

## Group Support Interventions for People With Cancer

### Benefits and Hazards

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In this chapter we discuss group support interventions for people with cancer. We examine the value of a group-level approach for intervention and discuss the strengths and weaknesses of the existing literature. We present our own group-level intervention, briefly summarize the findings of our study (Helgeson, Cohen, Schulz, & Yasko, 1999), and use the results to discuss important issues that should be considered in this kind of research. We discuss in depth the development of our intervention and the implications of our findings for the field of research. Finally, we conclude by raising issues for future research to consider.

### Why Study Group Interventions?

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There are a number of reasons to evaluate group interventions for people with cancer. Cancer is the second leading cause of death in the United States and affects one out of three Americans (American Cancer Society, 1997). The disease and treatment affect a wide array of domains of functioning (psychological, social, vocational, physical). If a group-level intervention is effective in improving quality or quantity of life, it has the potential to be more cost-effective than individually tailored

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interventions. That is, group-level treatments reach a larger number of people at a reduced cost compared with individual-level treatments.

Second, group support interventions are widely used in the community. These interventions, typically referred to as *support groups*, are often assumed to be beneficial by the people conducting the groups and by the people referring patients to such groups. There are a number of group-level programs that exist at the national level. Programs such as 1 Can Cope and Reach to Recovery, sponsored by the American Cancer Society, and Us Too, sponsored by the American Foundation for Urologic Disease, are commonly found in larger communities. Although participants rate these programs favorably, the effectiveness of such programs has rarely, if at all, been evaluated.

A final reason to evaluate the efficacy of group support interventions is that benefits from a few scientific studies of peer support groups have been popularized by the media to encourage people to join support groups. Many people with cancer and many health care professionals are familiar with the findings from David Spiegel's study (Spiegel, Bloom, Kraemer, & Gottheil, 1989) of women with breast cancer or Fawzy's study (Fawzy et al., 1990) of people with melanoma, both of which documented survival benefits of attending a group support intervention. People may be less familiar with the particulars of these interventions. The Spiegel psychotherapeutic group lasted 1 year, was limited to women with metastatic breast cancer, and was conducted by trained therapists. Fawzy's intervention lasted only 6 weeks but was multifaceted and included coping skills, education, cognitive-behavioral therapy, and group discussion. Although the results from these two very different studies are certainly encouraging, they do not provide a sufficient basis on which to base an unequivocal recommendation that cancer patients should join community support groups, particularly under the guise that doing so increases longevity.

### Research on Group Interventions

Despite popular belief about the benefits of support groups for people with cancer, few evaluations of support group interventions have been undertaken. Many of the few studies that do exist suffer from methodological flaws or conceptual weaknesses. Some studies do not include a control group, partly from the belief that withholding treatment (i.e., the support group) would be harmful to patients. Such studies typically use a pre-post design, often demonstrating that patients' quality of life improves or psychological distress diminishes after attending a group. These findings, however, cannot be interpreted because the passage of time is a strong predictor of improved quality of life. A comparison group is crucial to the evaluation of a support intervention. Other studies do not randomly assign patients to conditions, which means that patients can "select" into the intervention group. The problem with this design is that the benefit of the intervention may be unique to the patients who

selected into the group. Alternatively, these "self-selectors" may have been the kind of people to improve without the intervention. Because group interventions are difficult to conduct, studies often have very small sample sizes. The typical group intervention study compares one intervention group with one control group. Thus, the modal number of groups being compared is one. Because the dynamics of a particular group of patients can influence individuals' response to treatment, it is necessary to include multiple groups within each level of treatment to evaluate the effectiveness of a group intervention.

Interventions that have been evaluated often lack a theoretical basis for their design. Historically, health care professionals such as nurses and social workers were the ones conducting and evaluating support groups. The design of those groups is likely to have been based on the nurse's clinical experience of what would be helpful to people with cancer. The difficulty with this kind of procedure is that one cannot determine why a particular intervention was effective. It is difficult to replicate the effects of an intervention without understanding its theoretical underpinnings. Previous research has rarely examined explanatory mechanisms for an intervention's effect. For example, Spiegel et al. (1989) hypothesized that their intervention increased feelings of mastery; provided emotional support; and decreased isolation, helplessness, and feelings of worthlessness. Yet, most of these mechanisms were not evaluated. Among those that were examined (self-esteem, locus of control), intervention effects were not observed. Fawzy et al. (1993) found effects of their intervention on immune function, but the immune changes did not account for the mortality benefit. Sophisticated studies by David Spiegel and Barbara Anderson, however, are evaluating a wide array of psychological and physiological mechanisms.

