

COGNITIVE-EXISTENTIAL GROUP THERAPY FOR PATIENTS WITH PRIMARY BREAST CANCER — TECHNIQUES AND THEMES

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SUMMARY

We describe a model of cognitive-existential group therapy designed to be integrated over 6 months with regimens of adjuvant chemotherapy given as conventional medical treatment to breast cancer patients with stage 1 and 2 disease. Our broad therapy goals are for members to develop a supportive network, work through grief over losses, improve problem solving and develop cognitive strategies to maximise coping, enhance a sense of mastery over life and re-evaluate priorities for the future. Specific group themes include death anxiety, fear of recurrence, living with uncertainty, understanding treatment with chemotherapy, radiotherapy and hormone regimens, the collaborative doctor-patient relationship, body and self image, sexuality, relationships with partner, friends and family, surgical reconstruction, life style effects and future goals. Active coping skills are developed through teaching formal problem solving and cognitive restructuring of automatic negative thoughts. Technical aspects of the therapy are discussed. © 1997 by John Wiley & Sons, Ltd.

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INTRODUCTION

Breast cancer, the most common form of cancer in women, affects 1 in 13 (Coates, 1994). Overall, 7% of Australian women will be diagnosed with breast cancer at some stage in their lives (Giles *et al.*, 1993). Psychological and social morbidity in these women is high. Indeed, in the first year following mastectomy up to a third of women have mood or sexual problems severe enough to warrant psychiatric help (Maguire *et al.*, 1978). Dean (1987) found that one year after mastectomy, 18% of patients have suffered minor and 5% major depression. Women with breast cancer generally show greater distress, concern with

physical symptoms, anxiety, and interpersonal difficulties, and more negative attitudes towards themselves and their future than control subjects (PABCSG, 1987). The expectation that conservation surgery would be associated with reduced psychiatric morbidity has generally not been fulfilled (Fallowfield *et al.*, 1990), the inherent fears in cancer ostensibly being more harmful than a change in body image. Thus, these studies clearly demonstrate that psychosocial morbidity is a major concern in patients with breast cancer.

Interventions that facilitate more effective adjustment and coping should reduce this morbidity and improve quality of life. Early trials of group therapy for patients with advanced cancer did lead to improved quality of life (e.g. Spiegel *et*

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al., 1981). Moreover, a 10-year follow-up showed a significant survival advantage for group therapy patients compared with women receiving conventional clinical care, highlighting the beneficial role of psychological well-being (Spiegel *et al.*, 1989). Several further studies have suggested a clear association between mental attitude to cancer and survival (Mulder *et al.*, 1992).

A range of therapeutic models — individual, group and family — have emerged since the 1970s. There seems to be no difference in outcome between treatments delivered individually and those delivered in groups (Farash, 1979; Cain *et al.*, 1986; Anderson, 1992; Krupnick *et al.*, 1993). Perhaps the first model most suitable for application to cancer patients is that described as existential psychotherapy by Yalom (1980), in which anxiety about death and uncertainty of purpose are confronted. This approach has been incorporated into supportive-expressive group therapy (Spiegel and Spira, 1993), linked with occasional family sessions. Moorey and Greer (1989) have opted to adapt cognitive-behavioural therapy for their cancer patients and applied it, individually, to high risk patients. Another model that promotes the use of active coping strategies has been developed by Fawzy *et al.* (1994). A pivotal question immediately arises: which model is the most appropriate for the respective stages of breast cancer?

We see a role for a model of therapy which meets the needs of women with early stage breast cancer, whose concerns may differ considerably from those with metastatic disease. Since the introduction of mammographic screening, women whose cancer is diagnosed earlier are more likely to survive; it is estimated that two thirds of women with breast cancer will survive the disease (Tabar *et al.*, 1993). Complex treatment comprising hormones, chemotherapy and radiotherapy are routinely used following initial surgical management. Such programs add to the strain of the experience. We, therefore, set out to develop a new psychological model which could be integrated into medical management and combined the existential and cognitive psychotherapy traditions. In so doing we have selected those aspects of the two theories we consider central in meeting the needs of patients with early breast cancer. We have particularly applied a group model, not only because of cost-effectiveness but also given the mutual support members can provide.

