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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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

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Appendix

Analyzing the difference between psycho-therapy groups and social support groups for breast cancer patients: The use of video recordings

Bert Garssen
Petra J. Vos
Eltica de Jager Meezenbroek
Cora de Klerk
Adriaan P. Visser
Abstract

When comparing the efficacy of different interventions for cancer patients, there should be certainty that these types are sufficiently different in the way they are actually presented. The focus of the present study is on the difference between support groups and experiential-existential psychotherapy groups. Independent and blind raters assessed video fragments of both intervention types, using a self-developed checklist. This checklist was first evaluated by a group of experts for appropriateness, importance, and reliability. Three out of the five questions were selected on the basis of these experts’ evaluation and on inter rater reliability. The scores on these questions were used to evaluate five social support groups and six experiential-existential psychotherapy groups for breast cancer patients. According to the independent and blind raters the content of the two intervention forms appeared to be significantly different. It is concluded that this method of assessment, is profitably as a check to compare the aimed content of psycho-oncological interventions.
Introduction

The effectiveness of psychological interventions for people with cancer has been demonstrated in many controlled and randomized studies [1-10]. Although most of these studies did find an improvement with respect to anxiety, depression, worry, confusion, self-esteem, experienced control, quality of relationships and somatic symptoms, there is limited knowledge about which types of psycho-oncological interventions make a significant contribution to their effectiveness.

Various group interventions have been compared [11-16]. The types of group interventions distinguished in these studies are: Self-help groups [17,18], social support groups with and without psycho-education [15], cognitive behavioral oriented ‘stress management’/’coping skills training’ groups [19-22], psychodynamic therapy groups [23], and experiential-existential centred therapy groups [24]. The contrast most often studied, is between support groups and stress management groups [11-14]. Stress management appeared to be more efficacious than social support alone. Helgeson et al. (2000) [15] compared group psycho-education, peer-discussion (support group) and no therapy. Psycho-education -either on its own or in combination- generated greater benefits than supportive discussions alone.

Differences between social support and experiential-existential psychotherapy groups

We compared the effectiveness of social support groups and experiential-existential psychotherapy groups; a contrast which had not been evaluated before. The present study is part of an intervention project [25].

When comparing different intervention types, there should be certainty that these forms are sufficiently different in the way they are presented during the study. The distinctive features of social support and experiential-existential psychotherapy groups are rather subtle (see Table 1), which makes such a check the more necessary.

<table>
<thead>
<tr>
<th>Similarities and differences in goals between social support groups and experiential-existential psychotherapy groups</th>
</tr>
</thead>
<tbody>
<tr>
<td>Social support group</td>
</tr>
<tr>
<td>1. Group leader has a professional background in psychotherapy</td>
</tr>
<tr>
<td>2. Mutual support group members</td>
</tr>
<tr>
<td>3. Exchange of disease and treatment related experiences and emotions</td>
</tr>
<tr>
<td>4. Discussion of practical solutions for disease and treatment related problems</td>
</tr>
<tr>
<td>5. Psycho-education</td>
</tr>
<tr>
<td>6. Utilizing group processes for learning</td>
</tr>
<tr>
<td>7. Attention for personal meaning of experiences and emotions</td>
</tr>
<tr>
<td>8. Systematically analysing problems</td>
</tr>
<tr>
<td>9. Encouragement to express emotions</td>
</tr>
</tbody>
</table>
Sivesind and Baile [26] mentioned four distinctive features of social support groups. (1) Support groups offer in their view concrete guidelines, such as directing patients as to when they should report troubling symptoms to their physician, which is often discouraged in psychotherapy groups. The difference is, in our view, more gradual. A therapy group for cancer patients will not avoid discussion of practical aspects, although explicit guidelines do indeed tend to be set more often in a support group. (2) According to Sivesind and Baile (1997), support groups often run for an indefinite period of time and change members frequently, whereas psychotherapy groups usually have an identified ending point and strive to maintain a stable group membership. Support groups are in our view indeed more often open-ended, whereas therapy groups are more often closed and time limited. However, these differences are far from being absolute and not imperative. (3) Members of support groups are often identified by a common problem, whereas in group psychotherapy, members are not, according to Sivesind and Baile (1997). However this characteristic does not always apply. If it means limiting group membership to a certain disease, phase of disease or subgroup, then this limitation has been applied in psychotherapeutical interventions, focused on specific groups, such as spouses of lung cancer patients [27], adolescents with cancer [28], metastatic breast cancer patients [29,30] or gastrointestinal patients undergoing surgery [31]. (4) According to Sivesind and Baile [26], group psychotherapy generally focuses on making personal changes through insight to enhance interpersonal skills or relieve intrapsychic distress. Support groups, in contrast, specialize in helping patients cope with the trauma of an illness, such as cancer or another life crisis, decreasing the sense of isolation of group members and helping find a new meaning in life. However, the delineated aims for support groups apply in our view equally to therapy groups. It would be unfortunate if therapy groups for cancer patients did not have these objectives.

