attitude toward the intervention, mentor competence, and perceived benefit attributable to the intervention, plus four open-ended questions eliciting ideas for improvements.

Semi-structured qualitative exit interview

Mentors completed a semi-structured qualitative interview at the end of the mentorship intervention. Example questions included: What is your overall impression of being a mentor? Was the mentor training and supervision helpful to you in your role as a mentor? Was being a mentor personally beneficial to you? Was there any harm to you in being a parent mentor?

Mentees also participated in a semi-structured qualitative interview following the completion of their mentorship relationship. Example questions included: What is your overall impression of being part of the mentor program and did you find it helpful? How connected to and/or supported by your mentor did you feel? What did you like best about the parent mentor program? What did you like least about the program?

Secondary outcomes for mentors

Attitude toward active listening

Two subscales of the Attitude of Active Listening[23] measure were used, which is a self-report instrument assessing listening skills on four-point Likert scale. The Listening Attitude subscale (13 item) has a Cronbach's alpha of 0.84 and the Listening Skill subscale (11 item) has a Cronbach's alpha 0.78. They both have test-retest reliability of 0.83.

Toronto empathy Questionnaire

The Toronto Empathy Questionnaire[24] is a 16-item self-report measure of the emotional components of empathic responding. It has been shown to possess high internal consistency (Cronbach's α = .85), and has demonstrated convergent and discriminant validity.

Secondary outcomes for mentees

Pediatric parenting stress inventory

The Pediatric Parenting Stress Inventory[25] is a 40-item self-report measure assessing the impact of having a child with cancer on family life, managing family/medical stressors, and emotional stress. Reliability is excellent with a Cronbach alpha of 0.94, and construct validity has been established.

PROMIS emotional support – short form

The Patient-Reported Outcomes Measurement Information System (PROMIS) Emotional Support-Short Form[26] is an eight-item self-report of perceived emotional and social support developed by the NIH. Raw scores are transformed into T-scores (with a mean of 50, standard deviation of 10) for analysis.

Statistical analysis

Feasibility outcomes

Descriptive analyses (frequencies, means) were used to evaluate hypotheses regarding expected enrollment (>50%), retention (>75%), and frequency of engagement during the intervention. Satisfaction ratings were also analyzed with descriptive analyses. Qualitative data from exit interviews and open ended questions were thematically coded following Braun and Clarke's framework.[27] Two members of the research team became familiar with the data through repeated reading and noting preliminary themes. These coders independently generated initial themes, with any discrepancy resolved through discussion. These themes were further refined by checking

to make sure themes worked in relation to the entire data set, resulting in a thematic map. Themes were subsequently defined, named, and described, with excerpts from the transcripts which illustrate the themes.

Secondary outcomes

Changes in secondary outcomes from baseline to follow-up were evaluated using two-sided paired t-tests. Cohen's d was calculated as a measure of effect size.

Results

Participant characteristics

Mentor recruitment occurred in the fall of 2021 with the mentor workshop taking place *via* Zoom in November 2021. Mentee recruitment occurred from December 2021 thought August 2023 with the final mentoring intervention ending November 2023. A total of 10 mentors and 14 mentees participated in the study (see Table 1).

Feasibility outcomes

Recruitment and retention

Fifteen parents of childhood cancer survivors were referred and eligible to be parent mentors. All but one expressed interest in participating in the study. Ten were consented and participated in the parent mentor training program; the four that expressed interest but did not participate declined due to time conflicts with the required parent mentoring workshop.

Table 1. Participant demographics.