Previous group interventions, especially those that have been successful, also have provided patients with multiple resources—information, coping skills, relaxation training, hypnosis, and social support (Fawzy et al., 1990). The difficulty with this approach is that the particular component of the intervention responsible for its benefits is not clear. It may be that only a single component is necessary, that all components are necessary, or that there is a synergy among components. In a recent meta-analytic review of the literature on psychosocial interventions (mostly individual level) for people with cancer, Meyer and Mark (1995) concluded that psychosocial interventions can improve adjustment to cancer and that there is no evidence that one approach is more effective than another. Interventions, however, are rarely compared with one another. Meyer and Mark suggested that future research should attempt to tease apart the effective components of psychosocial interventions and determine who benefits most from which kind of intervention.

Helgeson and Cohen (1996) reviewed the literature on group interventions for people with cancer. They found more evidence for the effectiveness of interventions that contained an educational component than interventions based on peer discussion only. To be fair, however, the authors also concluded that few sound evaluations have been conducted of the peer discussion intervention and that studies have not

compared the effectiveness of these two components of group interventions. In this era of rising health care costs, it is important to know the components of a group intervention that are critical to its success.

We attempted to address many of the previously raised issues by designing a group-level intervention for women with Stages I and II breast cancer that included a no-treatment control group, randomized patients to condition, and included multiple groups within each treatment. We had a conceptual framework for the development of the intervention and identified mechanisms by which we expected the intervention to improve adjustment to breast cancer. We also designed these interventions to be cost-effective and easily transportable to the community. The interventions lasted 8 weeks and were conducted by oncology nurses and social workers, the people who are usually in charge of hospital support groups.

## Our Study

### Method

#### *Interventions*

We used the literature on psychosocial issues women confront when faced with breast cancer as the basis for the two interventions we designed. The literature suggests that the diagnosis and treatment of cancer is associated with a loss of control and an assault on self-esteem (Fobar, Hoppe, Bloom, Cox, & Varghese, 1986; Lesko, Ostroff, & Smith, 1991). People tend to perceive control over the events that happen to them (Taylor & Brown, 1988). A traumatic event threatens this perception of control. A diagnosis of breast cancer threatens our perceptions of control over our lives in general and our bodies in particular. Rarely are there warning signs of breast cancer. Most women with breast cancer do not have a family history of the disease. The first sign of the cancer is a lump in the breast or a suspicious routine mammogram. Because it is difficult to identify a single cause of the disease, it is difficult for women to gain a sense of control over the illness or perceive that they can prevent a recurrence of disease. Instead, women struggle with the question of "why me?"

The treatment for breast cancer also challenges perceptions of control. The treatment and accompanying side effects are disruptive and often unpredictable. For example, chemotherapy treatments are frequently postponed because women's white blood cell counts do not reach acceptable limits to tolerate the next dose of treatment. Thus, even on a day-to-day basis, it can be difficult for women to feel any control over their bodies or daily activities.

The diagnosis of and treatment for breast cancer also affects self-image. Cancer is still associated with a stigma in our society. People with cancer are often labeled as victims. Interactions with network members can be awkward because people are

afraid of cancer, may fear it is contagious, or find it unpleasant to be reminded of the existence of a life-threatening disease (Peters-Golden, 1982). The treatment for breast cancer also influences self-esteem. Women diagnosed with early stage disease felt healthy prior to their diagnosis and then feel sick as the treatment (e.g., surgery, radiation therapy, chemotherapy) debilitates them. The loss of a breast through surgery, the loss of hair through chemotherapy, and the fatigue associated with radiation are assaults to self-image.

Thus, we designed group-level interventions to improve quality of life by ameliorating these two psychological threats—loss of perceived control and loss of self-esteem. We designed two support interventions, both patterned after the kinds of interventions that exist in the community. One was based on the provision of informational support through education, and one was based on the provision of emotional support through peer discussion. The ways in which we thought the interventions would influence quality of life are shown in Figure 14.1.

The first intervention was education based. We thought that by providing women with information about their disease and treatment and some ways of coping with their illness, perceptions of control over the illness experience would be enhanced. We also thought that such information would reduce women's feelings of confusion surrounding their illness. To the extent that the information addressed women's unanswered questions and enabled them to make sense of the experience, unwanted disturbing intrusive thoughts about the illness should diminish.

