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SUPPORTIVE-EXPRESSIVE GROUP THERAPY: THE TRANSFORMATION OF EXISTENTIAL AMBIVALENCE INTO CREATIVE LIVING WHILE ENHANCING ADHERENCE TO ANTI-CANCER THERAPIES

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SUMMARY

Supportive-Expressive Group Therapy (SEGT) has been developed and manualised in the research setting, but there have been few clinical accounts of its utility. In this qualitative review of its application in the Melbourne-based randomised control trial (RCT) for women with advanced breast cancer, SEGT is considered from the perspective of the structure and framework of therapy, its therapists, the issues that develop in exploring its common themes and what constitutes a well functioning group. Groups move through identifiable developmental phases. The mature group process transforms existential ambivalence into creative living, evidenced by humour, celebration, assertiveness, altruism, new creative pursuits and eventually courageous acceptance of dying. Challenges and pitfalls include avoidance, non-containment of ambivalence, intolerance of difference, anti-group phenomena and splitting. A key element is the *medicalization* of the group culture whereby members and co-therapists explore health beliefs and attitudes about care. This promotes compliance with anti-cancer treatments, including both the initiation of and perseverance with chemotherapy. This mechanism could prove to be a potentially important pathway in promoting longer survival. Copyright © 2004 John Wiley & Sons, Ltd.

INTRODUCTION

Oncology self-help groups burgeoned during the latter half of the twentieth century as patients sought mutual help and support when conventional medical care systems struggled to meet their psychosocial and spiritual needs (Cella *et al.,* 1993; Presberg and Levenson, 1993). Professionally led groups also emerged as varying models of therapy were explored under the broad rubric of improving quality of life (Krupnick *et al*., 1993). Thus, from a long tradition of psychoanalytic group therapy, various combinations of the supportive, existential, cognitive-behavioural, interpersonal and psycho-educational models were hybridised to better suit the needs of the chronically and seriously medically ill. One particular amalgam that has succeeded in the setting of advanced cancer has become known as supportive-expressive group therapy [hereafter SEGT].

Although initially developed during the 1970s within Yalom's existential school (Yalom and Greaves, 1977; Spiegel and Yalom, 1978; Yalom, 1980), SEGT really took shape with David Spiegel during the 1990s. Although evidence of its potential to optimise quality of life had been established (Spiegel *et al*., 1981), the intriguing possibility of a survival benefit (Spiegel *et al*.,

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1989) became the impetus for several studies. Thereafter SEGT was manualised (Spiegel and Spira, 1991), described in handbooks (Spiegel, 1993; Spiegel and Classen, 2000) and tested in randomised controlled trials (Leszcz and Goodwin, 1998; Goodwin *et al*., 2001; Classen *et al*., 2001, Kissane *et al*., 2001; Spiegel, 2002). While Fox offered a cautionary caveat, citing sample bias in the original Stanford cohort with its control arm surviving less long than would be usually expected (Fox, 1998), Goodwin's later multi-site Canadian study failed to replicate any survival advantage (Goodwin *et al*., 2001). Yet patients experiencing these groups attested to their worth (Goodwin, 2003).

BRIEF OVERVIEW OF SUPPORTIVE-EXPRESSIVE GROUP THERAPY

The goals of SEGT have been well summarised as building bonds, expressing emotions, 'detoxifying' death and dying, redefining life's priorities, fortifying families and friends, enhancing doctor–patient relationships and improving coping (Spiegel and Classen, 2000). In the process, therapeutic factors that potentially mediate adjustment to illness include the consolidation of social support, active coping and the promotion of collaborative patient-clinician communication (Leszcz and Goodwin, 1998). SEGT thus places a major emphasis on relationships, both within the group of metastatic cancer patients, their families and circle of friends, and with their clinicians in the oncological treating team.

There is clear epidemiological evidence for the protective benefit of social support in reducing mortality in the community, for example, marital status. Spiegel (2002) presented an excellent summary of these findings, and argued that emotional expressiveness serves as a mechanism to promote understanding and enhance connectedness. Alongside this proximal goal of increased social support, success of the group intervention has been also gauged by more distal outcome measures, especially psychological wellbeing in the form of reduced anxiety or depression, improved coping and control of physical symptoms such as pain (Spiegel *et al*., 1981; Spiegel and Glafkides, 1983; Classen *et al*., 2001; Goodwin *et al.,* 2001).

In the midst of this growing body of research, few therapists (aside from Spiegel's group) have published accounts of the techniques and themes or the challenges and pitfalls involved in SEGT. Yet aspects of SEGT are strikingly different from conventional psychoanalytic group psychotherapy. Alongside prominent changes in the frame, structure and boundaries of the group are considerable differences in therapist approach and activity. In this paper, a qualitative commentary on the experience of SEGT for women with advanced breast cancer is based on a randomised controlled trial (RCT) conducted in Melbourne, Australia. The data on therapy outcome from this study will be reported subsequently. The emphasis here is on the therapy itself, the role of the co-therapists, the factors that advance success and issues that can interfere with a beneficial outcome.

