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Online Publication Date: 01 March 2008

To cite this Article: O'Brien, Mary, Harris, Jill, King, Robert and O'Brien, Tom (2008)

'Supportive-expressive group therapy for women with metastatic breast cancer: Improving access for Australian women through use of teleconference', Counselling and Psychotherapy Research, 8:1, 28 - 35

To link to this article: DOI: 10.1080/14733140801889071

URL: http://dx.doi.org/10.1080/14733140801889071

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Supportive-expressive group therapy for women with metastatic breast cancer: Improving access for Australian women through use of teleconference

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Abstract

While supportive-expressive group therapy (SEGT) has been found to be effective in significantly reducing distress associated with life-threatening illness, the challenge in Australia is to develop a means of providing supportive interventions to rural women who may be isolated both by the experience of illness and by geographical location. In this study an adaptation of SEGT was provided to women with metastatic breast cancer (n = 21), who attended face-to-face or by telephone conference call. Participants showed significant gains on standardised measures of well-being, including a reduction in negative affect and an increase in positive affect, over a 12-month period. A reduction in intrusive and avoidant stress symptoms was also observed over 12 months; however, this difference was not significant. These outcomes suggest that SEGT, delivered in an innovative way within a community setting, may be an effective means of moderating the adverse effects of a diagnosis of metastatic breast cancer while improving access to supportive care for rural women. These results are considered exploratory, as the study did not include a matched control group.

Keywords: Breast cancer, metastatic cancer, psychosocial, support groups, supportive-expressive group therapy, telephone

There is evidence that the diagnosis of metastatic breast cancer (also known as secondary or advanced breast cancer) results in high levels of psychological morbidity, including depression, anxiety, and traumatic stress responses (Burke & Kissane, 1998; Turner, Kelly, Swanson, Allison, & Wetzig, 2005). Despite this, studies have shown that the psychosocial care of women with metastatic breast cancer is lacking (Coristine, Crooks, Grunfeld, Stonebridge, & Christie, 2003; Parle, Gallagher, Gray, Akers, & Liebert, 2001; Scholten, Weinlander, Krainer, Frischenschlager, & Zielinski, 2001). A recent Australian study of women with metastatic breast cancer identified psychological and health information domains as the highest unmet need of this group (Aranda et al., 2005). Sanson-Fisher et al. (2000) found that, compared to a heterogenous group of cancer patients, women with metastatic breast cancer expressed greater need for counselling and support services.

Diagnosis of metastatic breast cancer, which refers to cancer which has spread to distant parts of the body, is often more devastating than the original diagnosis (Hall, Fallowfield, & Ahern, 1996). This is perhaps not surprising, given the life-threatening nature of the disease. Currently there is no cure for metastatic disease and treatment is aimed largely at improving quality of life while attempting to contain the spread of the disease.

Given the high incidence of breast cancer in developed countries, the life-long risk of recurrence, and the emergence of metastatic breast cancer as a chronic illness, requiring management over many years for large numbers of women, there is a need to develop a range of effective psychosocial support services for women with metastatic breast cancer. These services aim to improve quality of life and address the identified unmet psychological needs.

There is the additional challenge in a country like Australia to develop effective ways of delivering psychosocial support interventions to women in rural and regional areas, who may be doubly isolated by their illness and their geographical location. The incidence of breast cancer in Australia is similar to that in other developed countries, being 83.2 new cases per 100,000 population in 2002 (Australian Institute of Health and Welfare & National Breast Cancer Centre, 2006). Breast cancer is the leading cause of cancer death in women in Australia. As one of the most decentralised states in Australia, Queensland is an ideal site to evaluate an innovative model of service delivery:
What does this study explore?

- Assesses the clinical effectiveness of a professionally led face to face and telephone support group for women with metastatic breast cancer

41% of women diagnosed with breast cancer in Queensland live in a rural area (Hill et al., 1999).

Supportive-expressive group therapy (SEGT) for women with metastatic breast cancer has been demonstrated, in randomised controlled studies, to be effective in ameliorating emotional distress (Classen et al., 2001; Goodwin et al., 2001; Spiegel, Bloom, & Yalom, 1981), improving coping (Spiegel et al., 1981), and reducing pain and fatigue (Goodwin et al., 2001; Spiegel & Bloom, 1983; Spiegel et al., 1981), especially in women who presented with more distress (Classen et al., 2001; Goodwin et al., 2001) or higher pain levels (Goodwin et al., 2001) on entry to the group. A recent Australian randomised controlled trial found that while SEGT did not prolong survival, it improved quality of life, ameliorated and prevented new DSM-IV depressive disorders, reduced hopelessness and trauma symptoms, and improved social functioning (Kissane et al., 2007).

