Psychosocial adjustment in women with early stage breast cancer: the effectiveness of experiential-existential psychotherapy groups compared to social support groups

Vos, P.J.

Citation for published version (APA):
Vos, P. J. (2008). Psychosocial adjustment in women with early stage breast cancer: the effectiveness of experiential-existential psychotherapy groups compared to social support groups
Effectiveness of group psychotherapy compared to social support groups in patients with primary, non-metastatic breast cancer

Petra J. Vos
Adriaan P. Visser
Bert Garssen
Hugo J. Duivenvoorden
Hanneke C.J.M. de Haes

Reprint from Journal of Psychosocial Oncology, 25, 2007, 37-60
Abstract

The aim of the present study is to compare the effectiveness of experiential-existential group psychotherapy and a social support group for women with a primary breast cancer on psychosocial adjustment. Sixty-seven well adjusted women who had been operated for breast cancer no longer than four months prior to the start of the study were randomised into one of two conditions: Participating in the group psychotherapy or in the support group. They were questioned at the start of the study, at the end of the intervention and one year after completion of the intervention. Results at follow-up were mixed: Positive changes were reported for Body Image and Recreation, regardless of type of intervention. Other psychosocial adjustment indicators did not change.

In general, we may conclude that well-adjusted women diagnosed with breast cancer do not specifically benefit from these types of interventions.
**Introduction**

In the past decades the psychosocial problems patients encounter after being diagnosed with cancer have been extensively studied [1-4]. Acknowledging these problems, many intervention studies have been developed and tested. A review of the literature shows that most of these intervention programs are effective in reducing emotional distress and improving coping abilities [5-10]. Focussing on group interventions, Trijsburg and colleagues (1992) reported that group interventions were often as effective as the individual intervention programs they were compared with [6]. Edelman and colleagues (2000) reported positive results for psychoeducational interventions, but limited evidence for efficacy in reducing stress or improving psychosocial adjustment when supportive group interventions were reviewed [11]. Conclusions of Rehse and Pukrop (2003) were that especially interventions lasting more than 12 weeks were effective [12]. After reviewing the literature, Fawzy and Fawzy (1998) recommend a group intervention consisting of health education, stress management, behavioral training, coping skill training and psychosocial group support for patients who are newly diagnosed or in the early stage of their treatment [13].

The efficacy of interventions especially designed for women with breast cancer have been investigated in many studies as well. Again, most studies showed beneficial effects, but findings were not always consistent. A short psychotherapy group intervention for women with metastatic breast cancer yielded positive results just after completion of the intervention: Participants showed significant improvement in depression and total mood disturbances compared to non-participants. At follow-up, these differences were no longer apparent [14]. Another study among women with metastatic breast cancer who participated in a longer lasting psychotherapy group, showed no differences between participating women and women of the control group when mood or quality of life was concerned. However, the therapist reported profound clinical changes in the participating women [15]. Classen and colleagues (2001) found no differences between participants of a supportive-expressive therapy group in mood disturbance at first glance. When, however, the final assessment, which occurred within one year of death was removed from the analysis, participants of the intervention showed a greater decline in mood disturbance than controls did [16].

Intervention programs among women with early stage breast cancer show the same results as studies among women with metastatic breast cancer. Participants of a short psychotherapy intervention program reported positive results: Though psychosocial adjustment did not improve significantly just after the completion of the intervention, it did at six and twelve months follow-up, although the authors cannot rule out the possibility that the emotional course of these women would have been the same without the intervention [17]. Antoni and colleagues (2001) showed an improvement of early stage breast cancer patients who participated in a cognitive-behavioral stress management program. Not only after completion of the intervention was their distress declined, but this change was enhanced at 3 and
9-months follow-up [18]. In a study among depressed women with breast cancer, both the experimental and the control group improved, though the improvement was somewhat less for patients of the control group [19], while in a study of Samarel and co-workers (1997) no significant differences were found between participants of a social support group and women in a control group, though in both groups symptoms decreased over time [20]. The authors state that this lack of intervention effect could possibly be contributed to the early start of the intervention (2 months after surgery) and to the fact that all participating women were free of advanced disease and sufficient recovered from surgery. They were also not experiencing severe side effects from adjuvant therapy.