Common and important elements in both interventions are in our view: Mutual support among group members and sharing experiences and emotions. Social support groups are more practically oriented and tend to dedicate more attention to psycho-education (conceived as structured provision of information about the disease, its treatment and psychological adjustment, and discussion of this information). In psychotherapy groups, psychotherapists will use the group interaction as learning experiences for participants. They also systematically analyse psychological problems of participants and focus on the personal meaning of the experiences and emotions expressed by participants, more than leaders of social support groups do. Emotional expression itself is important in psychotherapy, partly because venting one's emotions can be salutary in itself, but mainly because it helps to discover what is essential to the individual. Emotional activation is often a clue to what is personally relevant. These differences are related to the professional background of group leaders, which is often a psychotherapist in therapy groups, whereas leaders of support groups are more often social workers, medical doctors or oncology nurses (without extensive psychotherapeutical training).
**Aim of the study**
The aim of the present study is to analyze the differences between social support groups and experiential-existential psychotherapy groups in the way they are offered to patients. A checklist was developed on the basis of the abovementioned differences; to be used by independent raters to score recorded video fragments of both intervention types. The relevance and validity of the checklist was first evaluated by a group of experts. Subsequently, the checklist was applied by independent raters, who rated the video fragments of group therapy and social support group sessions to determine inter rater reliability. On the basis of the experts’ opinions and the inter rater reliability scores, questions were selected that appeared to be valid, relevant and reliable for analyzing the differences between support groups and experiential-existential psychotherapy groups. Based on the selected questions it was established whether the two intervention forms actually differed in the expected direction. Further, the degree to which an intervention group fulfils the psychotherapy and social support group model, was determined for each of the eleven groups that participated in this study.

**Methods**

**Design of the study**
This study is part of a larger intervention study to evaluate the effectiveness of psychotherapy groups in comparison to social support groups. Breast cancer patients were randomly allocated to a psychotherapy, social support or waiting list condition. Patients in the waiting-list condition were later randomly allocated to one of the two types of intervention [25]. The sample included six therapy and five social support groups. Each intervention consisted of twelve weekly sessions and two follow-up sessions, which were scheduled one and two months after the last weekly session. Sessions lasted two-and-a-half hours and included a short break halfway through.

For the purpose of this study every second, sixth and eleventh session was recorded on video. Afterwards, five minutes fragments were selected from each session: One before and one after the break. Fragments had to satisfy the following two conditions to be included in the evaluation tape. First, it should not include a meditation or relaxation exercise, and secondly it should show at least two people speaking, one of whom was a therapist/group leader. The first fragment, which after twenty minutes of the videotape satisfied the two mentioned conditions, was chosen. Video fragments were selected from the eleven groups, three sessions per group, and two fragments from each session, making a total of 66 fragments minus three unusable fragments, due to failed recordings. The selected 63 fragments were placed in random order on a new tape and were rated by three raters, who were blinded to the conditions.
The raters were three paid psychology students, who had completed a short observation training course. During this training course they practised the rating system, using recordings from group sessions made during a pilot study. The raters were intentionally not provided with descriptions of a psychotherapy group and social support group. The raters were blinded to the type of intervention. They were expected to use their own expertise as clinical psychology students in answering this question.

The checklist

The checklist consisted originally of five questions, presented in Table 2. The questions in the checklist are based on the differences between a social support group and an experiential-existential therapy group, as described in Table 2. Question 1 is mainly related to point 4 and 5 in Table 1. Question 2 refers to point 3, 4 and 8 in Table 1, while question 3 refers to points 3 and 4, and question 4 to point 3, 4, and 6.