The feasibility and benefits of telephone support groups for cancer patients and other patient populations, including decreased isolation, improved social support, and improved coping, have been described in a small number of studies (Colon, 1996; Curran & Church, 1998, 1999; Rounds, Galinsky, & Stevens, 1991). However, few studies have evaluated their effectiveness or efficacy compared to face-to-face groups. Heiney et al. (2003b) found that therapeutic processes evident in a six-week telephone group for women with primary breast cancer were similar to those in traditional face-to-face groups. Surprisingly, in a related study, deterioration in quality of life (QOL) and mood at three-month follow-up was observed compared to the control group (Heiney et al., 2003a).

Audio teleconferencing is a convenient and flexible means of accessing a group, particularly for rural women or sick women, as they can call in from wherever they happen to be – at home, in hospital, or visiting family or friends. Thus, combining face-to-face and telephone delivery in a support group for women with metastatic breast cancer could not only increase access to psychosocial support for rural and sick women, it could also enable rural women to benefit from the experience of urban women, who have greater access to specialist treatment and resources.

In this paper we report on a long-term, professionally led supportive-expressive group for women with metastatic breast cancer conducted in Brisbane, Queensland. Women were able to attend face-to-face or using the telephone. The aim of this study was to assess the clinical effectiveness of the intervention, by determining whether changes in positive and negative mood dimensions and stress symptoms after 12 months’ attendance were consistent with the outcomes of controlled studies with a similar population, using similar standardised measures, or normative data where available.

Method

Participants

The original sample consisted of 34 women who participated in a supportive-expressive group from August 2001 to September 2005. Inclusion in the group/study was on the basis of diagnosis of metastatic breast cancer and a reasonable expectation that women would be well enough to participate in the group for at least one year. Women with primary or node positive breast cancer were excluded from participation in the group because of the difference in prognosis compared to women with metastatic breast cancer.

The data of 13 women were excluded from the 12-month analysis: seven women died prior to completing the 12-month assessment, three died six months after completion, one woman was too ill to complete it, and two women withdrew from the group prior to completion. Death within six months of the final assessment may confound 12-month assessment outcomes because of increased pain and psychological distress in the last year of life, due to end stage disease (Butler et al., 2003). The low attrition rate, of two women over a four-year period, is notable, suggesting that the group was highly cohesive and valued by the women who joined it.

The final sample of 21 had a mean age of 50.46 years (SD = 6.44 years, range 42.75–63.58 years). The median time since breast cancer diagnosis was 38 months (M = 53.1 months, SD = 49.2 months), and median time since diagnosis of metastasis was six months (M = 17 months, SD = 23.7 months). Of the participants, 17 were married (81%), two were divorced (10%), one was separated from her spouse (5%), and one was single; 95% had completed 10 years of education or more; and seven (29%) had dependent children.

Nine women (43%) lived in Brisbane, six (29%) lived approximately 100–200 km (or one to two hours’ drive) from Brisbane, and six (29%) lived in rural areas: four in coastal towns up to 1500 km from Brisbane, and two on properties or farms. Participants attended a mean total of 26.10 sessions (SD = 9.84, range 10–44 meetings) over the 12-month study period. Ten women attended more than 70% of sessions face-to-face, and nine women attended more than 70% of sessions using the telephone. As might be expected, women who lived in or nearer to Brisbane attended more sessions face-to-face, while those in rural areas attended more sessions using the telephone. Most women used both methods of access at some time, as only three rural women did not attend face-to-face, and all but one of the Brisbane women telephoned into the group. Reasons for urban women using the telephone included fatigue or health issues.
illness, with some women ringing in from their bedside at home or in hospital – even from the oncology ward while having chemotherapy.

Description of service

The group is a weekly supportive-expressive group conducted by two female group therapists (psychiatrist and social worker [MO'B] 2001–2003; occupational therapist and social worker [MO'B] 2004 onwards), each with postgraduate clinical training in individual and group psychotherapy and over 20 years of clinical experience, but no previous experience of group work with cancer patients. SEGTT aims to encourage participants to confront and express feelings about having a life-threatening illness, to develop new supportive relationships to help overcome isolation, and to review priorities in life (Spiegel & Spira, 1991).