The abovementioned studies investigated both psychotherapy groups and social support groups. In our opinion, there are some objective differences between these types of interventions. First of all are psychotherapy groups usually led by psychotherapists and social support groups by leaders with different educational backgrounds. Psychotherapy groups often focus much more on the personal meaning of having (had) cancer and the accompanying experiences, while the focus of the social support groups is much more on practical aspects of having (had) cancer. A third difference is that psychotherapy is often less structured compared to social support groups. Although we have made a theoretical distinction between group psychotherapy and social support groups for this study, this distinction is not always sharp. Some interventions are called ‘psychotherapy’ while their content is mainly psycho-educative, supportive or based on coping skill training. Other interventions are called ‘Social support groups’ while in fact they offer much more than only providing social support.

A special type of interventions are interventions which are based on the principles of experiential therapy. The aim of this kind of therapy is to change the patients’ experience of life and facilitate existential reorganisation. The approach is dynamic and its focus is on fundamental concerns of the patients’ life such as fear of death, experience limitations of freedom, existential isolation, relationships, autonomy versus dependence and helplessness, and meaning of life [21-23]. In a famous study of Spiegel and co-workers (1981), women who participated in a psychological support group based on these principles not only lived longer than women in the control group, but also reported less tension, depression, fatigue and confusion and more vigor [24]. Results of a study of Goodwin and co-workers (2001) who replicated Spiegels’ study, were comparable for psychological outcome [25]. However, a study done by Van der Pompe (1997) did not find a change in psychosocial adjustment [22]. All these mentioned studies were carried out among women with metastatic breast cancer. Cunningham and Edmonds (1996), concluded in their review, that there were not enough studies which researched interventions of this type to draw firm conclusions about the efficacy of these kind of group interventions [8].

The abovementioned studies investigated the effectiveness of a group intervention compared to a control group. Other studies examined the effects of one intervention compared with an intervention of another kind. Hosaka (1996) for instance, studied a group interven-
tion which was compared to an individually intervention program [26]. Findings showed that participants of both interventions improved in emotional distress, but they did not significantly differ from each other. Helgeson and co-workers (1999) studied two kinds of group interventions: Education groups and peer discussion groups, which were compared with a control group [27]. Findings of this study showed that at completion of the intervention there were no significant effects on positive affect, but a positive effect in the education group on vitality, while this effect was negative in the peer discussion group. At six months follow-up, the education groups showed a significant effect on positive affect, while in the peer discussion groups decremented effects were found for negative affect and vitality.

The aim of the present study is to compose the effectiveness of two types of interventions: 1) a group psychotherapy intervention, based on Experiential-Existential (EE) premises [21], and 2) a social support group intervention. Our first hypothesis is that participants of both interventions will improve on psychological, psychosexual and social adjustment. Secondly we expect that the participants of the EE group psychotherapy will improve significantly more than those of the social support groups, because in the therapy groups the focus will be on incorporating cancer in one’s life instead of only exploring practical solutions to deal with the cancer at the very moment, as was done in the social support groups.

We expect also that Age, Type of surgery and Stage of the disease are predictive for all the psychosocial adjustment indicators one year after completion of the intervention programs.

**Methods**

**Subjects and procedures**

Patients were recruited from several hospitals in the region of Rotterdam, The Netherlands. The ethical committees of all participating hospitals approved of the study. Eligible participants were women between 18 and 70 years of age, who had surgery for primary breast cancer no longer than four months ago at the time of the first contact, no distant metastases, sufficient knowledge of the Dutch language, and no psychiatric illness. An oncology nurse, who also judged the absence of psychiatric illness, informed the women about the study during regular appointments. Women were told that they would be randomly allocated to one of two conditions after the first interview: Participating in an EE group psychotherapy or a social support group. The oncology nurse would hand a leaflet to the patients, so they could read the information about the study at home. If a woman was not motivated to participate, she could indicate this by returning an answering-form, which was enclosed into the leaflet. If not returned within three weeks, the investigator attempted to contact the women by telephone. If consent was given, an appointment was made for the first interview. During the interview women were asked to sign a written informed consent and a set of questionnaires was handed over at the end of the interview. Women were asked to complete these
questionnaires at their earliest convenience, but at least within one week and mail them to the researcher. After having received the questionnaires, patients were randomised into the group psychotherapy or the social support group. The intervention programs for both conditions lasted three months. There were three measurements: The first (T0) within four months after surgery, before randomisation and thus before the start of the intervention, the second just after completion of the intervention (T1) and the final measurement twelve months after completion of the intervention (T2).

