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

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Summary and general conclusion
Introduction

In the past decades, there is a growing body of literature concerning the effects of psychosocial interventions for cancer patients. The scope of these interventions is broad: Some interventions focus on psycho-education [1-4], some on coping style [5-10], others on cognitive restructuring [11-14]. Also some interventions have been designed for cancer patients in general [15-21], some for patients with specific types of cancer [4,7,10,22-25], some for newly diagnosed cancer patients [10,12,26-28] some for patients with advanced disease [11,29-31] and some for cancer survivors [32-34].

The effectiveness of these interventions are studied in different ways. Some studies compare an intervention with a control group [13,35-38] while other studies compare two different types of intervention with each other [39-41]. In some studies patients are screened for case-ness before participating [13,14,35,42,43], in other studies this is not the case [2,12,38]. In some studies patients can choose in which intervention they would like to participate [35,39,43], while in other studies patients are randomly allocated to the intervention [3,6,9,37,38].

However, in the late '90s, when the current study started, the general impression from the literature was, that psychosocial interventions would help cancer patients to deal with the stresses (see Chapter 1) occurring after being diagnosed with cancer [8,15-17]. Based on these results and on the results of an earlier study performed at the Helen Dowling Institute among women with advanced breast cancer, the current study was designed. In the earlier study, women with advanced breast cancer were assigned to experiential-existential group psychotherapy. It turned out that only women who had high levels of distress at the start of the study reported beneficial effects of the intervention. The researcher recommended that a more direct comparison between different kinds of interventions should be carried out [11,44].

The present study

This study was a randomised controlled study in which women diagnosed with breast cancer without distant metastases were participating in one of two conditions: Group psychotherapy or a social support group. Women could participate if they had surgery in the past three weeks to four months. They were assigned to either group psychotherapy or a social support group and were randomised into a waiting-list condition, meaning that their intervention would start three months later.

The aim of the study was to investigate whether women who participate in any of these two conditions (i.e. group psychotherapy or social support group) would show a reduction in psychosocial problems. We expected this reduction to be more prominent in those women who participated in the group psychotherapy condition. A second aim of this study was to investigate what the effect of no treatment for three months and delayed intervention would be.
The outcomes we studied concerned psychological problems, psychosexual problems and social problems. Important factors, which we assumed might contribute to psychological outcome, were the amount of social support women experienced and the way women coped with their situation. Therefore, these factors were studied as well.

In total 251 women were contacted to participate in this study. Of these women, 104 women agreed to participate and 87 of them actually enrolled into the study. Of these 87 women, 67 completed the study.

Summary of the study

Chapter 1: Introduction

A short introduction is presented of the problems women encounter when diagnosed with breast cancer. These problems are divided into three areas: Psychological problems, sexual problems and social problems. Also, an outline for the current study is given.

Chapter 2: Level of adjustment

Offering psychosocial interventions shortly after diagnosis and surgery for breast cancer, is based on the assumption that women suffer most from psychological problems during this period. This assumption is justified, since several studies report that up to 56% of the women diagnosed with breast cancer report emotional problems initially [45-49]. These problems disappear in most women, though up to one third of the breast cancer patients still experience psychological problems after one year [50-53].

In the present study we started exploring the level of adjustment of the women participating and determining the relations between the various kind of variables, especially the baseline values of the outcome variables (distress, vitality, sexual functioning, body image, recreational activities and social interactions), the biomedical variables and the mediating variables coping and social support. We expected a relationship between psychosocial adjustment and medical and demographic factors in both a direct and an indirect way. Coping and social support were expected to be related to psychosocial adjustment, medical variables and demographic variables.

Results show that in general the women who participated in this study, were rather well adjusted. They were comparable to women of the general population. We further found that shortly after surgery especially illness specific coping is of high relevance for psychosocial adjustment, while generic coping (i.e. the way one copes generally with different kinds of daily stresses) was less relevant. Women who reported to have an optimistic attitude as a coping strategy, reported less depression, more vitality, a better body image, having more recreational activities and more social interactions. Women who used, on the other hand, an illness orientated coping style reported more distress and a negative body image, while
women who reported to use a more repressive coping style, experienced more distress and less vitality.

We also found that older women and women who had had a breast conserving therapy, used more often an optimistic attitude as their coping strategy. Not surprisingly, the latter group also reported a more positive body image. The positive role of social support often reported by others could not be confirmed.

In general, the findings of the baseline measurements were surprising. Especially the fact that the women who participated in this study did not suffer from more psychosocial problems than their healthy counterparts is important, because possibly of influence to therapy outcome.