	Mentors ($n = 10$)	Mentees ($n = 14$)
Gender		
Female	8 (80%)	11 (78.6%)
Age		
18–30 years	–	3 (21.4%)
30–40 years	1 (10%)	5 (35.7%)
40–50 years	3 (30%)	5 (35.7%)
50–60 years	6 (60%)	1 (7.1)%
Child's age at diagnosis	7.1 ± 8.9 yrs	7.6 ± 14.4 yrs
Child's gender		
Female	4 (40%)	28.6%
Child's diagnosis		
ALL	8 (80%)	9 (64.2%)
AML	–	1 (7.1%)
Hodgkin's Lymphoma	2 (20%)	1 (7.1%)
Non-Hodgkin's Lymphoma	–	2 (14.2%)
Osteosarcoma	–	1 (7.1%)

Thirty-two parents of children recently diagnosed with cancer were referred and eligible to be mentees in the intervention. Of the 32 contacted, 16 were consented (50%) and 14 completed baseline questionnaires and were paired with a mentor (43.75%). Nine mentees completed the study (56% of those consented). There was no significant difference in demographic or baseline measures between those that dropped out and those that completed the study. While formal data was not collected about reason for declining to participate or dropping out, several potential mentees commented they felt participation was too difficult as they wanted to solely focus attention on their child.

Engagement

For the intervention, mentoring dyads were asked to have at least one contact per week *via* voice call, video call, or text message. A communication platform that recorded the time and type of communication was used to track frequency of contact during the first ten months of the intervention; however, due to changes in the health care system's contract with this company, the service was discontinued halfway through the study. Following this, mentors were asked to track whether they had at least one communication with their mentee each week. Participants were considered to have completed the study if they remained enrolled for all 12 wk of the intervention and completed the post intervention questionnaires, even if they did not interact with their mentor each week. Among those that completed the study ($n = 9$) 66.67% completed one contact per week ($n = 6$), which fell below the predefined feasibility threshold of 75%. Those who did not have one contact per week had at least three contacts.

Acceptability

Mentors. Overall, mentors expressed satisfaction with the training; on a 5-point scale (0–4), participants reported high satisfaction with preparedness for being a parent mentor ($M = 3.60$, $SD = 0.52$) and understanding of what is expected of them as a parent mentor ($M = 3.80$, $SD = 0.42$). Participants also indicated that training enhanced or reinforced active listening skills ($M = 3.50$, $SD = 0.53$) and gave them clear instructions regarding confidentiality ($M = 3.60$, $SD = 0.52$). When asked an open-ended question about what part of training was most useful, themes included giving clear guidelines and role expectations, benefit of role playing, and how to be a better listener. When asked what could be improved, one participant indicated that the training workshop was too long (four hours), and the others ($n = 9$) indicated that they did not believe anything needed to be changed or added.

Mentoring intervention. After engaging in the intervention, using a 5-point scale (0–4), all mentors indicated they agree or strongly agree that the workbook and workshop were useful in helping them learn to be a mentor ($M = 3.33$, $SD = 0.71$ and $M = 3.56$, $SD = 0.57$ respectively) and that they felt competent in their role as a parent mentor ($M = 3.44$, $SD = .53$). There was moderate agreement about satisfaction with the three-month duration of the program ($M = 2.75$, $SD = 0.89$) with 75% agreeing with the duration, 12% reporting to neither agree or disagree, and 12% disagreeing (indicating they would have liked it to last longer). Similarly, there was moderate agreement on the at least once per week frequency of contact with the mentee ($M = 2.75$, $SD = 0.87$) with 67% reporting agreement, 22% neither agreeing or disagreeing, and 11% disagreeing. All mentor participants agreed or strongly agreed it was personally beneficial to be a parent mentor ($M = 3.78$, $SD = 0.44$) but were less sure they were helpful to their mentee ($M = 2.78$, $SD = 0.41$) with 78% indicating they agreed they were helpful and 22% indicated they neither agreed nor disagreed that they were helpful.

Using a 5-point scale (0–4), all mentees who completed the intervention agreed or strongly agreed that the mentorship program provided emotional support and decreased feelings of isolations ($M = 3.78$, $SD = 0.44$) and strongly agreed that their parent mentor was warm and supportive ($M = 4.0$, $SD = 0.0$). Mentees were slightly more varied in reports about whether the program was beneficial overall, but 88% ($n = 8$) reported they agree or strongly agree it was beneficial and 12% ($n = 1$) reported "neutral;" No one reported that they "disagreed" that it was helpful ($M = 3.67$, $SD = 0.71$). Mentees rated the program similarly with regard to the mentor helping them to cope with their child's cancer ($M = 3.67$, $SD = 0.71$) and the mentoring helping to decrease feelings of distress ($M = 3.56$, $SD = 0.88$). Specifically, all mentees indicated that they either agreed/strongly agreed the mentor helped with coping (88%) and deceasing feelings of distress (78%) or were neutral.