The descriptions of the two intervention types were intentionally labelled with the neutral description of an A and B type of intervention, and not as descriptions of a therapy group and a social support group, to prevent any possible prejudices by the raters. The first four questions included a short description of a ‘Type A’ and a ‘Type B’ intervention. The raters

<table>
<thead>
<tr>
<th>Question</th>
<th>Type A</th>
<th>Type B</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>The group supervisors have a guiding role, though attention is also given to themes introduced by the participants. Participants are provided with a lot of information about the disease and its treatment, psychological reactions, and practical adjustments.</td>
<td>The group supervisors stimulate and guard the group process: Does everyone receive sufficient attention, are individual differences honoured, and is sufficient attention paid to the personal meaning of experiences?</td>
</tr>
<tr>
<td>Question 2</td>
<td>Emotional aspects are discussed, but the emphasis is on practical solutions to the problems discussed.</td>
<td>Practical solutions are discussed, but the emphasis is on emotional aspects and personal meaning of problems and solutions.</td>
</tr>
<tr>
<td>Question 3</td>
<td>If participants have found solutions to their problems themselves, they are invited to share them. That people are themselves often capable of finding their own solutions is emphasized, and attention is also paid to what people are good at, in addition to those problems they are struggling with.</td>
<td>If participants have found solutions to their problems themselves, they are invited to share them, because these solutions may be helpful to others.</td>
</tr>
<tr>
<td>Question 4</td>
<td>Discussing certain topics may touch participants emotionally. Room for expressing emotions is allowed for, but this is not the focal point. Finding a practical solution is attempted.</td>
<td>Discussing certain topics may touch participants emotionally. Time to express emotions is allowed for and what these emotions mean to the individual is discussed.</td>
</tr>
<tr>
<td>Question 5</td>
<td></td>
<td>Does the fragment represent mainly a ‘therapy group’, ‘a social support group’, both or neither of both</td>
</tr>
</tbody>
</table>
were asked to score whether a fragment was ‘more Type A’, was ‘more Type B’, ‘somewhat of both Type A and Type B’, or was ‘neither similar to Type A or Type B’. For questions 1, 2 and 4 the answer ‘resembling more Type A’ was coded as –1; ‘more Type B’ was coded as +1; and ‘somewhat of both Type A and type B’ or ‘neither Type A or Type B’ was coded as 0. For question 3 the coding was the opposite. The fifth question asked directly whether the rater found the fragment mainly representing ‘a psychotherapy group’, ‘a social support group’, ‘somewhat of both’, or ‘neither of both’ (later coded as 1, -1, 0 and 0, respectively).

**Evaluation of the checklist**

We asked twelve experts in the field of psycho-oncology to evaluate the relevance and appropriateness of the first four questions in the checklist, supposing; there was no doubt about the relevance and appropriateness of the fifth question. Eight psychotherapists and four support group leaders were asked to indicate on a checklist, first, which of the two descriptions for each question they would classify as describing a social support group; secondly, whether they thought the descriptions were appropriate; in the third place whether the descriptions expressed an important difference between the two types of intervention; and fourth whether they thought the question could be reliably rated.

**Statistical procedure**

Kappa coefficients were used to determine inter rater reliability. A squared weighted Kappa coefficient was used to value a difference of one point between two raters as more acceptable than a difference of 2. A difference of 1 point occurs, for instance, if one rater defines a fragment as ‘Type A’, while the other rater defines the fragment as ‘neither of both’. A difference of 2 points is obtained if one rater defines a fragment as ‘Type A’, whereas the other defines it as ‘Type B’. A Kappa larger than 0.40 is considered as reasonable [32].

To determine whether the raters were able to differentiate between the two intervention forms on the basis of the video fragments, only those questions were used that were rated as acceptable by the experts and showed sufficient inter rater reliability. The raters’ scores for the two intervention types were compared with a General Linear Model Repeated Measures Procedure, using the mean of the scores of the three raters. In this analysis, the ‘cases’ are the eleven groups (six versus five cases). Each ‘case’ has six repeated measures (= the scores for the six video fragments per group, averaged for the three raters). The repeated measurements in this study are interrelated at two levels: The three sessions of each group are interrelated and the two fragments of each session are interrelated, nested within the first series of data. A significance level of p=.05 was used in all tests.
Results

Evaluation of the checklist

The experts rated three of the four questions (1, 2 and 4) as appropriate, important and rateable: Their mean scores were between 2 (‘reasonably’) and 3 (‘good’).