**Measures**

Medical and demographic data were obtained from a general questionnaire containing anamnestic questions (size of tumor, date of diagnosis and surgery, type of surgery, number of affected lymph nodes, adjuvant therapy) and demographic questions (age, education, marital status, work status). The oncology nurse, who referred patients to the researcher, checked the information in medical records for those women who agreed to participate.

Three scales covered psychosocial adjustment. **Emotional adjustment** was measured with the Dutch version of the Profile of Mood States (POMS) [28], which measures mood states in five dimensions: Depression (8 items; $\alpha = 0.89$), Anger (7 items; $\alpha = 0.91$), Fatigue (6 items; $\alpha = 0.91$), Tension (6 items: $\alpha = 0.89$), and Vigor (5 items; $\alpha = 0.80$). A higher score indicates that a particular mood is experienced more often. The POMS should be scored on a 5-point scale.

**Psychosexual functioning** was measured with the subscales Sexual Functioning (2 items; $\alpha = 0.81$) and Body Image (4 items; $\alpha = 0.89$) of the breast cancer specific module (QLQ-BR32) [29] of the EORTC QLQ-30 [30]. The breast cancer specific module includes questions about side effects of different treatment modalities, body image and sexuality and should be scored on a 4-point scale. Higher scores on the subscale Body Image represent worse level of functioning, while higher scores in the subscale Sexual Functioning represent a better level of functioning.

**Social adjustment** was measured with the subscales Social Interactions (20 items; $\alpha = 0.75$) and Recreation (8 items; $\alpha = 0.75$) of the Sickness Impact Profile (SIP) [31]. This is a daily functioning questionnaire, which describes the impact of illness on behavior in 12 aspects. In this study, only two of these aspects were used, since the other aspects were already covered by other questionnaires, or were irrelevant for this study. In the questionnaire, statements should be answered with ‘right’ or ‘not right’. Higher scores represent more impact of the illness.

Reliability and validity for a Dutch population were adequate for all used questionnaires [28,29,31].

**Interventions**

Both intervention types consisted of twelve weekly sessions of 2,5 hours, which included a 15 minute coffee-break. After the regular weekly sessions, two follow-up sessions were
Effectiveness of psychotherapy groups and social support groups for breast cancer patients

scheduled, one and two months later. Both groups were closed groups, in which six to ten women could participate. Two trained therapists led the EE psychotherapy groups and two trained group leaders led the social support groups. At least one of the therapists or group leaders had to be a woman.

**Group psychotherapy**

**Theoretical background** The group psychotherapy is based on experiential therapy [32,33]. This means that in the therapy much attention is paid on themes such as awareness and joy in life, freedom and limitations, and meaning of life, and also on the way attention is paid to these themes. It is important to start from the here-and-now situation instead of changing ‘wrong’ behavior. Important elements of the existential approach were incorporated [32,33]. The emphasis lies on stimulation of exploration of needs, problems and personal strength to find personal solutions of problems.

**Structure of the intervention** In the first session the central theme is getting to know each other. Participants introduce themselves and give some background information about their illness, their motivation for participation and expectancies of what they will learn from their participation. All other sessions have the same structure: Start with a relaxation or meditation exercise, followed by a round in which each participant is invited to tell something about feelings of having cancer. From this round, the therapists summarize which topic is important at that moment for the group.

Information about important topics comes from the report by the therapists of what happened in the previous session and what the previous session had done to participants. The therapists use individual processes in the group setting in such a manner that these are helpful for all group members. The round functions as a basis for the rest of the session, in which the emphasis lies on addressing feelings and thoughts. In this part, the experiences of one or more group members are addressed. Half way through the session there is a 15-minute coffee break, in which the therapists leave the group. At the end of the session, the group members are shown possibilities and applications in daily life of what they have learned in the session. The session ends with a short relaxation or meditation exercise.

**Topics of the session** Because the focus of the intervention is on the needs of the participants, there is no fixed scheme of topics per session. However, some topics tend to come up in interventions for women with breast cancer and these topics are bound to be discussed in the course of the intervention (see Box 1). During one session, more than one topic can be discussed, and some topics can be discussed in more than one session and in more than one way. (see Box 2). The therapists use therefore a checklist, to make sure that each topic is discussed. In case a topic is not discussed, the therapist is bound to search for the cause of it, and will try to bring it in one of the sessions left.
The themes of the follow-up sessions are fixed. In the first follow-up session, the central theme is holding on to the change one has made during the therapy. The theme of the second follow-up session is ‘going on without the group’.