The group, a brief account of which has been given elsewhere (Beacham, Hill, McDermott, O’Brien, & Turner, 2005), is similar to the SEGTT described by Kissane et al. (2004) and Spiegel and Claassen (2000) except that it is delivered by telephone as well as face-to-face, meets for an hour per week instead of 90 minutes, and is offered as a clinical service rather than as part of a clinical trial. The framework is open-ended, with new women being admitted to the group over time; the format is unstructured, with no set topics and the agenda set by participants; and participants are encouraged to have social contact outside the group.

It is beyond the scope of this paper to give a full account of what occurs within the group. Women are encouraged to share their experience, which includes the shock of receiving the diagnosis, their experience of treatment (more usually, a succession of treatments, often with debilitating side effects), the anxiety associated with having regular scans to monitor the progress of the disease and the effectiveness of treatment, and their gradual acceptance of death and the mourning and loss which accompanies this. Paradoxically, by confronting their fears about death and dying within the group, women are more able to embrace life and decide what is important to them. Preparation for the end of life, which may include thinking about where they want to die or planning their funeral, helps women feel more in control and frees them to enjoy the time they have left. Dealing with the death of a woman is a sad but inevitable part of this type of group. However, observing other women die, and observing how they are valued and mourned within the group, inspires and reassures surviving women that they too can approach death without fear and that they will be remembered by those left behind. This type of group presents special challenges for therapists and requires a high level of training, self-reflection, and supervision to be effective and sustainable.

Using the telephone to deliver the group requires some accommodations, but generally the group functions much the same as a face-to-face group. The teleconference unit is placed in the middle of the room. A white board is used to list women attending (face-to-face or by telephone) and record apologies (which are important as members worry that absence may be due to illness), and is an aid to remembering who is on the telephone. Speakers are encouraged to identify themselves by name, until voice recognition is developed. New members are invited to introduce themselves at their first session. In the absence of visual cues, therapists may check from time to time how group members are feeling; however, the emotional state of group members on the telephone can often be gauged by tone of voice, silence, etc.

New members are asked to provide a narrative and photograph of themselves for circulation to all members. This is designed to increase cohesion between face-to-face and telephone members. Once women are settled in the group they are given the contact details for other group members to facilitate additional contact outside the group. Social activities organised by group members include a coffee group after the formal group and occasional barbecues attended by group members (including rural women who travel to these events), partners, and families.

Recruitment to the group was by self-referral and referral from oncologists, surgeons, breast care nurses, a cancer helpline, other cancer support groups, and other women in the group. The group was promoted to potential referrers and women through brochures, newsletters, and presentations. The optimal size for a group such as this is 12, however, at times there were as many as 15 women in attendance.

Measures

The Derogatis Affects Balance Scale (ABS; Derogatis, 1996) measures eight different mood dimensions: four positive (joy, contentment, vigour, and affection) and four negative (depression, anxiety, guilt, and hostility) affects, plus a total positive and total negative affect score. In all, 40 adjectives are presented and participants rate the degree to which they have experienced each during the past two weeks, using a five-point scale ranging from 0 (‘never’) to 4 (‘always’). Individual affect dimensions range from 0 to 20, and total scores range from 0 to 80, with increased well-being associated with higher scores on the positive dimensions and lower scores on the negative dimensions. Derogatis (1996) provided normative data for the ABS for an adult non-patient population.

The Impact of Event Scale (IES; Horowitz, Wilner, & Alvarez, 1979) is a 15-item self-report measure that assesses the occurrence of intrusive (seven items) and avoidant (eight items) symptoms as a result of a stressful event. An example of an intrusive item is ‘I have thought about the problem when I didn’t mean to’; an example of an avoidant item is ‘I tried not to think about the problem.’ Participants are asked to indicate on a four-point scale (where 0 = ‘not at all’, 1 = ‘rarely’, 3 = ‘sometimes’, and 5 = ‘often’) the extent to which they have experienced symptoms during the past two weeks in relation to a stressful event. In the current study the stressful event was the
member’s experience of metastatic breast cancer. Item scores are summed to generate individual intrusive and avoidant totals, plus a total IES score indicating severity of symptoms. Scores on the intrusive and avoidant subscales range from 0 to 35 and 40 respectively, with higher scores indicating increased incidence of the stress response. In the current study, the IES analyses used participants’ mean comparison and avoidance scores, which allowed equivalent comparison of the two subscales.