When asked which description (A or B) referred to a social support group or psychotherapy group, one of the twelve experts systematically scored in a direction opposite to what we considered correct on theoretical grounds. All other experts agreed on questions 2, 3 and 4. However, question 1 was only by 8 of the 12 experts scored in the “correct” direction. On the basis of these expert ratings only questions 2 and 4 appeared to be valid and relevant (see Table 3).

Table 3: Evaluation of the checklist by the twelve experts. Mean values of appropriateness, importance and rateability of the questions are presented. Scores range from 0 (‘not at all’) to 4 (‘very’).

<table>
<thead>
<tr>
<th>Question</th>
<th>Appropriate</th>
<th>Important</th>
<th>Rateable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>2.6</td>
<td>2.8</td>
<td>2.9</td>
</tr>
<tr>
<td>Question 2</td>
<td>2.8</td>
<td>2.8</td>
<td>3.0</td>
</tr>
<tr>
<td>Question 3</td>
<td>1.8</td>
<td>2.1</td>
<td>1.5</td>
</tr>
<tr>
<td>Question 4</td>
<td>2.3</td>
<td>3.0</td>
<td>2.6</td>
</tr>
</tbody>
</table>

Inter rater reliability

The squared weighted Kappa coefficients of the five questions are presented in Table 4.

Question 1 and 3 could be considered as unreliable, because the inter rater reliability is too low. Question 2 as nearly reliably and question 4 as rated reasonably reliably, according to the view of Landis and Koch (1977) [32].

Table 4: Reliability of the questions.

<table>
<thead>
<tr>
<th>Question</th>
<th>Squared weighted Kappa coefficient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 1</td>
<td>0.15</td>
</tr>
<tr>
<td>Question 2</td>
<td>0.38</td>
</tr>
<tr>
<td>Question 3</td>
<td>0.17</td>
</tr>
<tr>
<td>Question 4</td>
<td>0.44</td>
</tr>
<tr>
<td>Question 5</td>
<td>0.47</td>
</tr>
</tbody>
</table>

A check was made to determine whether one of the raters systematically deviated in his judgement from the other two raters, which appeared not to be the case. A check was also made to determine whether reliability was different for fragments before or after the interval, or differed per session. This was generally not the case, with some rare exceptions (reliability was sometimes lower for session 2, compared to the later sessions for questions 2 and 4).
The difference between the two intervention types

For this analysis only question 2 and 4 were used, because only these questions appeared to be valid and relevant. The raters’ scores did not change over time. There was no significant effect for session (early, middle or late session) or interval (before or after interval). Only once was an interaction effect noted: for question 2 the interaction between session, interval and intervention type was significant (p=.03 for a Multivariate Test).

What is most important, is that the main effect for intervention type was significant for the three remaining questions (question 2, F=11.4, p=.008; question 4, F=13.9, p=.005; question 5, F=23.6, p=.001). Apparently, the raters rated the two intervention types as being different. Table 5 and 6 show the mean scores for psychotherapy and social support groups, for the different type of fragments: Early, middle or late session (Table 5) and before or after the interval (Table 6).

Table 5: Mean raters’ scores per session and intervention type.

<table>
<thead>
<tr>
<th></th>
<th>Therapy groups (n=5)</th>
<th>Social support groups (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Session 2</td>
<td>Session 6</td>
</tr>
<tr>
<td>Question 2</td>
<td>0.49</td>
<td>0.31</td>
</tr>
<tr>
<td>Question 4</td>
<td>0.33</td>
<td>0.33</td>
</tr>
<tr>
<td>Question 5</td>
<td>0.39</td>
<td>0.33</td>
</tr>
</tbody>
</table>

Positive score = more like a psychotherapy group; negative score = more like a social support group

Table 6: Mean raters’ scores for fragments before and after the interval per intervention type.