METHODOLOGY

In the Melbourne-based RCT, 227 women with metastatic breast cancer were randomised in a 2:1 ratio to group therapy or control conditions. To ensure adherence to the SEGT model, co-therapists from five groups presented process notes on the therapy to their supervisors fortnightly, while all therapists (10) and supervisors (4) met in a combined quarterly meeting across 6 years. A qualitative analysis of these group and meeting notes formed the basis of the observations we report here about the experience of SEGT. These observations have been arranged into five distinct sections: the structure of SEGT, the role of therapists, key themes, group transformation and anti-group phenomena.

THE STRUCTURE OR FRAMEWORK FOR SEGT

A series of important differences exist between conventional psychotherapy groups and SEGT, especially with respect to the structure or framework of this therapy: the group size, open style, boundaries and the range of in-group and out-of-group activities.

The nature of SEGT groups

Meeting weekly for 90 min, SEGT groups strive to accompany each woman through her illness

until death. The long term nature of this therapy is best served by open groups, in which new members join as former ones die. Thus, in continuing on and on, the group-as-a-whole risks adopting an expectation that it will never end, an unreality disrupted occasionally by therapists leaving or closing a group down. This myth of continuation does help to counter death anxiety, but it avoids the experience of ending therapy, a process which can ordinarily facilitate considerable individual development. On the other hand, facing death with open awareness is such a significant 'termination process' that group-as-a-whole mourning can be as powerful as the traditional psychoanalytic ending.

Given some inevitable level of absence due to planned holidays or hospital admissions with treatment complications [for instance, septic neutropenia], the group achieves greater diversity and related strength from a larger size. We have found 10–12 active members ideal, rather than the more traditional eight members recommended in Yalom's classic text on group therapy (Yalom, 1985).

Another major variation in the guidelines and boundaries for SEGT relates to the promotion of 'out-of-session' contact. Given the relational goal of encouraging social connectedness, members are invited by their therapists to exchange telephone numbers and meet for refreshments after a session. As cohesion develops, groups enjoy lunches, birthday celebrations and other festive gatherings together, these activities occurring without the therapists. This out-of-group contact is vastly different from the usual group norms, and as such, requires careful monitoring by the therapists through questions during the group session to ensure that these gatherings are inclusive and considerate of the needs of all. Predictable issues arise for the widowed, divorced or single woman if partners are being invited to functions. Similarly, childless members and those with very divergent ages or sociodemographic backgrounds need astute monitoring through which the therapist models tolerance of difference and appropriate involvement of all.

Our independent follow-up of study patients has identified that out-of-group discussion is not necessarily social chit-chat—the women will pursue agendas that have sometimes been avoided or perceived to be 'taboo' within the therapy room. Thus, if a therapist were felt to appear disdainful of alternative therapies, the members might exchange information about vitamins and diets over a subsequent cup of coffee. On the other hand, when a woman avoids open discussion of marital or personal problems with the group-as-a-whole, she may select one or two members to reveal her worries. Not only is this potentially burdensome for the latter women, but the creativity of the whole group is not drawn into assisting. Therapists seek therefore to cultivate an ethos of respect for the group room through inquiring about out-of-session conversations and emphasising the importance of members bringing relevant material back into session time.

Therapists who are predominantly used to no out-of-session contact find this relaxation of boundaries challenging. They might need to work harder to cultivate respect for the therapy, ensuring focus and that it starts and finishes on time. When a group is new, apologies about absence usually start off being passed to the therapist, but as relationships grow, women choose to send the apology through another group member. The potential then exists for a member to miss several sessions without any communication with the therapists. We will have more to say about the importance of telephone contact in a later section on therapist's tasks.

Preparation for group membership

Preparation for membership is as crucial to SEGT as for any other psychotherapy group. Therapists should meet patients individually to hear their life narrative and develop an understanding of their concerns. Have they attended self-help groups? What experiences did they have and what fears do they carry? Cancer patients fear almost invariably that SEGT groups will prove morbid, contagiously spreading overwhelming grief and the burden of others' distress. Therapists do well therefore to describe the group's membership, morale and spirit during preparation, emphasising the benefits of support and connectedness with others who share a comparable cancer journey.

The group should be identified as a safe place to come and be oneself. Rules need to be stated regarding confidentiality, mutual respect, starting and finishing on time, commitment to attend, giving notice about absences, apologies when ill [including information to allay others' anxiety]—these all help to set the tone and protect the therapy, usefully differentiating what happens in

sessions from other levels of socialisation within their communities.