Our purpose in this paper is to describe this

cognitive-existential approach in the hope of promoting and exchanging ideas in the quest for an optimal model of psychotherapy for women with early breast cancer. The following account stems from our pilot work covering seven groups and 48 patients.

THE THERAPEUTIC MODEL

Goals of therapy

We identified six goals to fulfil our overall aim of improving patients' quality of life: promoting a supportive environment; facilitating grief work over multiple losses; altering maladaptive cognitive patterns; enhancing problem solving and coping skills; fostering a sense of mastery; and providing an opportunity to sort out priorities for the future. In pursuing these goals, we recognise the limits of the enterprise and thus avoid the ever present temptation to delve into long-standing personality difficulties; these would be more appropriately tackled in long-term insight-oriented individual or group psychotherapy.

Process

Patient selection and group formation. In addition to receiving referrals directly from surgeons and oncologists, we are able to inform patients about the availability of the group by building and maintaining a close working liaison with several chemotherapy and radiotherapy units. We check that potential members have early stage breast cancer to ensure homogeneity, and confirm that they have sufficient English speaking skills to participate effectively. Groups consist of six to eight patients and two therapists and meet weekly for 90 minutes for a total of 20 sessions. To avoid delay in launching groups, it has proved distinctly advantageous to recruit simultaneously from a few neighbouring hospitals. To this end, we have initiated a collaborative network covering ten metropolitan hospitals affiliated to the two medical schools in Melbourne. The group approach has proved acceptable to two thirds of women invited to participate; the remainder either indicate that they are coping satisfactorily or that the prospect of group therapy is unappealing or anxiety-

provoking; on occasion various logistical complications have precluded participation.

Therapists. Therapists are recruited from the mental health professionals' disciplines of psychology, psychiatry and social work as well as nursing. Motivation and a deep interest in psycho-oncology are regarded as key criteria in selection. We arrange that one co-therapist be a woman, who can more readily react sensitively to a range of gender issues that arise. Therapists are trained in a series of workshops, applying a detailed manual especially prepared for this form of group therapy (available from the authors). Our manual is a 68 page document comprising the following chapters: background, study protocol, goals of therapy, establishment of groups and general guidelines, themes specific to breast cancer, the cognitive approach and problem members in groups. Weekly supervision follows throughout their initial group experience. Once trained, therapists meet monthly with a supervisor to enhance their developing skills and to ensure conformity with the manual; this permits a flexible approach but within the context of our objectives and goals. Therapists take responsibility for establishing and maintaining group rules and norms, and for involving all members. Overall, therapists are relatively more active than is the case in psychodynamic group therapy.

Co-therapists review each session including audio and video-taped material when these are available. Process notes are prepared for supervision in the course of these reviews.

Preparation. Preparation of women selected for group therapy is undertaken individually, so permitting therapists to become acquainted with them and to map out their wishes and goals. From the outset, therapists counter the widespread notion of unrealistic 'positive thinking', indicating that the group is a forum to share concerns and fears, deal with losses and to disentangle meaningful priorities. The therapists hasten to reassure members who could be concerned about being overwhelmed or harmed by group participation. Indeed, an optimistic message about the benefits experienced by previous groups is imparted. Customary norms about confidentiality, punctuality and apologies for absence are mentioned. We explain that contact between members is not restricted to the sessions as they are encouraged

to meet informally over light refreshments after each session.

During this phase, we invite the women to commit themselves to therapy, but also suggest that should any ambivalence arise, they should feel free to share this in the group. Finally, it proves helpful for members to anticipate differences as well as shared features in the group.

The group in practice. Groups progress through three developmental phases: beginning, middle and end. During the initial phase, therapists actively promote the therapeutic factors of self-disclosure, cohesion and recognition of the universality of their experience, thus overcoming any sense of isolation. In the middle phase, further vicarious learning and self-disclosure are highlighted as we confront anxiety about death, grieve losses, seek more adaptive coping through the cognitive model, instil hope and promote a sense of mastery. Information exchange, altruism, and mutual support are other powerful mid-phase therapeutic mechanisms. In the final phase, loss and grief are revisited as the group's end is mourned, but this is balanced by a reappraisal of priorities and commitment to the future. The evolution of a typical group is described in the sections that follow.