The IES has been shown to discriminate a variety of traumatised groups from non-traumatised groups (for a review see Briere, 1997). Horowitz (1982) identified low, medium, and high IES total score cut-offs. Scores below 8.5, between 8.6 and 19, and above 19 indicate low, moderate, and high levels of symptoms, respectively. Further, Corcoran and Fisher (2000) suggest that scores above 26 on either subscale suggest moderate to severe impact of symptoms. Briere and Elliot (1998), using a sample of 505 participants from the general population, found that an intrusion or avoidance total of 26 represented a percentile equivalent of 95.

These measures were selected because they have been used extensively in studies of cancer patients and would therefore prove useful for comparison with the present cohort.

Procedure

To assess eligibility and interest in joining the group, women were first assessed individually, either face-to-face or by telephone, in an interview conducted by the two group therapists. At the interview women were invited to participate in the study and either given or sent an information and consent form together with a brochure about the group, written guidelines for participation within the group, information about the telephone link-up, and questionnaires (ABS and IES). It was made clear to all prospective participants that participation in the study was voluntary and would not affect their membership of the group. All of the women seeking membership of the group between August 2001 and September 2004 volunteered to participate in the study and provided written consent. Women were asked to complete the questionnaires at six-monthly intervals thereafter. Questionnaires were either sent to women for completion, or completed over the telephone. If women chose the latter option a non-clinical staff member administered the questionnaire.

Ethics approval was sought and obtained from the Royal Brisbane Hospital and the University of Queensland. However, the study continued not as a funded research project but rather as a routine clinical evaluation, so continuing ethics approval was neither required for the full duration of the project. Nonetheless, informed consent and data management protocols continued to be implemented in accordance with the principles of the approved protocol throughout the life of the project.

Statistical analysis

Repeated-measures ANOVAs were used to determine differences between means at baseline and at 12 months. Alpha was set at .05. Effect sizes (η²) are reported for all significant effects and are interpreted in terms of Cohen’s (1988) guidelines (0.01 small, 0.06 medium, and 0.14 large).

Results

Descriptive data

Raw and standardised scores for the ABS are reported in Table I. A comparison of the sample’s baseline ABS scores with ABS normative data taken from an adult non-patient sample (Derogatis, 1996) showed that our scores for joy, contentment, affection, anxiety, guilt, and hostility were within a normal range. In contrast, the baseline level of vigour was low (corresponding to the 7th percentile) and the level of depression was high (corresponding to the 88th percentile). At 12 months, level of vigour remained low, but level of depression had decreased and was near to the normal range of the normative data (69th percentile).

Total IES scores at baseline and 12 months were 29.42 and 24.62 respectively, indicating a high level of stress symptoms at both time points (using cut-offs from Horowitz, 1982). According to Corcoran and Fisher (2000) more stringent cut-offs, at baseline four participants were experiencing moderate to severe intrusive symptoms and five participants were experiencing moderate to severe avoidant symptoms.

At 12 months, two participants met the criterion for moderate to severe intrusive symptoms and one participant met the criterion for moderate to severe avoidant symptoms.

Repeated measures analyses

ABS results. To analyse changes in positive and negative affect (ABS) over time, a repeated measures ANOVA was conducted using the variables affect (positive affect, negative affect) and time (baseline, 12 months). This analysis revealed significant main effects for affect (F[1,20] = 15.85, η² = .44, p < .01) and time (F[1,20] = 4.69, η² = .19, p < .05), and a significant affect x time interaction (F[1,20] = 7.02, η² = .26, p < .05). Post-hoc comparisons indicated that the total negative affect score was significantly lower at 12 months than at baseline ((t[20] = 3.20, η² = .34, p < .01), and although the total positive affect score had increased at 12 months this change was not statistically significant (η² = .13, p = .10). This interaction is displayed in Figure 1.