Chapter 3: Comparing the intervention and waiting-list condition

The next step in the study was comparing women who participated in the 12 weeks intervention to women who were on the waiting-list for the same kind of intervention. As the women in the waiting-list condition started with their intervention only three months later than the group who started immediately after enrolment into the study, we could only compare the short-term effects. Women were compared with respect to psychosocial adjustment, social support and coping.

At the start of the study, the intervention and waiting-list groups did not differ at demographic, medical and psychosocial adjustment (including coping and social support) variables. At the end of the study, women in the intervention groups did not differ from women on the waiting-list groups with respect to psychosocial adjustment and coping. It appeared that women who had participated in the social support group received more social support from non-significant others at the end of the intervention than women who had participated in the psychotherapy group or who were on the waiting-list. Another finding of this part of the study was that there was no significant change in psychosocial adjustment in women who participated in any of the intervention groups. We concluded that women diagnosed with breast cancer but without psychosocial problems after being diagnosed with breast cancer do not especially benefit from a short-term psychosocial intervention compared to women in a control group at short-term.

Chapter 4: The effects of delayed intervention

As half of the participating women were randomised into a waiting-list condition and receive the same type of intervention after the waiting period, the next step of this study was to investigate the effect of receiving delayed intervention compared to receiving immediate intervention. Comparisons were made just after completion of the intervention and at 6 months follow-up.

The main finding of this part of the study was that women in the delayed intervention condition were significantly more distressed at 6 months follow-up than women in the immediate
intervention condition. This finding suggests that women should be offered the possibility of participating in psychosocial intervention programs shortly after receiving surgery for breast cancer.

We also compared the pre- post- and follow-up measurements. As we also found in an earlier part of this study (see Chapter 3), pre-post changes did not occur, but at 6 months follow-up there was a change in body image and recreational activities in a positive direction. There was also a trend, indicating that women were less distressed and reported less social interactions at six months compared to the start of the study. However, these changes did not result from participating in any of the two intervention types, but from the passage of time.

Chapter 5: The effect of group psychotherapy and social support groups

The main aim of this study was to compare the effects of a social support group to experiential-existential (EE) group psychotherapy. We hypothesized that participants of both interventions would show a positive change in psychosocial adjustment, but that these changes would be more prominent in women who participated in the EE psychotherapy groups. The findings concerned the measurements just after completion of the intervention and at 12 months follow-up.

In agreement with previous findings, no changes in any of the psychosocial adjustment variables were shown. At 12-months follow-up, women of both intervention conditions reported an improvement in body image and in recreational activity. Apparently, the change reported in the previous part of the study at 6 months, was maintained at 12 months. However, no changes in any of the other psychosocial adjustment variables were found. Again, the reported changes were not the result of participating in any of the intervention conditions but of the passage of time.

Chapter 6: Illness specific coping in relation to psychosocial well-being

Finally, we studied the role of illness specific coping in relation to psychosocial well-being. We focussed on illness specific coping because this type of coping appeared to be more strongly related to psychosocial well-being than generic coping in an earlier part of this study [54]. We determined the stability of psychosocial well-being, of illness specific coping and the relationship between illness specific coping and psychosocial well-being over time. It appeared that both well-being and illness specific coping were fairly stable over time. It also appeared that women who use an optimistic attitude as a coping strategy reported more positive psychosocial well-being over time. Women, on the other hand, who tended to use illness orientated coping were more distressed and showed less psychosocial well-being. Women who used repressive coping strategies at the start of the study, report less vitality at that time. However, over time, there appeared to be no relationship between repressive coping and psychosocial well-being.
**General conclusions and recommendations**

The conclusion of this study is that the studied interventions, a social support group and experiential-existential group psychotherapy generally were not effective in reducing psycho-social problems in women suffering from a primary breast cancer without distant metastases. Neither changed these interventions maladaptive coping styles or increased social support. A result of this study was that 6 months and 12 months after completion of the intervention, body image has improved and women undertook more recreational activities compared to the start of the study. However, these outcomes were not the result of participating in any of the interventions, but the result of passage of time.

**Results in perspective**

When this study started in the late ’90s, the conclusions of most intervention studies were that psychosocial interventions for cancer patients would reduce psychosocial problems such as depression and anxiety [15-17]. In these studies, participants were sometimes selected on the basis of high levels of psychological problems at the start [14,35,42], some studies did not apply randomisation [6,14,27,35,42], the used intervention programs were not always clear [27,28,35,42] or very specific [14]. As a consequence, it was easier to gain positive results, implying that psychological interventions for cancer patients were effective.