The procedures of the psychotherapy group are described in more detail elsewhere [34,35].

**Social Support Group**

The social support groups were designed to let breast cancer patients share their mutual experiences with respect to the diagnosis and treatment for breast cancer, and to receive information from experts on topics they are interested in. Usually these groups meet for 90 minutes, without a coffee break. However, for the sake of comparability, the duration of this group was extended to 2,5 hours with a coffee break. In making both the interventions 2,5 hours, we could guarantee that any result could not be subjected to the different length of interaction in the different kind of groups. Patients were encouraged to use the group to obtain peer support and emotional encouragement from other participants. It was based on the regular support groups provided by the Comprehensive Cancer Centre in Rotterdam. For this support group, no manual was developed. The social support groups were semi-structured: The structure of the sessions was fixed, but the participants had to give each session a specific theme by deciding which topic was discussed in the session. During the
12 weeks intervention, occasionally, an expert was invited to give background information about a particular topic, such as nutrition or immune system.

Each session, with exception of the first and twelfth session, followed the same structure: Opening, discussion of the topic of that week, choosing next week's topic (see Box 1), closing of the session.

During the opening, the group leaders introduce the topic of that session and will shortly look back at the previous session. Other, for the participants' important subjects, could be discussed in a short round.

The central theme of the first session is introduction and getting to know each other. The group leaders introduce themselves and explain the aim of the social support group. Then the group members introduce themselves, giving them as much time as they need. The basic rules and the structure of the sessions are explained, and a topic for the next session is chosen.

In the twelfth session, the participants will evaluate the social support group and there will be much room to say goodbye to each other. Participants are offered the chance to discuss what they learned, what they missed and to give suggestions for improvement. They can also choose the topics of the two follow-up sessions.

### Box 2: Ways of discussion topics in the EE group psychotherapy

<table>
<thead>
<tr>
<th>Topic</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>Exploration of the aim of the intervention; introducing group members; creation of safe surroundings; explanation of rules; inventarisation of expectancies</td>
</tr>
<tr>
<td>Emotions/coping with emotions</td>
<td>Exploration of members' own anxieties and anger; confrontation with anxieties of others; coping with anxiety</td>
</tr>
<tr>
<td>Coping with uncertainty</td>
<td>Making members aware of their own uncertainties</td>
</tr>
<tr>
<td>Self-image</td>
<td>Exploration of the theme &quot;who am I&quot;; paying attention to the influence of cancer and the following surgery on one's self-image; stimulation of acceptation; the feeling of 'I have a right to be here and to be who I am'</td>
</tr>
<tr>
<td>Body image, sexuality, intimacy</td>
<td>Experiences and changes in body image, sexuality and intimacy are discussed and participants learn from each other how to deal with these changes</td>
</tr>
<tr>
<td>Learning from the past</td>
<td>Learning from experiences from one's youth</td>
</tr>
<tr>
<td>Personal meaning of having cancer</td>
<td>Participants become aware of personal thoughts and emotions about having had cancer, with acknowledging of similarities and respect for differences in feelings and emotions</td>
</tr>
<tr>
<td>Support system</td>
<td>Exploration of available support; what kind of support is needed and how to get this kind of support; how to communicate with others to get the needed support</td>
</tr>
<tr>
<td>Saying goodbye</td>
<td>Emotions about having to say goodbye; going on by themselves</td>
</tr>
<tr>
<td>Planning for the future</td>
<td>How to hold on and being aware of what one has learned in the future</td>
</tr>
</tbody>
</table>
Differences between group leaders

The therapists of the EE group psychotherapy were trained therapists, with several years of experience in leading this kind of therapy groups for people with cancer at the Helen Dowling Institute. They received extra training of one day, to become familiar with the study-objectives and with working along the lines of the manual.

The leaders of the social support groups were social workers or oncology nurses who were experienced in working with people with cancer and in working with groups. They received a training of one day in leading this specific social support group in which the study objectives, the structure of the group and the topics were explained, as well as how to handle these topics in the group setting. They could ask for support, intervision, supervision or any other kind of advise from the Comprehensive Cancer Center, Rotterdam.