Launching the group. After members introduce themselves, they share their expectations and relate their experience of having breast cancer. This 'go-round' is invariably poignant as members honestly express their feelings. One woman, for example, opened the inaugural meeting by exclaiming 'Can I go first? It will help me get through the session. I'm divorced, a mother of two, but I need to say that my second child, Steven, died of a brain tumour last year. He was 12. He was a patient in this hospital. I'm still coming to terms with it. My own breast cancer was discovered 8 months after Steven died. It's been easier than his death. My daughter, Julia, is 17 and in her last year of school. My mother also had breast cancer. Thank you for letting me go first.'

As such stories unfold, members become intensely interested in similarities and differences between their experiences of coping with the diagnosis and treatment. Much information about medical matters is exchanged during this phase. Our therapists are trained to resist assuming the role of cancer expert by inviting the group to be

the reference point regarding accuracy of medical aspects of the experience and how to go about obtaining reliable information.

The middle phase. Following the exchange of 'cancer stories' the main work of the group consumes the rest of the sessions, except for a few at the end devoted to saying farewell. Each group covers a series of predictable themes, most arising spontaneously: anxiety about death; dealing with fear of recurrence and living with uncertainty; understanding treatment with chemotherapy, radiotherapy and hormones; the doctor-patient relationship; body- and self-image; sexuality; surgical reconstruction; relationships with partner, family and friends; and life-style and future goals (Kissane *et al.*, 1994).

Anxiety about death usually arises first; therapists aid members to acknowledge it and explore its meaning for each person. The group then begins to accept cancer as a threat to life, and grapples with the reality of finitude. Principles of existential psychotherapy, as highlighted by Yalom (1980), are introduced to deal with death anxiety in the recognition that, as a 'universal given', it is an inescapable part of human experience. Through sharing these thoughts and feelings, members feel less threatened and isolated. Considerable grieving unfolds as this theme is explored; indeed, mourning is a feature of therapy throughout the group's life. Eventually, the typical attitude adopted is 'One day we will die, but until then we can choose to live well'.

The fear of recurrence of cancer seems universal and is often linked to undue preoccupation over bodily health and function. Members, for instance, explore the question of how to react to a somatic symptom, developing both more adaptive problem-solving methods and cognitive approaches to their fears. As the uncertainty about the future is faced, members consider the options of helplessness or taking control over their lives. The latter is fostered as the more advantageous (e.g. a sense of control of their treatment) with a sense of mastery ensuing; this in turn enhances mature coping with the unpredictable.

Discussion of treatment — chemotherapy, radiotherapy and hormones — focuses on concerns and fears about its potential failure, risks and side-effects. Coping strategies to deal with the latter (e.g. tiredness) are shared and treatment compliance thus improved. Invariably, the role of

alternative therapies is explored, including the group's expectations of them. Other issues include whether the women should feel blame or guilt over prior life styles, what underlies the search for a cure, and how best to acquire accurate information about breast cancer and its optimal treatment.

The doctor-patient relationship is inevitably tackled, particularly members' attitudes to their professional caregivers. The group is encouraged to explore ways of building collaborative relationships with doctors and other staff, so that members actively participate in planning and implementing their treatment.

The breast is an obviously significant aspect of body and self-image; members devote much time sharing their experiences of loss. Grief work combines with identifying new coping strategies. Negative self-appraisal is identified and challenged, thus improving self-confidence. Relationships with partners (Sabo *et al.*, 1986) often intersect with body aspects, as does sexuality (often a neglected topic). Frank exchange of feelings, particularly in the second half of the program, when trust is better established, paves the way for a clearer understanding of any difficulties regarding sexuality (Fallowfield *et al.*, 1990; Kaplan, 1992). Members not only come to appreciate that they are not alone with these intensely personal sorts of problems but also provide mutual support in wrestling with them.