The second intervention was peer discussion. We expected that this intervention would influence self-esteem in three ways. First, we expected that sharing experiences with others facing the same common stressor would help to normalize the cancer experience and reduce feelings of deviance (Coates & Winston, 1983; Lieberman, 1993; Spiegel, Bloom, & Yalom, 1981). Women should receive validation from one another. Second, we thought the discussion group would influence self-esteem and subsequently promote adjustment by providing opportunities for women to help one another. The "helper-therapy" principle has long been thought to be a way that group interventions benefit participants (Rosenberg, 1984). By helping one another, women gain a sense of competence. The third process—social comparison—was an implicit rather than an explicit process. When people are faced with threat, such as the diagnosis of a serious illness, one way that they cope is by comparing themselves with other people. The social comparison literature suggests that the most prevalent kind of comparison among people faced with threat (cancer, in particular) is a downward comparison, a comparison with others who are worse off (Buunk, Collins, Taylor, Van Yperen, & Dakof, 1990; Wood, Taylor, & Lichtman, 1985). Such downward comparisons are usually thought to be positive, meaning one feels lucky in comparison with less-fortunate others. Positive downward comparisons have been shown to increase self-esteem (Reis, Gerrard, & Gibbons, 1993; Wills, 1981). We thought that the mere presence of the group would lead women to make such comparisons with one another. In addition, women in the group could compare the entire group favorably with other people (e.g., "At least we

caught our breast cancer in time!"). We also expected that sharing experiences and expressing emotions in a warm and accepting atmosphere would reduce disturbing intrusive thoughts about the illness.

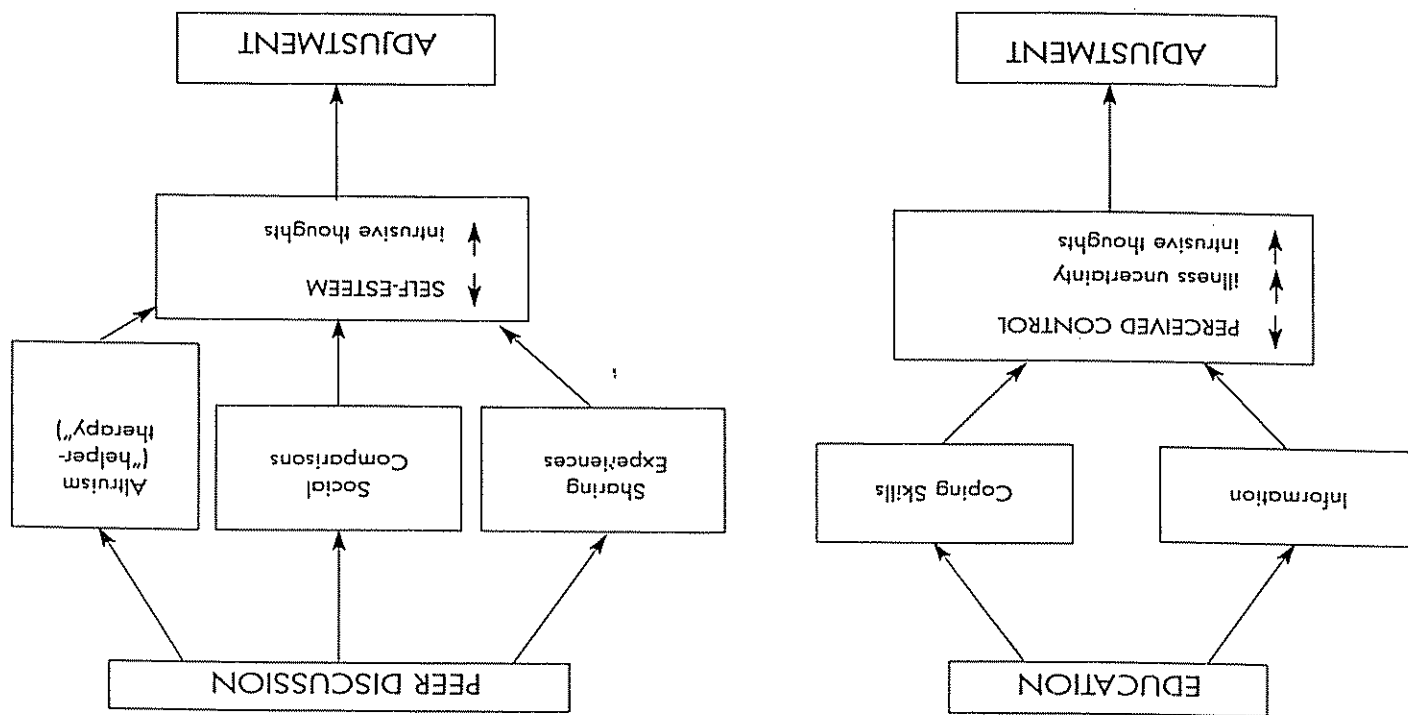
The content of the education and peer discussion interventions have been previously described (Helgeson et al., 1999) but are summarized here. Each of the interventions consisted of eight weekly meetings. The education intervention addressed the following topics: what breast cancer is, symptom management, nutrition, exercise, body image, communication, future health care issues, and relationships—sexuality. Each of these topics was addressed by either a facilitator or an expert in the area. The theme of the group was fostering perceptions of control—control over the illness experience rather than control over the illness. The intervention was conducted in a classroom-like atmosphere to minimize interaction among patients. Although patients could not be prevented from talking with one another, facilitators attempted to minimize such interactions by starting and ending the groups on time.