Introducing new members

We have found that starting two or three new members together is generally easier than introducing any person individually. When new members join the group, mutual exchange of cancer stories can be fostered. Older group members may reminisce about their respective beginnings in the group, so that a new member is reassured that others also found the group stressful at first. Therapists' support for the shy or anxious member models acceptance and nurtures a containing environment.

Each new person brings something novel and alters fundamentally the group dynamics. Their nurturance and support is vital to assist this transition. Cultivating a group norm of inclusiveness avoids the phenomenon of splitting into old and new clusters, which otherwise proves destructive to cohesion.

Sufficient preparation of new members, which invites their commitment to attend 4–6 sessions before withdrawing, is one key to avoiding early dropouts. The timing of entry into an established group requires care to ensure that sufficient mourning of the recently deceased has occurred. Where a group member dies in the week of planned introduction of a new member, the latter is burdened by the immediacy of this loss. The unpredictability of death, however, means that sometimes this coincidence cannot be avoided.

With effective preparation, drop out rates are kept to 10%. Without such, and effective containment by therapists, they have quickly doubled in our experience.

Getting started

One key issue in starting SEGT groups includes having sufficient members to form a quorum. Size recurs as a concern when deaths diminish the membership. Recruitment from two to three oncology services in a region may be necessary to have a sufficient population to establish a program. Promotion of the group experience by oncologists is crucial to achieve adequate referrals. Only half to two-thirds of women are willing to join a group, the others declaring that they are 'not a group person', have had a prior unhappy experience with self-help groups, or are unavailable through work commitments or geography.

Sustaining the group

As the work of the group unfolds with time, another challenge is the focus of activity. Some groups feel they are revisiting issues well covered previously; they yearn for new agendas. A larger group size with resultant diversity appears beneficial to counter boredom. New members bring fresh vigour. From time to time, the knowledge base of groups can be further stimulated with input about new therapies.

Members enjoying stable health, especially when they continue in the workforce, might not prioritise the group over other aspects of their lives. Searching for any ambivalence about sickness and death is pertinent to their decision-making about attending group sessions. Maintaining connectedness with members who attend infrequently presents a challenge to cohesiveness.

Recurrent death

A major source of sadness for the well established group is the eventual loss of original and long surviving members or the cumulative loss of several members in a short space of time. The latter particularly challenges groups if spouses come to resent the preoccupation with and impact of the group. Therapists need to be especially active in inviting expression of feelings about these losses and the resultant changes in the group environment.

Groups in the home, around the death bed, and attendance at funerals

While the neutral space of the therapy room helps preserve the framework or structure of the therapy, from time to time, a session will be held in the home or hospital room of a frail or dying member to sustain their connectedness with the group. Therapists can usefully initiate this idea and explore its practicality and safety for all concerned. Active negotiation is needed, including checking the day before a planned home visit for continued suitability. Not only does this prove

very supportive of the seriously ill, but it empowers conversation about the process of dying.

More recent group attendees will often express doubt about the wisdom of funeral attendance, but group-as-a-whole involvement in this activity both mirrors respect for the deceased, while also helping the living continue to support one another in their grief.

The funeral ritual of eulogising the dead is seen as a worthy commemoration, while the group itself reminisces and compares its knowledge of the deceased with that expressed by family and friends. Sometimes the group discovers that it had much more to learn about a deceased colleague; on other occasions, members feel they had achieved a very deep friendship. Nevertheless, in even highly functioning groups, a universal tendency to avoid detailed review of a funeral will still be evident. Therapists need to draw out personal comments about how members experienced the loss, thus promoting active sharing of grief.

The relatives of the deceased will commonly thank the group during or after the funeral ceremony. Such acknowledgement reinforces the role and benefit of the group, modelling its merit for continuing members.

Disruptions to SEGT

When members leave the group, understanding their reasons and the group response is important. Sometimes a move interstate or a return to work represents a perfectly comprehensible explanation. In other instances, a person may feel unsuited to the ethos of the group-as-a-whole, leading some group members to inevitably feel responsible. Therapists can assist through careful exploration of all the feelings within the group, in the process mirroring respect for the individual's rationale. Nurturance of this virtue of respect for others is a vital feature of the mature group and leads members to a deepening sense of commitment to the group.

Occasionally a therapist needs to leave a group, something that potentially causes puzzlement and conjecture among group members. Again a thorough exploration of feelings is of paramount importance. Where that therapist has been valued, even idealised, the potential for demoralization in the group is theoretically countered by adaptive anticipatory mourning and farewell in a manner similar to the death of a member. A new therapist would thereafter be welcomed akin to a new group member.