Talking to children about their cancer is a concern for some members; daughters of mothers with breast cancer are especially vulnerable to anxiety and need both reassurance and guidance through insights gained from their peers. Relationships with family, both nuclear and extended, as well as with friends are considered, with emphasis on them as potential sources of support.

The encounter with a life-threatening illness leads members to evaluate their priorities and future goals. By recognising that only they can assume control over their lives and pursue them meaningfully, members often develop a new sense of purpose. This focus on a spiritual dimension is actively promoted.

Integrating the cognitive position.

1. Problem solving

Group work has traditionally employed problem solving approaches in searching for group solu-

tions. The focal-conflict model, for example, scrutinises the ways in which the group evaluates advantages and disadvantages of potential solutions in terms of the tension that exists between satisfying members' needs and alleviating their fears (Stock Whitaker and Lieberman, 1964). Cohesive groups readily become a vehicle for active problem solving, as members strive to help each other. Through the additional use of a handout, the therapists guide members in applying the necessary steps in this problem solving process. Furthermore, therapists affirm realistic problem solving efforts. Their repetition over many weeks consolidates the procedure into a refined coping skill.

2. Cognitive reframing to examine and deal with negative thoughts

A specific cognitive therapy technique of clarifying associated thoughts and feelings when members disclose a personal experience is introduced during early sessions. Not only 'Tell us how that made you feel' but also 'What went through your mind at the time?' is the pair of questions posed. Alternatively, therapists comment 'It sounds like you had particularly upsetting thoughts when you felt like that.' As the group engages in therapy, such clarification implicitly reflects the cognitive model. Gradually, with examples concerning cancer that reveal links between events, thoughts, behaviours and feelings manifesting in the course of the sessions, the model is made more explicit. The elements of cognitive therapy are not didactically conveyed, but rather integrated as smoothly as possible into members' life experiences. Before long, their understanding of links between experience (*Activating event*) and thought (*Belief*), which in turn leads to behaviour and feeling (*Consequence*), is established.

Homework is added, specifically the monitoring of thoughts that accompany any distressing experience between sessions. At no stage should this be understood to promote suppression of appropriate affects, but rather to enhance greater understanding of what underlies them. Members as a group evaluate the thoughts, discern distorted or unrealistic patterns and seek more adaptive alternatives. 'Realistic' rather than 'logical' responses are valued since patients need to remain anchored in existential reality.

Throughout the middle phase, we weave in themes pertinent to breast cancer. The goal is the

development of techniques to recognise automatic negative thoughts and to reframe them appropriately; ensuing skills evolve to counter anxiety about recurrence, to boost self-esteem and to encourage full engagement with life. A series of handouts is incorporated into this 'cognitive restructuring' phase and complements the group's growing appreciation of the model. They cover 'Identifying automatic negative thoughts' (adapted from Moorey and Greer, 1989); 'The characteristics of automatic negative thoughts — recognising them more easily'; 'The daily thought record for automatic negative thoughts'; 'How to challenge an automatic negative thought'; and 'Common thinking errors in cancer patients'. These are given out sequentially over five sessions in the context of themes emerging in the group.

The handouts have not only promoted greater uniformity of therapeutic method but also enabled members to discover habitual thinking errors and core beliefs. By having the group scrutinise the list of thinking errors, members find the experience less persecutory than if therapists were to expose the faulty thoughts. Groups become supportive during this process, members identifying with each other's examples; associated modelling facilitates change.

The following three examples illustrate cognitive work:

- (i) Distressing feelings are associated with loss of hair during chemotherapy. A member may think she won't be loveable, or even worse, will be rejected. This distorted thinking, involving overgeneralisation and negative prediction, will compound her distress.
- (ii) One patient recounted: 'Each time I take a tablet, it reminds me of my cancer and that's getting me down. I fear the cancer, so I hate taking the medication.' The group surmised that the underlying fear was of dying and suggested that medication be seen as a lifeline. One member proffered an alternative attitude: 'I think of cancer treatment as the gardener, pulling out the weeds; then I, the garden, am all the more beautiful and better off because of it'.
- (iii) After an energetic day one member described an ache down her side and anxiously thought: 'Is this my cancer coming back? I'll really be in trouble.' She imagined the worst, resulting in anxiety and diminished morale. An alternative thought was offered: 'It's most likely tiredness from your

day's exertions. A check up can be undertaken if it persists, but it will probably be gone tomorrow'. Caution is always wise if symptoms persist; realistic appraisal is not about false reassurance. Hence a sensible pathway needs to be travelled between minimising unnecessary anxiety and practising sound medicine.