In the initial ABS analysis, reported above, the positive affect total was a summation of the scores from all four positive affect subscales (joy, contentment, affectation, and vigour). Given the trend for improvement in positive affect across time and the small sample size of the current study, a second analysis was run with the vigour subscale total
removed from the positive affect total. An inspection of the data revealed that vigour, relative to other subscales, was less amenable to change across time. Prior research has shown that levels of vigour remain low across time in women with metastatic breast cancer (Classen et al., 2001; Goodwin et al., 2001). This subsequent analysis indicated main effects for affect ($F_{[1,20]} = 5.83$, $\eta^2 = .27$, $p < .05$) and time ($F_{[1,20]} = 6.73$, $\eta^2 = .25$, $p < .05$), and a significant affect $\times$ time interaction ($F_{[1,20]} = 9.12$, $\eta^2 = .31$, $p < .01$). A post-hoc comparison found that total positive affect (excluding vigour) was significantly higher at 12 months ($t_{[20]} = -2.19$, $\eta^2 = .19$, $p < .05$).

IES results. To analyse changes in IES stress symptoms over time, a repeated measures ANOVA was conducted using the variables stress symptoms (intrusion, avoidance) and time (baseline, 12 months). Mean intrusion and avoidance scores at baseline and at 12 months are displayed in Figure 2. This analysis indicated a significant main effect for stress symptoms ($F_{[1,20]} = 25.04$, $\eta^2 = .56$, $p < .001$), with ratings of intrusion being significantly higher than ratings of avoidance. Despite there being a reduction in stress symptoms across time, this change was not significant ($\eta^2 = .13$, $p = .10$). This outcome may be the result of low observed power (.37), due to the small number of participants included in this study. A larger effect size was associated with change in intrusive symptoms over time than was associated with change in avoidant symptoms over time, indicating that the magnitude of change was greater for intrusion. This outcome is consistent with the results of Spiegel et al. (1999), who similarly found a larger effect size for improvement in intrusive stress symptoms than for improvement in avoidant stress symptoms in a group of women with primary breast cancer before and 12 months after a 12-week SEGT intervention (see Table II).

Discussion

This study aimed to assess the clinical effectiveness of SEGT for women with metastatic breast cancer delivered in a community setting, using an innovative mode of delivery (telephone and face-to-face), by comparing baseline scores and outcomes after 12

| Table I. Raw scores (and $t$ scores)* and standard deviations for the positive and negative dimensions of the Affects Balance Scale and the Impact of Events Scale.** |
|-------------------------------------------------|----------|--------|
| **Baseline scores**                             | **SD**   | **12-month scores**                          | **SD** |
| **ABS**                                         | **M**    | **SD** | **M** | **SD** |
| Joy                                             | 11.33(43)| 3.51   | 12.86(47)| 3.90 |
| Contentment                                     | 11.05(43)| 3.71   | 12.43(46)| 3.44 |
| Vigour                                          | 8.81(35) | 3.66   | 9.62(38) | 5.09 |
| Affection                                       | 12.48(40)| 3.44   | 13.38(43)| 3.26 |
| Positive affect total                           | 43.67    | 12.82  | 48.29   | 13.58 |
| Anxiety                                         | 9.19(55) | 3.93   | 7.05(50) | 4.26 |
| Depression                                      | 7.52(62) | 4.64   | 4.90(55) | 3.85 |
| Guilt                                           | 6.62(59) | 4.77   | 4.00(50) | 3.21 |
| Hostility                                       | 6.71(54) | 3.81   | 5.19(50) | 3.95 |
| Negative affect total                          | 30.05    | 15.46  | 21.14   | 14.03 |
| IES                                             |          |        |        |
| Intrusion                                       | 17.52    | 8.76   | 14.29   | 9.05 |
| Avoidance                                       | 11.90    | 11.88  | 10.33   | 8.35 |
| IES total                                       | 29.42    | 19.69  | 24.62   | 15.87 |

* $M = 50$, $SD = 10$; ** normative data not available for IES raw scores.
months in the group and comparing effect sizes for changes in this group with those reported in controlled studies using similar standardised measures.

The sample was generally homogenous on demographic characteristics but displayed greater variance on time since diagnosis of breast cancer and metastasis. Difference was also evident in the place of residence of women, which influenced the way in which women attended sessions (by telephone or face-to-face). These differences may have contributed to high variance among group members’ responses to measures, as evidenced by higher standard deviations. Variance in severity of disease may also have been a factor, as this was a community-based intervention, it was not possible to control for variations in the clinical characteristics of participants.

Overall, we found significant improvement on the positive (when vigour was excluded) and negative mood dimensions of the ABS after 12 months in the group. Intrusive and avoidant stress responses, measured using the IES, were reduced at 12 months compared to baseline. While this effect was not significant, a small effect size was associated with reduction in intrusive stress responses across time.