The peer discussion intervention focused on the expression of feelings and sharing of experiences. Women were provided with workbooks each week, wherein they recorded personal experiences and problems related to the illness. Workbooks were used as a way to begin each group and guide discussion. Facilitators were told not to offer information in this group. Although they could answer patients' questions and were ethically bound to correct misinformation, they were told to encourage patients to focus on their own experiences and feelings. Facilitators encouraged patients to help one another.

**Study Design**

Women who were diagnosed with Stage I or Stage II breast cancer and were treated with surgery and adjuvant chemotherapy were eligible to participate in the intervention. Nurses from over 40 medical oncologists' offices identified eligible patients. Groups were run in three locations around the Pittsburgh area to maximize accrual rates. Once 10–12 women at a given site agreed to participate in the study, the group was randomized to one of four conditions: education, peer discussion, combined (education followed by peer discussion), and control. The three intervention groups met for 8 consecutive weeks. Education sessions lasted 45 minutes, peer discussion sessions lasted 1 hour, and combined sessions lasted 1 hour, 45 minutes. We convened seven separate groups in each of the four conditions. An oncology nurse and an oncology social worker facilitated the interventions. Each pair of facilitators conducted each of the three interventions so that facilitator was not confounded with intervention.

We measured quality of life with the Medical Outcome Survey Short Form 36 (MOS SF-36; Ware & Sherbourne, 1992). We also used the positive and negative affect scales from the PANAS (Watson, Clark, & Tellegen, 1988). Instruments



Processes by which education and peer support interventions were expected to influence adjustment to breast cancer. The arrows indicate the pathways that we expected the interventions to take to influence adjustment.

FIGURE 14.1

were administered before random assignment to condition, immediately after the intervention, and 6 months after the intervention. We are continuing to follow women on an annual basis.

## Results

The results of the study showed clear benefits of the education intervention and no benefits of the peer discussion intervention. On some outcomes (negative affect and a couple of the SF-36 scales), the peer discussion intervention led to worse outcomes. The combined intervention seemed to reflect the positive benefits of education and the null effects (and sometimes adverse effects) of peer discussion. All of these findings appeared immediately after the intervention and held up for 6 months. We also analyzed the data by using the particular group of women as the unit of analysis. For these analyses, the sample size was 28. Using the conservative group-level analysis, the findings were the same. We sought to explain the positive effects of the education intervention and the null—and sometimes negative—effects of the peer discussion intervention.

## Discussion

The primary mechanism by which the education intervention benefited patients—in the short-term (1–2 weeks after intervention) and long-term (6 months after intervention)—centered on self-image. The education intervention enhanced self-esteem and body image. This was unexpected. In fact, self-image was hypothesized to be the mechanism by which the peer discussion intervention would promote adjustment. The information women received may have made them feel better about themselves by normalizing their experiences. The information also may have provided women with the tools to make themselves feel better. For example, women were provided with information about how to enhance appearance, what to eat during chemotherapy, how to regain arm motion, and what precautions to take against lymphedema. To the extent that they used this information in their daily life, feelings of competence may have been promoted.

In the short term, the education intervention also reduced feelings of confusion over the illness and increased discussion about the illness with network members. The information gained from the educational sessions may have been used as a safe and positive way to promote discussions about the illness with network members. In the long term, the education intervention increased feelings of control over the illness experience and reduced intrusive thoughts about the disease. Control was hypothesized as the primary mechanism by which the intervention would enhance adjustment. It is interesting that the effects of the intervention on feelings of control were not realized until 6 months after the intervention ended.

One reason why the peer discussion intervention was not effective and led to an increase in negative affect was that these women increased their rate of negative

downward comparisons. We expected the peer discussion intervention to promote downward comparisons—comparison with worse-off others—but we expected those comparisons to be positive in nature (e.g., feeling lucky). Instead, women in the peer discussion intervention reported feeling anxious and concerned about their own condition when they faced worse-off others.