<table>
<thead>
<tr>
<th></th>
<th>Therapy groups (n=5)</th>
<th>Social support groups (n=6)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Before interval</td>
<td>After interval</td>
</tr>
<tr>
<td>Question 2</td>
<td>0.17</td>
<td>0.43</td>
</tr>
<tr>
<td>Question 4</td>
<td>0.15</td>
<td>0.29</td>
</tr>
<tr>
<td>Question 5</td>
<td>0.19</td>
<td>0.33</td>
</tr>
</tbody>
</table>

Positive score = more like a psychotherapy group; negative score = more like a social support group

As expected, psychotherapy group fragments were rated as psychotherapeutic (scores > 0) and social support group fragments were in general rated as social supportive (scores < 0).

The scores for the therapy groups were near zero during the last session, which means that they are then judged as being in between a psychotherapy and social support type of intervention. Intervention types differ the most in week six (the middle session) and fragments after the interval are more therapy alike than before the interval.

Though it was demonstrated that psychotherapy groups were rated by independent and blind raters as being different from social support groups, some psychotherapy groups could have been in fact more like a social support group and vice versa. Figure 1-3 show the mean scores (average of the six scores for each fragment) for the eleven groups with respect to the three most important questions.
The figures show that there is quite some difference in how the groups were rated. Some groups were rated as not clearly representing the expected intervention type, or even as representing the not-intended type of intervention (Group 4, 5, 8 and 11).

Discussion and conclusion

The aim of the present study is to analyze the differences between social support groups and experiential-existential psychotherapy groups in the way they are presented to the clients. Therefore a checklist was developed, based on theoretical grounds to distinguish their manifestations of both interventions in practice. These two types, namely a social support group condition and an experiential-existential psychotherapy group, differ only gradually, which makes a test for actual differences even more important. Further it is necessary that the differences should appear from observable behavior of group members and group leaders and be determinable by raters who have interest in but are not specialised in this specific field of psycho-oncological interventions. Another difficulty was the absence of generally accepted guidelines in the literature about what constitutes a support group and a psychotherapy group.

A checklist with five questions was developed, to be used by three independent raters in their assessment of video fragments of therapy and social support groups. A group of experts evaluated the appropriateness, importance and rateability of the first four questions. Two
questions were rejected on the basis of their evaluation. Three independent raters scored the video fragments using the five questions and agreed on most questions except two based at the Kappa coefficients. These were the same two questions already rejected by the group of experts.

The three main questions were used to determine whether the two intervention forms differed, according to the independent raters, in the direction that was theoretically assumed. Despite the low power of this test, being based on six repeated measurements for only six intervention groups versus five social support groups, all three tests showed a significant difference. The scores for all three questions were in the expected direction. Apparently, the raters found the content of the two types of intervention clearly different.
Appendix

Discussion

It is a methodological flaw to test validity and reliability of a measuring method in a certain sample, and to use the same sample to apply this method for testing a hypothesis. However, the samples for testing validity, reliability and intervention differences were different. Three tests were performed in this study. First a test on relevance and rateability of the checklist, Second a test of inter rater reliability, and in the third place a test whether the two intervention forms differed in their actual manifestations. The samples for these three tests consisted of the group of experts, the three judges, and the eleven intervention groups, respectively. The items of the checklist were chosen on the basis of expertise of therapists at our institute and our own view as therapy researchers, because generally accepted guidelines for social support groups and therapy groups for people with cancer and formulations about their differences, did not exist. There is a lack of uniformity in the classification of these types of intervention. A clear description of what constitutes a support group and a therapy group is difficult to pinpoint from the literature [33-35]. Our conception of a social support group is comparable to the ‘support group therapy’ and ‘supportive counseling’ condition applied by

![Figure 3: Mean scores to question 5 for each of the eleven groups](image-url)
Telch and Telch (1986) [11] and Moorey et al. (1998) [36] respectively, which they compared to a cognitive behavioral intervention. These investigators used the support group condition to control for the attention and support given by the therapist in the coping skills training condition. In our case the effects of support groups and psychotherapy groups were compared.

**Conclusion**

A concomitant advantage of an assessment method, as developed in the present study, is the necessity to conscientiously analyse and formulate the differences between support groups and therapy groups. Types of interventions and their distinctive characteristics have not been clearly described in the psycho-oncological literature and, consequently, intervention studies cannot be easily compared.
References