Women in the current sample experienced low levels of vigour at both time points. Other studies have reported similar outcomes in women with metastatic breast cancer and found that group psychosocial support (across one year) did not improve ratings of vigour in this population (Classen et al., 2001; Goodwin et al., 2001).

Another area of interest in relation to the ABS outcomes is that group involvement elicited more improvement in negative affect ($\eta^2 = .34$) than in positive affect (vigour excluded: $\eta^2 = .19$). Importantly, normative data showed that levels of ‘depression’ were reduced after 12 months to near an average range. This suggests that the intervention may have been more effective in alleviating distress than in improving positive emotions. This outcome highlights the complexity of measuring affect in this particular population, as affect is not only transient but multidimensional; when combined with possible somatic influences as a result of illness, interpreting affect outcomes is complex. Voogt et al. (2005) argued for the importance of differentiating the absence of positive affect and the presence of negative affect when assessing psychological distress; they also argued that measures which focus mainly on negative emotions (i.e. depression and anxiety) may miss mood disorders in patients with advanced cancer.

With regard to the IES, women reported higher levels of intrusive stress responses than avoidant stress responses across both time periods. This result is perhaps to be expected, as individuals who are more likely to respond to traumatic events using avoidant behaviours are perhaps less likely to join a group where confrontation of emotional distress is encouraged. Plass and Koch (2001) similarly found significantly higher scores on the intrusion subscale of the IES, and higher distress generally, in participants accessing psychosocial support than in non-participants in a heterogenous sample of cancer patients, who were predominantly breast cancer patients. Grande, Myers, and Sutton (2006) found that cancer patients attending a community peer support group, compared to patients who were not in a group, used more active, adaptive coping strategies, but were also more distressed and anxious than non-participants. It may be hypothesised that stress response may influence the take-up of therapeutic support groups or therapeutic interventions in general. The fact that women in our study self-selected to join the group, rather than being randomised to this condition, may indicate a sample biased towards women who are more distressed but use less avoidant coping strategies.

Baseline scores on the IES in the current study are comparable to baseline scores in controlled studies of SEGT with women with metastatic breast cancer; Classen et al. (2001) and Giese-Davis and Spiegel (2001) reported mean scores on the intrusion subscale between 14.9 and 16.9 and on the avoidance subscale between 13.5 and 15.1. Our outcomes converge with the findings of these authors to suggest that women in this population experience moderate to high stress symptoms (according to the criteria of Horowitz, 1982). One factor that may moderate stress symptoms is time since diagnoses of metastasis. Evidence for this comes

Table II. A comparison of effect sizes (Cohen’s $d$) associated with baseline and post-intervention change in subscales of the Impact of Event Scale (IES) for the current study and that of Spiegel et al. (1999).

<table>
<thead>
<tr>
<th>Study</th>
<th>IES: avoidance</th>
<th>IES: intrusion</th>
<th>IES: total</th>
</tr>
</thead>
<tbody>
<tr>
<td>M1 (SD1)</td>
<td>M1 (SD1)</td>
<td>M1 (SD1)</td>
<td>Cohen’s $d$</td>
</tr>
<tr>
<td>M2 (SD2)</td>
<td>M2 (SD2)</td>
<td>M2 (SD2)</td>
<td>Cohen’s $d$</td>
</tr>
<tr>
<td>Current study $n=21$</td>
<td>11.90 (11.88)</td>
<td>17.52 (8.76)</td>
<td>29.42 (19.69)</td>
</tr>
<tr>
<td></td>
<td>10.33 (8.35)</td>
<td>14.29 (9.05)</td>
<td>24.62 (15.87)</td>
</tr>
<tr>
<td></td>
<td>.15</td>
<td>.36</td>
<td>.27</td>
</tr>
<tr>
<td>Spiegel et al. (1999) $n=111$</td>
<td>16.1 (6.32)</td>
<td>14.5 (10.54)</td>
<td>24.8 (13.7)</td>
</tr>
<tr>
<td></td>
<td>14.7 (6.96)</td>
<td>11.9 (5.94)</td>
<td>19.4 (12.87)</td>
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<tr>
<td></td>
<td>.21</td>
<td>.30</td>
<td>.41</td>
</tr>
</tbody>
</table>

*M1 score at baseline; *M2 score post-intervention; *Spiegel et al.’s sample included women with primary breast cancer; IES assessment was before and 12 months after a 12-week SEGT intervention.
from a comparison of our IES results with those of a local study of recently diagnosed women with metastatic breast cancer (Turner et al., 2005). The more recently diagnosed women reported considerably lower IES scores than those reported here, where the time since diagnosis was longer (M = 17 months). Thus, women may become more distressed over time following diagnosis, and experience a greater need for psychosocial support interventions than is evident at diagnosis.