A common cognitive problem encountered in every group are distorted and confused expectations and their adverse effect on various relationships. Feelings of anger or guilt inevitably follow the experience of unmet expectations. Recognition of the 'shoulds' in members' disclosures helps them to appreciate a habitual pattern. Expectations are held by members about the community's response to the cancer patient and about the roles of health professionals, family members, partners and friends. As these views are challenged, relationships are enhanced.

3. *Anger management*

Recognition of assertive rather than passive approaches in dealing with frustration, the avoidance of unrealistic expectations of others, and the benefits of active problem solving are explored through a handout on anger management. This is invariably linked to discussions among members of their relationships with others and their anger at having developed cancer (particularly in mothers of young children). Groups typically begin such discussions with the expectation that life should be fair.

This approach to anger is definitely not about suppression of affect, but rather the recognition of anger expression and its appropriate channelling into adaptive, constructive pathways. Group members actively encourage assertiveness and affirm the needs of members as problems of daily life are recounted.

In summary, we have been impressed by how readily existential themes are understood through the use of a reality-based cognitive therapy. Patterns in thinking that are based on long-held core beliefs about self and world are recognised. As members acknowledge these, they initiate appropriate revisions which empowers them to embrace life more confidently.

4. *'Group as a whole coping'*

While it may appear that this cognitive approach is directed primarily at the individual member, the

development of 'group as a whole' solutions is a complementary aspect of this work. Internalising these group-based solutions assists members even when they may not always be aware of the rationale of cognitive reframing. Illustrative of these attitudes adopted by the group are: 'We are not alone in living with cancer'; 'we need to take better care of ourselves'; 'one day we will die; until then we can choose to live well each day'; 'we can take control of much of our lives'; 'we gain a lot through sharing feelings and understanding'.

The ending of the group. Over the last three or four sessions, therapists direct the group's attention to the theme of endings. Three tasks flow from this. First, members are invited to identify 'unfinished business' and to share the responsibility of checking any unmet needs; work on them thus continues until the last. The second task entails disclosure of feelings about loss of the group which necessarily reminds the members of other key losses — of breast, health, dreams, future and perhaps life itself. Unlike the conventional therapy group in psychiatry, cancer group members may exchange phone numbers, plan reunions and often continue to meet informally. Notwithstanding, the therapists maintain a focus on the inescapable reality that the group as experienced will cease forever. Emphasis on this mourning process is a salient feature of the group experience, serving as a model for dealing with loss in general. The third task is future-oriented as each member is encouraged to reflect on how she has changed, and to review priorities in the months and years ahead.

Pursuit of these tasks in the final phase permits consolidation of members' understanding of their achievements, a process boosting their sense of morale. Thus, while the sadness felt in losing the group is dealt with as a model of coping with loss, gains are acknowledged and viewed as symbolic of potential for further change.

Members presenting difficulties for the group. From time to time therapists encounter members whose attitudes or behaviour disrupts or threatens to disrupt the group's functioning (Yalom, 1985). A special problem is progression of breast cancer which occasionally occurs during the life of the group. Although it may lead to intense distress, members face a formidable challenge to express concern and care. Therapists ensure that

any patient with progressive disease is not permitted to withdraw because of a sense of difference to her peers and on the premise of needing further medical treatment. Members usually encounter other distressing 'cancer stories' but benefit by recognising that the advance of cancer in one woman does not point to a gloomy prognosis in others. Acknowledging differences between members is helpful in this context, alongside the group's capacity to care compassionately for each other. Moreover, Spiegel (1993) reminds us, in talking about the dying member, of the reassurance felt by her fellows in observing how they will be supported if their turn comes.