Semi-structured interviews. Semi-structured interviews were completed with eight mentees and five mentors following the completion of the mentoring intervention (see Tables 2 and 3). Several themes emerged from the mentees including preferring communicating *via* text message, gaining hope, having emotional support, getting guidance/concrete advice related to coping and parenting, and the benefit of talking with someone with a shared experience. Two mentees expressed guilt or concern they may be a burden to their parent mentor. Themes from the mentors included finding the mentor training helpful, challenges feeling connected with their mentee using text messaging, feeling it was a good/rewarding experience, and helping them to process their own experience with their child having cancer. One parent

Table 2. Themes from mentee interviews.

Theme	Mentee quotes ($n = 8$)
Preference for communication *via* text	"Well, I think you could do it anytime, if things aren't 100% quiet at home, you can text. I feel like whenever I am on the phone someone needs me and it's hard to think. The texting worked out really well" [ID#16, mother]
	"I did talk to [my mentor] by text messages, so I think that really helped, instead of talking to someone over the phone because sometimes you might get emotional or something. If you send a text message you can talk, take a break, and then go back to the text message after a few minutes." [ID#23, Mother]
	"I know for me it helps to have a mentor who reached out to me and was understanding that I might not respond right away. Which is another reason why the text was good. Because you could respond a couple of days later." [ID#16, Mother]
Increased hope	"It's the fact that knowing in my mind that someone was in the very same situation as me and she is here to talk about it and she is here to give me guidance. If she made it through then I can definitely make it through." [ID#11, Mother]
	"It was nice to have an end picture of normalcy." [ID#16, Mother]
Gaining emotional support	"I had no one else to that could, like, how do you say, feel the same way I do. It was like sharing that with them. Somebody, like understands, which was really helpful." [ID#19, Mother]
	"Actually the first time I spoke to [my mentor] he was very genuine, so he made me feel very comfortable talking to him. Um, you know, he was available. When I spoke to him he was like "Whenever you want to speak about something, give me a call." [ID#25, Father]
	"Like I really think it's very beneficial. Like at the time it might feel a little overwhelming cuz you just got this diagnosis and stuff, but in the long run I think, I think it's very beneficial. It helped me" [ID#11, Mother]
Appreciation of concrete advice	"It helped out a lot, ya know, especially being beginner parents, you know with a cancer in a kid. Any little question we had you know they gave us insight into what they did. It worked for them and it was working for us, so, that helped out a lot." [ID#25, Father]
	"Yeah, because she kinda went through the same thing with her son, it was easy to ask her how she went about doing certain things vs talking to a family member who isn't aware of what to do." [ID#23, Mother]
Benefit of talking with someone with a shared experience	"It was great to have someone who I could talk to that has been there" [ID#16, Mother]
	"It was very helpful. I found my mentor [name] to be very helpful. She has been there, done that. I know it has been several years ago but she gave me a lot of guidance about to what her daughter went thought, kinda like what [my son] is going through now." [ID#11, Mother]
	"Definitely having somebody to talk to who went through the same experience. It's easy to talk to family and friends about it but it's different when you are communicating with someone who went through the same thing." [ID#23, Mother]

expressed frustration that their mentee was unresponsive, and another wondered if they were doing enough to be helpful.

Secondary outcomes

There were no statistically significant changes in pre to post measures; however, these analyses were exploratory and focused on effect size which can indicate meaningful trends despite the limited sample size. Mentors showed a small improvement in empathy (Cohen's $d = 0.24$) and listening attitude (Cohen's $d = 0.31$), but no measurable change in listening skill. It should be noted, however, that mentors were above average on both empathy and listening abilities at baseline (see Table 4) and the absence of measurable effects should be interpreted cautiously given the small sample

Table 3. Themes from mentor interviews.