After 1995, other researchers started intervention programs as well. Our review of the recent literature showed that in the past five years, several randomised intervention studies among women with breast cancer have been carried out [55-67]. Of these studies, only one study compared more than one kind of intervention [61]. All other interventions were compared to a control group receiving standard care, with some of these control groups receiving additional information [56,59,64-66]. The numbers of participants in these intervention studies were in general somewhat higher than in our study, varying from 66 [55] to 259 participants [56]. In some studies women with early stage breast cancer were studied, while in others women with advanced breast cancer [60,64,65] were studied. Most interventions were different from the type of intervention we carried out [55,57-60,62-64]. From the studies, which studied a comparable type of intervention, results were indeed comparable to our results: There was no significant change in distress in the intervention condition [56,61,65,67]. Kissane and colleagues (2003), reported in one study that although there was no change in distress, participants of the intervention condition reported a slight positive change in anxiety [56]. In a later study, Kissane and co-workers (2007) found that there was a positive change in social functioning, but no change in distress when the entire study group was taken into account. However, women who were at the start of this study at risk for developing depression, appeared to be improved at the end of the study [65].

The study of Chan and co-workers (2007) compared three intervention types: a Body-Mind-Spirit intervention, a supportive-expressive group intervention, which is comparable to our
therapy groups, and a self help social support group. The supportive expressive therapy group, showed no change in distress. Nor did the social support group [61]
In a series of meta-analyses published in 2006 [68], the effectiveness of psychological interventions for cancer patients is even questioned. The conclusions of Coyne and co-workers (2006) are not very optimistic. They state that 1) earlier published reviews were often narrative reviews in stead of systematic analyses of randomised trials, 2) non-randomised trials report more positive effects than randomised trials, 3) when no quality control was performed, effects turned out to be larger than in case quality control was applied, and 4) if only published studies are included, effectiveness is more often demonstrated than when non-published studies are included [69]. This negative opinion is not shared by Manne and Andrykowski (2006), who found at least five well designed randomised controlled trials [57,70-73] with positive effects [74]. Reviews published after 2002 show only minimal effect, especially with respect to reduction of depression [31,20,75]. Ross and colleagues [75] concluded after reviewing the literature, that the effectiveness of interventions remains unresolved, and Edwards and co-workers [31] concluded that there is not enough evidence to promote group psychosocial therapies (based on cognitive behavioral or supportive expressive premises) for women diagnosed with metastatic breast cancer. They concluded that the benefits of the interventions are only proven for some psychosocial outcomes and are only for short-term effects [31]. Newell and colleagues [20] concluded after an extensive literature search that it is not possible to recommend for or against psychosocial interventions. They found that most recommendations are only based on one or two fair-quality trials, making it difficult to state that psychosocial interventions are recommended for all cancer patients. Interestingly, however, in their meta-analysis the effect of group interventions was more evident than the effect of other psychosocial interventions.
In a review of psychoeducational interventions, it was reported that two third of the interventions were effective in reducing depression in adult cancer patients [76]. However, of the effective intervention studies, only one third were randomised controlled trials with more than 100 patients. Whether the remaining intervention studies were randomised controlled trials, remains unclear from the review. Taken things together, unfortunately, the effectiveness of psychosocial interventions among (breast) cancer patients is far from evident yet.

Study limitations
This study has some limitations. The women in our study were diagnosed with a primary breast cancer without distant metastases and had a rather good prognosis. It might well be that when the prognosis is worse, the interventions studied are more effective: In such case, women are struggling to survive or are bound to make some final decisions in their lives. Furthermore, most women in our study reported at the start of the study that they were not suffering from serious psychosocial problems. This is a problem if one tries to demonstrate
a reduction of distress in an intervention study. We would strongly suggest, therefore, that women should be screened for psychological problems first before invited them to participating in a psychosocial intervention study.

Another shortcoming of this study could be the selection of the questionnaires used. Although all questionnaires were reliable and most of them validated, they might not be sensitive enough to detect a change in our study group as a whole. However, this does not mean that these questionnaires should not be used in future research. The POMS [77] for example, has been proven to be useful in other kind of research and with other groups of patients [78-80]. Apart from that, some of these questionnaires could well be used in hospitals for screening patients or for monitoring the psychological status of patients. An example is the EORTC [81,82]. This questionnaire could be used in hospitals to monitor the quality of life of cancer patients in several areas (psychological, social, sexual, cognitive etc.) at different time points during treatment.