This finding was disturbing to us because negative downward comparisons were sometimes cited by women as a reason for not wanting to participate in the study. During recruitment, some women expressed concern about seeing other women who were dying or not coping well in the peer discussion condition. We naively assured women that the group was homogeneous with respect to diagnosis (i.e., all had a relatively good prognosis) and that facilitators would make sure a single distressed group member did not detract from the entire group. Given that no woman had metastatic disease and no one had died or faced a recurrence while a group convened, we were surprised that negative downward comparisons emerged.

In retrospect, however, we realize that there were other dimensions upon which women could have made negative downward comparisons. One dimension upon which women varied was the number of positive lymph nodes they had. We observed that women often introduced themselves by reporting their number of positive lymph nodes. In the first peer discussion group that we convened, facilitators told us that women reported their lymph node status at the first meeting and arranged themselves in the circle by lymph node status at subsequent meetings. That is, women with no positive lymph nodes sat on one side of the circle, and women with positive lymph nodes sat on the other side of the circle. Another dimension upon which women could compare was side effects of chemotherapy. Hair loss in particular was an important topic of group discussions, and women varied on this dimension.

That negative downward comparisons were problematic in this study suggests there could be even more difficulties with community support groups for people with different kinds of cancer and different stages of the disease. It may be, however, that women for whom negative downward comparisons were a problem would be unlikely to attend a “support group” or would drop out from a group early on. Nevertheless, our findings suggest that health care providers should think twice before encouraging a woman to join a support group if she expresses a reluctance to do so.

A second reason why peer discussion groups led to an increase in negative affect was that women reported an increase in negative interactions with network members during the period in which the group convened. Previous research has found an association between attending a support group and lack of support from family and friends (Taylor, Falke, Shoptaw, & Lichtman, 1986). This cross-sectional finding has often been interpreted to mean that people who lack social support are most likely to join support groups. Our results suggest that the reverse causal interpretation is viable. Attending a support group may adversely affect the social network.

How could a support group adversely affect one's relationships with social network members? First, attending the support group may have only altered group members' perceptions of their social relations. By listening and sharing experiences with one another, women may come to believe that network members were not as supportive as they once thought they were. Alternatively, attending the group may actually alter interactions with network members. Network members may feel excluded from the group. In our study we did not permit family and friends to participate in the group. Women may feel that it is no longer necessary to share feelings with family and friends because they have a group of people with whom they can do so. We cannot distinguish between these two explanations with our data. We do note, however, that the peer discussion group did not alter discussions about the illness with network members, whereas the education group increased discussion with network members. Thus, the peer support condition did not facilitate discussions with network members in the same way that the education condition did. The information in the educational intervention may have been used as a source of discussion with network members.

Six months after groups ended, the peer discussion group led to an increase in intrusive and avoidant thoughts about the illness. The education group, by contrast, may have raised issues that could not be resolved in 8 weeks. The length of two previous beneficial peer discussion interventions was 1 year (Kniss & Kraemer, 1986; Spiegel et al., 1989). Issues also may not have been resolved in our peer discussion intervention because the group was not designed in a way to resolve them. Although group members were encouraged to help one another solve problems, it is not clear that one can depend on group members to have the skills to provide effective help. A group receiving structured psychotherapy may have addressed emotional issues more effectively. This study suggests that venting feelings alone, presumably in a warm and accepting atmosphere, is not sufficient to reduce intrusive thoughts about one's illness and that the form of ventilation we provided actually increased intrusive thoughts.

#### *Who Benefits From What?*

The final question that we sought to address in this study was who would benefit most from which kind of intervention (Helgeson, Cohen, Schulz, & Yasko, 2000). We hypothesized that women who lacked emotional support might benefit most from the intervention designed to provide emotional support—peer discussion. To our surprise, reports of emotional support at the onset of the study interacted with each of the three interventions to predict adjustment. It appeared that women who lacked emotional support were buffered by all of the interventions from the deterioration in physical functioning observed in the control group. However, women who scored high on support at the beginning of the study reacted differently to the

three interventions. In the education group, their functioning did not change over time. In the peer discussion group, their functioning deteriorated over time. The results in the combination group, not surprisingly, fell somewhere between the two—a slight deterioration over time. Thus, the adverse effects of the peer discussion intervention may be limited to the women with high levels of support. These may be the women who reported more negative interactions with network members after attending the peer discussion group. Thus, women with emotional support from network members not only do not benefit from the peer discussion intervention but may actually be harmed by it.