Theme	Mentor quotes ($n = 5$)
Mentor training helpful	"I think the direction of the training really helped me zero in on what my role was, you know not so much of what to avoid or whatever, but what my role was. I mean I'm here for this particular reason. It gave me really good direction. Nothing was a surprise to me. Everything rolled out as indicated in the training." [ID#10, Mother] "I found that I used that information, honestly in my everyday talking to people, like a friend of mine who is going through something." [ID#7, Mother] "it made me [know] the steps I needed to take, when it was important to refer her to doctors instead of telling her what to do, that it's really not my place. So the rules were good—it kept things in a good perspective for me." [ID#9, Father] "I really liked the zoom call with all the other parent mentors and I think that you went through some scenarios and different suggestions and I felt like it was good to hear others' suggestions on how they would word certain things or how they would approach certain things." [ID#3, Mother]
Difficulty feeling connected using text messaging,	"I liked doing it but it was really hard through texting, not being face to face." [ID#7, Mother] "And I could never connect with her on the phone and I don't know the issue there. I don't know. I left her several voice mails but never got a call back. I guess the other hindrance was her, to be honest. I think it could have worked better, it might have worked better um, if she had picked up the phone and she had, yeah I can talk on Tuesday from 10–12 or like, she never provided any time or anything of when she could actually talk. The only thing she wanted was text messages. So, that based on that, it's all I could provide. You know, I wanted to be more involved." [ID#3, Mother]
Good/rewarding experience	"I really found it rewarding to be able to help out a family that is going through something we went through in the past and trying to do my best to give them hope. I felt very connected to [my mentee]. We had very similar stories, similar experiences. I could definitely relate to a lot of it. Same hospital, same experiences. I think it made a difference. I think [mentee] needed to hear that there was hope." [ID#4, Mother] "I got a lot of satisfaction. But it was very humbling. It felt like I was doing something very positive for someone. It was a good feeling." [ID#9, Father] "Yep. It just, I don't know, I can't put it into words. It just made me feel good to do it and I know that it made me feel good that she was doing so well getting through the hard times with her child and that I had a little part in that. It is like taking a bad situation in my past and making a positive situation for someone in the future." [ID#4, Mother]
Helped to process feelings related to their own experience having a child with cancer	"And I think also it in a way that it allowed me to kinda process um I guess my own experience in a different way. To kinda think through it in a way, like okay, if I had someone who could give me advice, what is the advice that I would want. And so it was beneficial in that it helped me, in that it helped me to emotionally work through some of the things that I hadn't realized I hadn't worked through. And just to feel like you were helping someone else." [ID#3, Mother] "It brought up some feelings, but frankly it's about time that I paid attention to them." [ID#10, Mother]

Table 4. Pre-post results for mentors ($n = 9$).

Outcome measures	Pre M(SD)	Post M(SD)	Cohen's d
ATAL Total	76.25(7.44)	77.98(5.93)	0.15
Listening Attitude	41.50(5.01)	43.13(3.91)	0.31
Listening Skill	34.78(2.95)	34.56(3.24)	0.06
TEQ	52.88(5.82)	53.63(3.62)	0.24

Table 5. Pre-post results for mentees ($n = 9$).

Outcome measures	Pre M(SD)	Post M(SD)	Cohen's d
PROMIS Emotional Support	56.81(7.67)	60.02(1.75)	0.52
PSSI Managing Family Life	1.19(0.95)	1.24(1.15)	0.08
PSSI Managing Finances	0.90(0.62)′	0.78(0.82)	0.24
PSSI Managing Emotions	1.19(0.76)	1.08(0.93)	0.21
PSSI Total	1.17(0.69)	1.12(0.89)	0.08

size. Mentees reported a moderate improvement in emotional support (Cohen's $d = 0.52$) and a small improvement in managing emotions (Cohen's $d = 0.21$) (see Table 5).