Statistical analyses

Missing data on item level were imputed if no more than 25% of item scores for a particular subscale and a particular participant were missing and if a subscale consisted of at least four items. The mean score of the remaining item scores of the pertinent person on the subscale at stake was multiplied by the mean of the scores of the other participants on that particular item (column mean) and then divided by the overall mean of that subscale (row mean).

Because of the high ratio between dependent variables and the number of participants, we have tried to limit the number of variables in the analyses. Intercorrelation coefficients were determined for subscales of the POMS. Because of high intercorrelations, Principal Component Analyses were performed on the subscales of the POMS. This procedure has been described in more detail elsewhere [36].

Differences between the groups with regard to demographic and medical variables and with regard to the baseline values of psychosocial adjustment were tested with univariate analyses of variance (ANOVA) for the continuous data and Chi-square analyses for ordinal data.

The intervention effect was tested by using Random Regression Modeling (RRM). RRM allows to estimate the effect of time and type of intervention (psychotherapy group or social support group) and simultaneously to test the effect of age, type of surgery and stage of the disease on all outcome variables. RRM has many advantages above repeated measures ANCOVA and ‘classical’ regression analysis: It allows for missing data or an unequal number of data per subject, and for the inclusion of fixed and time varying covariates. Furthermore, a realistic covariance structure (as opposed to compound symmetry or independence between repeated measures) can be implemented [37]. All significant testing was fixed at p = 0.05 (two-tailed).

For each outcome variable several models were tested. The first four tests concerned the effect of time. In the first series of model testing, the variable ‘linear time trend’ was being fixed (the slope of all individuals are equal). The second series of models encompassed in addition to linear time trend the variable quadratic time trend, which was entered as a fixed term. In the third and fourth series of tested models, the variable ‘linear time trend’ was incorporated
as being random (the slopes of all individuals are specific for each individual), while in the fourth series, the variable quadratic time trend was incorporated as a random term as well. The second set of four tests concerned the tests whether changes in time were different for the EE psychotherapy group condition and the social support group condition. To test the therapy effect, the same line as in the first four series of model testing was followed, with incorporation of the interaction term ‘linear time trend x Type of intervention’. The maximum likelihood method was used to test which model fitted best. A model was decided to have a better fit, if the maximum likelihood was at least significant better than the previous model [37].

Results

Sample description

The investigators contacted two hundred and fifty one eligible women by telephone. Initially one hundred and four women (41.4%) agreed to participate in the intervention. These women were interviewed and finally 87 (34.7%) women enrolled into the study. The reasons for not participating of 164 women were: 1) not interested (n = 26), 2) having enough support (n = 26), 3) being too emotionally distressed (n = 14), 4) could not be reached by telephone (n = 19), 5) other reasons such as distance and time (n = 27), and 6) unknown (n = 52).

Of the 87 women who started the study, 67 women (77.0%) completed the study. Of the 20 women who dropped out, one woman had died, for two women attending a group became too emotional, three women were too ill to attend group meetings, for one woman the group meetings were not what she had expected, and thirteen women did not feel like participating anymore without giving further reasons. Women who stopped participating, were significantly older (53.2 years, SD = 7.21) than women who continued their participation (49.0 years, SD = 7.92). They did not differ on any other demographic, medical and psychosocial adjustment variables at baseline.

None of the 67 participants was diagnosed with distant metastases. Seventeen women had affected lymph nodes. Most participating women had had a mastectomy (65.7%). Three of them had had a reconstruction at the time of T0. The mean age was 49.0 years (range 29-68; SD 7.92). Most women had finished secondary school as their highest education (67.1%). Fifty one women had a partner, six of them were not living with their partner. Of the 15 women who were single, three were never married, ten were divorced and two women were widowed. Medical and demographic data of patients are summarized in Table 1.

Of the 67 participants, 33 women were randomly assigned to the EE group psychotherapy intervention and 34 women were randomly assigned to the social support group intervention. They did not differ on age, type of surgery, stage of the disease and psychological, psychosexual and social adjustment at baseline.
The mean time between T0 and the start of the EE group psychotherapy was 14.1 weeks. The mean time between T0 and the start of the social support groups was 13.9 weeks. This difference was not significant.

At the end of the intervention, the mean number of attended sessions in the EE group psychotherapy group was 9.6, with 10 women attending all sessions and 3 women attending less than 2 sessions. The mean number of attended sessions in the social support group was 8.7. In this group 8 women did not miss any session and 3 women attended only 2 or less sessions. This difference was not significant.