We also examined whether personal resources, such as high self-esteem and feelings of control at the start of the study, would influence responsiveness to the interventions. We created a personal resource index that comprised feelings of control over the illness situation, high self-esteem, high body image, and reduced uncertainty about the illness. This index interacted with the education intervention only, such that women who had low personal resources were buffered by the education intervention from the deterioration in physical functioning observed in the control group.

#### *Implications of Findings*

To our knowledge, this is the largest randomized group intervention for people with cancer conducted to date. The results clearly showed support for benefits of education that were maintained for 6 months after the intervention. No benefits of peer discussion were observed. There were some adverse effects of peer discussion on negative affect and some of the specific SF-36 domains of functioning. These findings remained even when we used the conservative group unit of analysis, strengthening our confidence in the results. The results are consistent with Helgeson and Cohen's (1996) review of group interventions for people with cancer. In that review, they found more evidence for the effectiveness of education compared with peer discussion interventions. They also discussed a number of difficulties that may occur in peer discussion interventions, some of which were borne out in this research.

One of the major strengths of this study is that we were able to tease apart two of the common components of support interventions that exist in the community. Peer discussion is typically the focus of support groups in the community. Community support groups may or may not include an informational component. Peer discussion alone did not seem to benefit women, nor did it confer any special benefit when combined with education. In this era of limited health care resources, our data suggest that communities ought to emphasize education over peer discussion. The education intervention was easy to implement after it was developed because the materials were standardized. It is difficult to "standardize" a peer discussion, which may explain why it is harder to conduct.

The extent to which the benefits of the education intervention are due to the specific information provided rather than the group context is not clear. Future

research could provide women with the same information through mail or video to discern the impact of the "group" on the effectiveness of the intervention. The group context may have influenced the delivery of the information. Hearing someone else's question may trigger a question of one's own. People who are afraid to raise issues or have difficulty articulating their concerns may find that others raise their questions. Participating in a group also could have increased people's motivation to pay attention and to think about the information provided. In these ways, the presence of the group could have contributed to a greater knowledge gain.

The group context also could have inadvertently conveyed emotional support. The mere presence of other people facing the same situation may have provided some reassurance and validation. Although women in the education intervention were not encouraged to talk to one another and structural barriers to group discussion were created, some women did find ways to talk to one another—if not in the group, then in the parking lot after the group! If those kinds of exchanges were supportive and contributed to the positive effects of the education intervention, one would have to question the usefulness of structured support interactions compared with the usefulness of more naturally occurring support interactions.

#### *Why Wasn't the Peer Discussion Intervention Effective?*

At first glance, the ineffectiveness of the peer discussion intervention appears to be inconsistent with the existing correlational research on social support among people with cancer. Correlational studies suggest that emotional support is the most frequently sought support by people with cancer and that emotional support has the strongest effects on quality-of-life outcomes (see Helgeson & Cohen, 1996, for a review). However, the sources of support in these studies are family and friends—not a group of strangers who share the same problem. The literature also suggests that there are barriers to family and friends being effective emotional support providers when one is diagnosed with cancer, which leads to the suggestion that peers—people who are experiencing the same stressor—might be able to remedy any emotional support deficits.

This group may not have had the intended benefits for a number of reasons. First, perhaps these women did not perceive the group as supportive. We have some data to indicate that this was not the case. Women in all intervention conditions rated the groups favorably. Women in the peer discussion condition reported feeling closer to one another and were more likely to get together with one another after the group ended than women in the education condition. However, this does not negate the possibility that there were some unresponsive exchanges in these group sessions. We are currently conducting a content analysis of the peer discussion sessions to obtain more information about the nature of the group discussions.

Second, the question arises as to whether peers can compensate for emotional support deficits from network members. Because women who reported a lack of

emotional support from network members benefited from the peer discussion intervention, peer group members may be able to compensate in the case of problematic network relations. However, in cases where women were satisfied with the support they received from network members (which was the majority of women), peer discussion was not useful. One could conclude from this study that only women with support deficits should be referred to community support groups. Although these might be the only women who would benefit from the experience, the character of a support group composed only of women with support deficits is worrisome. People who lack social support might also lack some of the social skills needed to acquire support from other people or may have other major problems besides their cancer. It may be difficult for group leaders to facilitate naturalistic supportive exchanges among these people.