About 12% of women drop out in our experience, typically after one or two sessions. Their stated reasons relate to a lack of sense of belonging or a wish to avoid distress. The demands of weekly attendance over a 6 month period also necessitate development of a sense of gaining from the experience. When a group has achieved a cohesiveness which respects differences and functions as a container for anxiety and other distressing emotions, a safe environment is perceived despite the threats intrinsic to cancer. A minority of members however withdraw, fail to attend, or unusually, feel extruded when differences predominate. In response, the group reflects on absences, expresses concern for fellows and may initiate contact with the absentee. We have noted, for example, supportive members calling a single woman who felt apart from her peers, all married, responding sensitively to her sense of difference, and holding on to her as a group member.

DISCUSSION

Our model, initially tested with seven groups (48 patients), was generally well received. We are currently testing it as part of a randomised controlled trial of 300 patients with stage II breast cancer (256 patients have been randomised by May 1996, with an acceptance rate of 68%). As this work proceeds, we note the willingness of members to attend and their gratitude for the opportunity to meet others living through comparable life events.

The issues that challenge patients with early breast cancer differ from those with metastatic disease since survivorship or cure are distinct

possibilities for the former. Composing such homogeneous groups permits a focus on specific needs. In this context, it is our impression that the cognitive-existential model is more suited to patients with early disease, whereas supportive-expressive therapy as described and applied by Spiegel and Spira (1993), with greater emphasis on direct existential issues and less on cognitive processes, is more apt for those with advanced disease.

The strategies we have categorised as cognitively-based resemble those described by others as 'coping skills' (Rose, 1989) or cognitive training (see reviews by Trijsburg *et al.*, 1992; Anderson, 1992; Krupnick *et al.*, 1993) but our model extends well beyond this framework in order to satisfy the women's needs to deal with profound existential concerns. A 'coping skills' approach alone is in our view far too limiting and fails to do justice to the overall experience of having breast cancer. We therefore value the existential approach (Yalom, 1980; Mullan, 1992), which emphasises authenticity and honest confrontation with such 'givens' as the finitude of life, freedom to choose and accepting responsibility for one's life. But again, to stress the existential dimension without facilitating adaptive coping would be to short change the group members.

Some centres have conducted relatively brief programs — an average of six sessions — that concentrate on enhancing coping skills and are psychoeducational in nature (Telch and Telch, 1986; Fawzy *et al.*, 1990; Cunningham *et al.*, 1989, 1993); others have reported mixed results (Capone *et al.*, 1980; Bloom *et al.*, 1978; Baidar *et al.*, 1984). Our model contrasts considerably with these; it may be desirable eventually to compare these treatments. In the meanwhile patient factors may call for a range of therapies. Cunningham *et al.* (1993) for example noted less improvement from brief therapy in patients over 50 and in those with recurrent disease. We suspect that 20 sessions over 6 months enables more substantial change than briefer approaches can accomplish.

The customary therapeutic processes operating in our groups (Yalom, 1985; Bloch and Crouch, 1985) facilitate coverage of a wide range of themes central to the members' experience. Most of those themes are readily identified and dealt with by the group. Even a subject as profound as death anxiety is confronted without hesitation. On the other hand, a minority of themes, especially sexual difficulties, tend to arise later in

the group's life when a greater sense of trust has been established. Our very first groups were briefer and their members did struggle to disclose any sexual problems. In those lasting 6 months, members have shared such intensely personal experiences, albeit with therapist encouragement, gaining much from the realisation that their sexual difficulties are universal. In this regard, we generally view the therapists as proactive, with the responsibility to ensure that all the themes relevant to the breast cancer experience (described in detail in our manual) are tackled. Members however still determine to a large extent when and how the material is covered.

In developing our therapeutic model, we have adopted the approach pioneered in the NIMH study of depression (Elkin *et al.*, 1985), namely preparing a detailed manual, and then training and closely supervising participating therapists. We hope to demonstrate that improved quality of life can result from participation in group therapy based on a clear set of principles.

CONCLUSION

A cognitive-existential group model has been integrated into the clinical care of patients with early breast cancer, coinciding with other aspects of medical care.

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