In our study, women could not choose in which kind of intervention they would participate. They also could not choose when they wanted to start with their intervention. This means that, at least partly, the interventions were not tailored to their individual needs. This is an obvious result of the randomised study design, but it could have influenced the outcome of it as well.

A final shortcoming of this study was that there was no real control group. When we started this study, findings of other intervention studies were positive and it was thought unethical to withhold something ‘good’ from women who were diagnosed with breast cancer for the 15 months’ duration of the study. Especially since not being able to participate in any of the intervention groups was not a free choice but part of the randomisation process. In future research we would strongly recommend the inclusion of a no-treatment control group as some decrease in distress is expected in a non-intervention group. It could well be that being in any of the intervention groups prevented women from becoming distressed over time, because they learned how to deal with the stresses of having had breast cancer. In case a control group is included in this kind of study, women who are in the control groups should be monitored carefully, so that when psychosocial problems arise before the end of the study, they are offered psychosocial help.

Opportunities

From our study it could be concluded that women who participated in any of the intervention groups did not find the groups beneficial. However, this was not the case. Although there was not a result in the sense that they were psychosocially better adjusted at the end of the study compared to the start, women valued both interventions highly. Just after completion of the intervention and at 12 months follow up, we have asked women to value the intervention they had participated in. We asked them about the quality of the intervention, whether they would recommend this kind of intervention to other women, if they felt that the intervention
had helped them, if they were satisfied with the intervention and if they would come back to participate in the same kind of intervention in case they needed to. Women could answer on a scale from 1 (very bad) to 4 (very good). We also asked them to rate the intervention with a number between 0 (very bad) and 10 (very good). The findings are presented in Table 1. Scores on the 0 to 4 scale were 3 and 4 and were 7.8 and 8.1 on the 0 to 10 scale. In other words, participating women valued both interventions highly. There was no significant difference between the appreciation of the psychotherapy groups and the social support groups. Over time the members of the support groups valued the quality of the intervention better (p = 0.032). Chan and colleagues (2007) and Classen and co-workers (2008) also reported that they found no evidence of reduction in distress as a result of a supportive-expressive intervention program for women diagnosed with breast cancer but they also found that women valued the intervention as helpful [61,67].

Based on the results of our study and the high values of the women who participated in this study, we have some recommendations. Women need to know that if they need psychosocial support at any time in their illness process, it is possible to receive such assistance and where to get it. This applies to all women falling into the normal range of psychosocial adjustment. It does not mean that there is not a task for hospitals. Hospital staff should screen all women diagnosed with breast cancer on psychosocial adjustment and women who are at risk for developing psychosocial problems should be offered psychosocial help in a more proactive way. To test such approach, we recommend a ‘watchful-waiting’ study. In this kind of study, which should be randomised, women will be assigned to one of two conditions. In the first condition women participate in a psychosocial intervention group shortly after diagnosis (1–3 months). Women assigned to the second condition are regularly (every 1 or 2 months) monitored and start with the same intervention when the scores of the screening instrument indicates that psychological problems exists. In this way it is tested whether offering interventions when psychosocial support is needed is more effective than offering interventions to all women diagnosed with breast cancer.

**Table 1: How women valued the intervention**

<table>
<thead>
<tr>
<th>Subject</th>
<th>Therapy group</th>
<th></th>
<th>Social support group</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>After completion</td>
<td>At follow-up</td>
<td>After completion</td>
<td>At follow-up</td>
</tr>
<tr>
<td>Quality of intervention</td>
<td>3.13</td>
<td>3.34</td>
<td>3.37</td>
<td>3.53</td>
</tr>
<tr>
<td>Recommend to others</td>
<td>3.50</td>
<td>3.69</td>
<td>3.55</td>
<td>3.88</td>
</tr>
<tr>
<td>Did the intervention help</td>
<td>3.47</td>
<td>3.63</td>
<td>3.45</td>
<td>3.85</td>
</tr>
<tr>
<td>Satisfied</td>
<td>3.70</td>
<td>3.78</td>
<td>3.77</td>
<td>3.94</td>
</tr>
<tr>
<td>Would you come back</td>
<td>3.40</td>
<td>3.66</td>
<td>3.47</td>
<td>3.85</td>
</tr>
<tr>
<td>Mark</td>
<td>8.06</td>
<td>7.77</td>
<td>8.17</td>
<td>7.79</td>
</tr>
</tbody>
</table>
References


Summary and general conclusion