Third, the prognosis of the disease may influence the effectiveness of peer discussion. The vast majority of women were diagnosed with Stages I and II breast cancer, and none of the women had metastatic disease. An emotional support intervention may be more beneficial under more severe illness circumstances, as in the Spiegel et al. (1981) study. The kind of support that is most effective must match the needs of the situation (Cohen & Wills, 1985; Cutrona, 1990). Information may be most needed by people who are initially diagnosed with cancer and undergoing treatment. The information can be used to understand and cope with the disease and the treatment. Emotional support may be more beneficial when treatment is completed and one has the opportunity to reflect on the meaning of the illness for one's future. It is also possible that information is more helpful to people with a favorable prognosis because there is greater potential for control of the disease, and emotional support is more beneficial for those with advanced disease who have limited capacities to control the disease course. This latter hypothesis stems from Folkman's (1984) argument that problem-focused coping is more helpful when the circumstances are controllable, and emotion-focused coping is more helpful when the circumstances are uncontrollable. One could view Stages I and II breast cancer as a relatively more controllable situation (i.e., potential for cure) than Stage IV disease. The education intervention more directly maps onto problem-focused coping (i.e., providing women with information that they can use to influence how they are feeling), and the peer discussion intervention more directly maps onto emotion-focused coping (i.e., discussing feelings with the goal of changing how they feel about the situation).

The duration of the intervention—8 weeks—may not have been long enough for the peer discussion intervention to be beneficial. It may have taken women several weeks to warm up to the group discussion and to begin disclosing illness-related concerns. By the time these women were ready to discuss their hopes and fears, the group may have ended. Women who started the group by denying their illness may fall into this category. For these women, the group may have eventually challenged their denial and allowed them to express feelings of distress. Shedler, Mayman, and Mavis (1993) discussed the possibility that one reason why therapeutic

interventions do not appear effective is that discussions decrease distress for those who are initially willing to admit distress and increase distress for those who are initially unwilling to admit distress. In the end, it appears as if the intervention has no effect on the group as a whole.

Finally, it also is possible that the group discussion was not helpful and possibly harmful because discussing the illness with other women increased women's awareness of their own levels of distress. The intervention was not designed to teach women how to cope with the distress. The underlying premise of the intervention was that the ventilation of feelings and the sharing of experiences, in and of themselves, would be beneficial. Similar issues were recently raised by Frasure-Smith et al. (1997) to explain why their home-based nursing intervention for cardiac patients was associated with an increase in mortality among women. The authors suggested that frequent visits and telephone calls may have reminded women of their psychological distress and that the nurses, although equipped to provide emotional support, did not have the psychotherapeutic skills to resolve major difficulties.

It is possible that group discussion in and of itself is not sufficient to produce changes in the ways one thinks about and copes with an illness. The aim of the discussion was to provide emotional support, to reduce feelings of uniqueness, and to create bonds of similarity. However, more psychotherapeutic changes may need to occur for a support group to be effective. If that is the case, it is essential that such changes are documented and shown to explain the benefit of psychotherapeutic groups. Spiegel's psychotherapy group not only improved quality of life but extended longevity by 18 months among a group of women with metastatic breast cancer. We incorporated many of Spiegel's principles into our group discussion intervention (i.e., encouraging the expression of affect, both negative and positive; encouraging women to help one another; encouraging the sharing of feelings), but Spiegel referred to his intervention as *supportive-expressive therapy* rather than *peer discussion*. One difference between the two studies is that in the Spiegel et al. (1981) study, therapists taught specific coping skills, such as how to manage pain. According to Carithuff (1973), support groups are not effective unless skills are provided to participants to cope with the problem. He argued that groups that meet to discuss problems and share experiences, with the occasional insight from the group leader, could leave participants worse off at the end of the group. Participants return to their unchanged problems, with hopes having been raised that they will be able to cope more effectively with those problems.

Regardless of which of the above reasons account for the null effects of the peer discussion intervention, the implications for community intervention are the same. Health care professionals should be cautious about advising women to join their local community support group.

#### Future Directions

The lack of effects for the peer discussion intervention along with women's high needs for emotional support suggest to us that researchers might benefit from creating

different vehicles to deliver emotional support. Interventions could be aimed at families, in particular the patient-spouse relationship. The spouse is viewed as the most important source of support (Coyne & DeLongis, 1986; Jamison, Wellisch, & Pasnau, 1978). One could identify sources of miscommunication that arise among family members during the illness and deliver an intervention to reduce those miscommunications. Alternatively, a peer-dyad intervention might be more effective than a peer-group intervention in delivering emotional support. It is certainly the case that some women in support groups form close ties with one another and that the illness provides a common basis for discussion. Peers could be matched on characteristics of the disease (e.g., type of surgery, type of treatment) and demographic variables that provide a common basis for discussion, such as marital status and the presence of children. A newly diagnosed patient might benefit the most from a peer who has completed treatment. A study of patients awaiting coronary artery bypass surgery showed that patients preferred to be assigned a roommate who had already had bypass surgery rather a roommate who was awaiting the surgery (Kulik & Mahler, 1989). The nature of the interactions could be more closely controlled and monitored in a peer-dyad rather than a peer-group intervention. To the extent that peer role models are carefully selected and trained to deliver the intervention, unanticipated unsupportive interactions should be minimized.