Discussion

The results of this study highlight both the benefits and limitations of a peer-to-peer parent mentoring program for parents of children recently diagnosed with cancer. The majority of parent mentees who participated in the program expressed that the mentoring relationship provided valuable emotional support. Parents who completed the intervention reported reduced feelings of isolation, increased feelings of support, and in some cases, a reduction in distress. These outcomes indicate that for some parents, connecting with a peer who has experienced similar challenges can be a significant source of comfort during an emotionally challenging time. The qualitative feedback from mentees reinforced this, as they appreciated receiving support from someone who had firsthand experience with their situation. Similar results were also found in studies looking at parent peer-to-peer support for other chronic illnesses or disorders such as diabetes and substance abuse.[16,17]

The experience was also seen as valuable by the parent mentors. Overall, they expressed high satisfaction with the training in that it prepared them for their role and was helpful in improving active listening skills. The structured nature of the formal training and ongoing supervision were key factors that likely contributed to the success of the program. These elements provided a solid framework for the mentors, setting clear expectations and offering guidance on effective communication and support.

All parent mentors agreed it was personally beneficial to be a parent mentor, and qualitative interviews indicated that mentors felt that it was a rewarding experience, even if some had challenges feeling connected to their mentee. Some also commented that the experience helped them to process their own experience with their child having cancer. These results are similar to published work showing parents who participated in a program to become coaches or mentors for other parents of children with substance use disorders or diabetes found the training to be highly valuable in fostering effective coaching/mentoring relationships and described the experience of mentoring as both fulfilling and rewarding.[16,17]

However, despite these positive outcomes, the initial participation and retention rate among mentees was lower than expected, with 50% initially consenting to participant and only 56% of those enrolled completing the study. This indicates that while the program was beneficial for those who remained engaged, a significant number of parents declined to participate or dropped out. This suggests that a mentoring program, while helpful

for a subset of parents, may not meet the needs of all families. One major barrier appears to be the program's focus on the parent's own coping, as some parents commented that they wanted to solely focus on their child's treatment and participation in the mentoring program would be a distraction/burden. Possibly related to this, we approached potential participants purposefully during the first few months following diagnosis, as this time period can be emotionally overwhelming for parents, but this may have also been a barrier to participation for some parents. Allowing for greater flexibility for the timing of the intervention may have been beneficial. Some parent mentors expressed difficulty building rapport with mentees *via* text but mentees largely indicated they preferred texting to other forms of communication. Mentors may have benefited from training specific to communicating *via* text and perhaps having conversations prompts to facilitate text-based communications. Understanding the barriers to participation, such as time constraints, emotional readiness, or preferences for other forms of support, will be important in refining future interventions.

This study also raised questions about the settings best suited for a parent mentoring program. This study was performed in a smaller hospital setting with a limited pool of potential mentors and mentees. Because of this, the lower enrollment and retention rate were significant challenges. Mentors completed training but many had to wait up to a year to be paired with a mentee. Although they were asked to review the mentor workbook and had a brief check in with study staff, the training was no longer recent at the time of the pairing. However, training an adequate number of mentors was necessary to accommodate potential participant enrollment. A larger institution or regional foundation may be better positioned to sustain this type of program. The larger participant pool could result in enough active mentor-mentee pairs to maintain the program's viability despite lower utilization rates. Formal mentor training should remain a central component of programming, regardless of the setting.

Several limitations should be noted. The study was conducted in a smaller hospital setting with limited eligible participants, which may have affected recruitment, retention, and generalizability. There was also not a control group as this was a pilot study and no causal interpretations can be made. In addition, participants who chose to enroll may have been more motivated or receptive to peer support, limiting applicability to all parents. Language barriers and the availability of childcare while engaging with the mentor may have negatively influenced enrollment. Furthermore, outcomes relied on self-report which may have introduced response bias. Finally, long-term outcomes were not measured so the persistence of benefits beyond the intervention period is unknown.

While the peer-to-peer mentoring program shows promise for supporting a subset of parents, it may not be feasible to implement in smaller settings. Continuing to explore its application in larger institutions and organizations with more participants may provide a better understanding of its full potential and how to make it a more robust and sustainable intervention.

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