**Data reduction**

Intercorrelation-coefficients were determined for the subscales of the POMS. Intercorrelations of the POMS-subsubscales were all statistically significant ($r \geq 0.35$). Therefore, a Principal Component Analysis with Varimax Rotation was performed on the subscales of the POMS, which resulted in two dimensions. The first dimension represents ‘Distress’ and is formed by
the subscales Depression, Anger and Tension. The second dimension is constructed by the subscales (reverse of) Fatigue and Vigour and represents ‘Vitality’. For both components, the individual scores were calculated and used in the following analyses.

**Changes over time**

In the first series of testing, the effects of changes over time were tested. For all psychosocial adjustment indicators, with exception of Body Image, the best fitting model was the model in which the variable linear time trend was fixed. In the best fitting model for Body Image, linear time trend was incorporated as a random term.

Results show that there are no significant changes over time in Distress, Vitality, Sexual Functioning and Social Interactions (see Figure 1). Body Image and Recreation did change over time (see Figure 2): At the end of the study, women report a more positive body image than at the start of the study ($p \leq 0.001$). They also report that at the end of the study, their illness has less impact on their recreational activities ($p \leq 0.001$).

Of the biomedical variables, Type of Surgery was significantly related with Body Image ($p \leq 0.001$). Women with breast conserving therapy report a more positive body image than women who had mastectomy.

**Effect of interventions**

In the second series of model testing the effect of the interventions were tested. It was hypothesized that women participating in the EE group psychotherapy would report a greater improvement in psychosocial adjustment than women who participated in the social support groups. To test this hypothesis, the same models as in the first set of model testing were performed with the interaction term ‘linear time trend x type of therapy’ incorporated. Results of these analyses showed that for all psychosocial adjustment indicators, with exception of Body Image, the model in which linear time trend was incorporated as a fixed term, was

![Figure 1: Changes over time for Distress, Vitality, Sexual Functioning and Social Interactions](image-url)
the best fitting model (see Figure 3). The best fitting model for Body Image was a model in which linear time trend was incorporated as a random term (see Figure 4). As in the previous set of model testing we found changes over time for Body Image and Recreation, but not for the other psychosocial adjustment indicators. For none of the psychosocial adjustment indicators did we find an effect of the intervention.

**Discussion**

The aim of the present study was twofold. First we tested whether participants of the two kinds of intervention programs were more psychosocially adjusted after one year follow-up compared to the start of the study. Secondly we hypothesized that women who participated in an EE group psychotherapy would benefit more from the intervention program than women who participated in a social support group intervention.
The first hypothesis could only partly be confirmed. At one-year follow-up, there were no changes in Distress, Vitality, Sexual Functioning and Social Interactions. Positive changes were found for Body Image and Recreation. These findings seem to be contradicting with results of other intervention studies that report positive effects of the interventions on psychosocial adjustment [4,14,16,17,19,20,26,38]. However, positive results in the study of Samarel and co-workers (1997) concerned the control group as well and the results of Edelman and colleagues (1999) were no longer apparent at long-term [14,20]. Studies done by Berglund and co-workers (1994) [39] and Edmonds and co-workers (1999) [15] showed no significant effect of group interventions for women with breast cancer, although in the latter study, the therapist reported profound clinical changes [15]. Another study found mixed results: Participants of the group intervention improved when depression was concerned, but levels of distress remained the same [18].

Age and Stage of Disease were not related with any of the psychosocial adjustment indicators. Type of Surgery was related with Body Image in such a way that women who were treated with breast conserving therapy reported a more positive body image than did women who had mastectomy. This was an expected finding, since many studies already found this kind of relationship before [3,40].

We secondly expected that women who participated in the EE group psychotherapy would benefit more from the intervention than did women who participated in the social support groups. Results showed, however, that for none of the psychosocial adjustment indicators such a therapy effect existed. In the light of positive findings of other studies [27,41] this was a rather unexpected result. Bottomley and co-workers (1996) clearly found a more positive therapy effect for patients participating in a cognitive behavioral group therapy over those participating in a social support group condition [41], whereas Helgeson and colleagues
(1999) reports a stronger therapy effect for women in an education condition compared to women participating in a peer discussion group [27].