We may still be at the point where successful intervention studies raise more questions than they answer. One broad question that continues to be raised is this: What kind of intervention is beneficial for whom? We have attempted to examine one dimension of "what"—education versus peer discussion. We have addressed a couple of dimensions of "whom"—the helpfulness of the interaction depends on people's naturally existing support and personal resources. Researchers should more explicitly examine the dimension of disease severity or prognosis. Several researchers (e.g., Andersen, 1992) have suggested that disease severity may be a potentially important moderating variable of the effectiveness of a support intervention. Another potentially important moderator is gender. The majority of support intervention studies focus on breast cancer, and thus women. To what extent do these findings generalize to men with cancer? To date, there has been one evaluation of a support intervention that focused exclusively on men with prostate cancer (Lepore & Helgeson, 1998). It showed that combined education and peer discussion confers benefits. In the area of bereavement, Schut, Stroebe, van den Bout, and de Keijser (1997) examined whether men or women would benefit from a problem-focused coping or emotion-focused coping intervention. They argued that women had greater needs for how to cope with concrete problems, such as finances, after bereavement and that men had greater emotional support needs because they had lost their sole source of emotional support. The findings showed that women benefited more from the problem-focused coping intervention and that men benefited more from the emotion-focused coping intervention.

One issue that all intervention researchers should keep in mind is cost-effectiveness and community implementation. The two issues are related. Communities are more likely to implement short-term, low-cost interventions. Thus, to the extent that we can identify the most effective components of support interventions that can be delivered in a low-cost format, the more likely it will be that our intervention will be implemented in the community. The educational intervention tested in this study meets these criteria. It is short-term, structured, and delivered in group format. All of these features make the intervention low-cost and easily transferred to the community. An effective peer discussion intervention is likely to be of higher cost if it requires more qualified leaders (e.g., clinical psychologists or psychiatrists rather than oncology nurses and social workers) and more time (e.g., 1 year). This does not mean that the latter intervention would not be cost-effective, however. The outcome must be taken into consideration. Obviously, if a more complicated intervention or a longer lasting intervention can influence disease progression, the intervention could be cost-effective.

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## Psychosocial Interventions for Women at Increased Risk for Breast Cancer

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**B**reast cancer is the most common cancer among American women; more than 180,000 new cases and 46,000 deaths are expected this year (American Cancer Society, 1997). Researchers have identified a number of risk factors for breast cancer. Reproductive risk factors such as early age at menarche, nulliparity, or having a first child after the age of 25 have been found to increase a woman's risk for breast cancer (Gail et al., 1989). Environmental factors such as exposure to exogenous estrogens also increase breast cancer risk (Hoskins et al., 1995), and lifestyle factors such as excessive alcohol use and postmenopausal weight gain have also been implicated in breast cancer etiology (Kelsey & Bernstein, 1996).

A positive family history of breast cancer is perhaps the most important risk factor for breast cancer (Gail et al., 1989; Slattery & Kerber, 1993). Women with a single affected first-degree relative have a twofold to threefold increased breast cancer risk (Anderson, Duffy, Hallett, & Marcus, 1992; Slattery & Kerber, 1993). Those from families with multiple cases of breast or ovarian cancer may be at even higher risk, particularly if the breast cancers were premenopausal or bilateral. About 5-10% of breast cancer cases are attributable to inheritance of a mutation in a breast cancer susceptibility gene (e.g., BRCA1 or BRCA2). Women who have inherited BRCA1 or BRCA2 mutations have a lifetime breast cancer risk of 55-85% (Ford et al., 1994; Struwing et al., 1997), and they are also at increased risk for developing ovarian cancer (Struwing et al., 1997).

Researchers have categorized women with a family history of breast cancer into at least two risk groups. Women with a limited family history of breast cancer have low to moderate risk for developing breast cancer, particularly if the cancers were diagnosed later in life and there are no cases of ovarian cancer in the family (Hoskins et al., 1995). Women who have family histories consistent with hereditary breast cancer have been characterized as high risk (Hoskins et al., 1995; Offit & Brown,