While it is not possible to compare outcomes directly with those of controlled studies, due to differences in sample characteristics and methodology, it would appear that the outcomes in the current study are comparable to those of controlled studies in terms of improved psychological wellbeing, and that a SEGT intervention delivered within a community setting using both face-to-face and telephone delivery may be an effective means of moderating the adverse effects of metastatic breast cancer.

Our experience has demonstrated that it is feasible to deliver a group intervention by telephone, thus enabling rural women to access psychosocial support that would be otherwise unavailable to them. Using the telephone also facilitates participation by sick women, enabling them to remain in the group up until their time of death. Given the low take-up of support groups noted by other researchers (Taylor, Falke, Shoptaw, & Lichtman, 1986), it is important that women who would benefit from participation in a group such as this are not denied the opportunity. Interventions that facilitate participation by overcoming geographic and practical impediments should be encouraged.

There are important limitations to the current study. Without a control group we cannot be certain that the outcomes described are attributable to the SEGT intervention. Any perceived benefits could be due to other factors, including members’ use of antidepressant medication, involvement in other psychological treatments (e.g. individual or family counseling), or attendance at other groups or workshops. However, in our experience, group members’ use of other supportive interventions has been intermittent or less frequent than attendance at our group.

Despite this limitation, there is some evidence that the SEGT intervention has contributed to the improvement in mood dimensions and, to a lesser degree, stress responses reported in the current study. First, the outcomes are consistent with prior SEGT findings with women with metastatic breast cancer. Second, group members demonstrated the importance of the group to their well-being, as evidenced by attendance records and the development of supportive relationships with other women in the group, has been a key factor contributing to improved psychological well-being.

Another weakness of the study was the small sample, limiting the power of statistical analysis and meaningful comparison of variables such as face-to-face versus telephone participation. While nine women in the sample predominantly attended group sessions using the telephone and 10 predominantly attended face-to-face, most women have used both methods at one time or another, making comparison of face-to-face and telephone participation even more complex.

In conclusion, while we would not suggest that groups of this kind are beneficial for every woman with metastatic breast cancer, for those who seek out this form of psychosocial support our impression is that it can provide much needed support to improve psychological well-being.

**Acknowledgements**

We would like to acknowledge and thank our colleagues Pia Hirsch (current co-therapist), Dr Bronwen Beacham (former co-therapist and co-founder of the service), Dr Jane Turner, and Professor Patsy Yates for their contribution to the Reference Group advising the service and for their feedback on this paper, and all the women who have participated in the groups over many years. Funding for the service and ongoing evaluation has been provided by grants from the Queensland Country Women’s Association, the Gambling Community Benefit Fund, and Queensland Health. Further information about this service is available at [http://www.advancedbreastcancergroup.org](http://www.advancedbreastcancergroup.org)

**Biographical notes**

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**What does this study tell us?**

- Participants experienced significant improvement in mood and reduced distress after 12 months in the group
- The telephone is an effective and feasible means of delivering a group to both rural and sick women, and can improve access to psychosocial support engagement between group members and their families. We would suggest that, for the majority of women in the sample, regular attendance at the group, as evidenced by attendance records and the development of supportive relationships with other women in the group, has been a key factor contributing to improved psychological well-being.

Another weakness of the study was the small sample, limiting the power of statistical analysis and meaningful comparison of variables such as face-to-face versus telephone participation. While nine women in the sample predominantly attended group sessions using the telephone and 10 predominantly attended face-to-face, most women have used both methods at one time or another, making comparison of face-to-face and telephone participation even more complex.

In conclusion, while we would not suggest that groups of this kind are beneficial for every woman with metastatic breast cancer, for those who seek out this form of psychosocial support our impression is that it can provide much needed support to improve psychological well-being.
Tom O'Brien is a social worker and psychotherapist. He is a senior lecturer in the School of Medicine at the University of Queensland and a consultant psychotherapist for the Mater Child and Youth Mental Health Service in Brisbane.

References