Results for supportive expressive therapy were mixed. Spiegel and colleagues [16,17,24] did report a positive therapy effect in women with breast cancer, while in other studies such an effect was not found [15,22]. Unfortunately, none of these studies included a social support group condition, which makes it impossible to be conclusive about the beneficial effect of this kind of therapy over social support groups.

The women in this study were at the start of this study as well psychosocially adjusted as women from the general population [36]. This is not in line with findings in many other studies, who found that about one-third of the women diagnosed with breast cancer show mild to moderate levels of psychosocial problems [1,2,42-44]. However, the group of women we studied were comparable to the group of women both Spiegel and co-workers (1999) [17] and Samarel and co-workers (1997) [20] studied.

From this study we can conclude that women with a primary breast cancer, who are psychosocially well adjusted at the start of the study do not especially benefit from a social support group intervention, nor from an EE group psychotherapy when the effect is measured with standardized questionnaires. We explored several reasons for not being able to find positive results in our study, where other studies report improvement in the same kind of women. Just like in the study of Edmonds and co-workers (1999), no changes could be measured with validated questionnaires [15]. However, the clinical impression of the interviews held with all participating women at T2, was that they had benefited from participating in a group: They had build a social network of women suffering the same illness, learned that the physical and emotional problems they encountered were not unusual and they felt less alone in their illness. Women who participated in the EE group psychotherapy also stated that they had learned more to express themselves. However, these topics were not asked in the used questionnaires.

We provided women with psychosocial counseling rather soon after surgery for primary breast cancer. This was to prevent them from becoming psychosocially maladjusted after some time. It was thought unethical to prevent women from participating in any of the two intervention groups for one and a half year, so no non-intervention control group was included in this study. Research in which women were followed for some time after breast cancer diagnosis without receiving special psychosocial care, report that 31% of these women show some kind of maladjustment after one year [45]. In fact, some of the studies who report positive therapy effects, contribute these effects in part to the decline in psychosocial adjustment in the control group [41,46]. Another reason why we did not find an effect of the intervention could be that the psychosocial adjustment level of the participating women in our study was in general comparable to normal, healthy women. Women in our study sample were already well adjusted at the start of the study and remained so at one year follow-up. In studies who reported positive therapy effects, participating women are very often suffering from at least
some emotional problems at the start of the study [14,17,19,41], whereas the mental status of participating women in studies with no effect was within the normal range [18] or unclear [16,27,39].

A final reason why we did not find positive results could be the stage of the illness of the participating women. Women in our study sample faced a primary breast cancer with good prognoses. Studies by Spiegel and co-workers ([1981] [24] and Van der Pompe (1997) [22] were done among women with metastatic breast cancer, who were facing death in the near future. Having good prognosis is often accompanied with questions of how to incorporate the experience of having cancer into one’s life, while having to face death brings up questions about the meaning of life and saying definite goodbye to life, topics which are very well addressed in EE therapy. One could wonder whether this kind of therapy is recommended for the women in our study sample.

A limitation of this study is the number of participating women and the motivation for participation. In this study, only 27.5% of all approached women participated. This percentage confirms what is reported in other randomised intervention studies, which fully describe the number of eligible patients and the number of patients who completed the study [14,41,47]. Randomised studies with higher numbers do usually not describe how many eligible patients were sent a letter for participation or how many eligible patients were reached by other means initially [15,20,24,48]. These studies give, in our opinion underscore of the real number of eligible patients. We stress, therefore, that the women in our study are representative for women who are diagnosed with breast cancer and are willing to participate in a psychological intervention program.

**Implications for clinical practice**

Although we did not found any effect in reducing psychosocial distress in women with a primary breast cancer, after participating in an EE psychotherapy group or a social support group, we would still recommend to offer these kinds of psychological counseling. From the interviews we held one year after the interventions were completed, it became clear that the women thought the interventions helpful. They realised that being slightly depressed sometimes or having feelings of mild anxiety at times, are normal reactions. They stated also that the support from other breast cancer patients was helpful even at longer times. We do recommend, however, to screen women on psychological aspects, before entering a psychological group intervention, instead of providing this kind of support to everyone. Further, it could very well be that the women in our study group rolled too fast after their surgery into this groups. We yield that offering this kind of psychological support leads to greater success when offered at a later stadium in the illness process.
References

Effectiveness of psychotherapy groups and social support groups for breast cancer patients