In practice, none of our therapist departures proved successful; indeed, they were quite destabilising to their respective groups. A therapist's reasons for wanting to leave a group may prove difficult to talk about and include issues like personal and discomforting death anxiety, or unexpressed discomfort with a co-therapist. The intuition of the membership about this therapist's departure may be insightful, yet problematic for the surviving therapist to respond to adequately. The need for thoughtful supervision by an experienced group analyst is paramount when a therapist begins to consider withdrawing from an SEGT group. We have come to favour termination of the group when a therapist needs to retire and the formation of a new group with new co-therapists, rather than attempting to integrate another therapist into an established group culture.

The cohesive SEGT group

A key therapeutic goal is the establishment of a high level of group cohesion (Bion, 1961), based on mutual regard, tolerance of difference and recognition of a shared experience of life. Given that research into what is therapeutic about groups has repeatedly shown the importance of cohesiveness, therapists should wisely monitor this aspect of the group-as-a-whole (Bloch and Crouch, 1985; Ettin, 2000). In concluding this section on the structure and framework of the SEGT group, we reemphasise that a genuinely cohesive group serves to effectively contain distress.

THE THERAPISTS

Key issues in the effective provision of SEGT involve the background/discipline of the therapists, their experience and training, their relationship as co-therapists and the style of intervention that they offer.

Background—skills and training

The complex dynamics of the group process, with tensions between facilitating and restrictive

environments, the emergence of a group-as-a-whole culture, and the requirement for therapists to monitor and understand the roles and positions that members take in relation to the group call for therapists trained and experienced in group therapy (Stock Whitaker and Lieberman, 1964; Horowitz, 1995; Segal *et al*., 1995; Ettin, 2000). Alas, commonly such therapists have little training in oncology and psycho-oncology.

The complexity of modern cancer care derives from an ever expanding knowledge within oncology, the diversity of combination therapies and the challenge of collaborative decision-making. Psycho-oncologists are required to keep up to date with such advances, and although initially trained in disciplines such as psychology, psychiatry, counselling or social work, their clinical work draws heavily on their direct knowledge of cancer itself.

The dilemma posed by this need for a mix of clinical skills is partly relieved by the reality of the group-as-a-whole, for rather than responsibility being vested solely in the therapist (a stance that would create a dependent group), empowerment of the group ensures that the membership-at-large takes ownership of its tasks and processes. The use of a co-therapy couple further advances this position and enables the development of therapist teams, in which skill and experience in leading groups can be located in one partner, with a complementary knowledge of oncology in the other.

Co-therapy

This combination of one therapist from a medical/oncological background with another from a group/psychotherapy background constitutes in our experience a preferred mix. Where neither therapist has cancer training, the group culture may be less medically oriented, with the risk of insufficient development of knowledge and understanding of cancer treatments and their side effects. The group exists with a cancer-related agenda that should never be denied.

Gender mix then arises as a further question. The common occurrence of breast cancer as an illness mainly of women has understandably led experts to recommend against both co-therapists being men (Spiegel and Spira, 1991). But should a similar caveat be offered about the co-therapists both being women? While psychoanalytic theory recognises the masculine and feminine aspects of every therapist, with patients' projections and identifications possible irrespective of therapist gender, we noted some challenges when both our therapists were women. A hypothesis that we debated was the potential for merging with the other women or for the development of envy at their personal health and breasts. When the couple offer a gender mix, the parental image may be more easily perceived, with greater tolerance of both the good and bad parts of each therapist and a resultant, healthier orientation for the entire group.

Some co-therapists choose to sit together to enhance the image of a couple, while others prefer to sit opposite each other in easy eye contact. Compatibility between therapists is crucial and may be more readily achieved in the real clinical world than with arranged pairs, as in an RCT. An important way for co-therapists to recognise any changing dynamic in their relationship is to regularly and jointly conduct a pre-group review of sign-posted concerns (a checklist of issues noted for future sessions) and a post-group debriefing.

Therapists' tasks

The SEGT model involves questions that draw out emotional responses such as grief, anger, guilt or fear as personal experiences (Spiegel and Spira, 1991). Despite our best efforts to deliver a uniform model of therapy, we noted variance in co-therapists' leadership activity in initiating interventions. For instance, when group discussion wandered from cancer-related themes, therapists differed in their likelihood of refocusing the group. Some groups deny death anxiety and avoid discussion of death, akin to any other social group, unless a therapist recognises this and interprets the group's avoidant response appropriately. We noted that targeting issues or concerns associated with emotional ambivalence is a certain path to keeping the group-as-a-whole contained (Bion, 1961) through appropriate focus on relevant issues.

This containing function of the co-therapy couple forms a vital facilitatory process, in which threats, anguish and profound emotional pain can be heard and understood. The therapists can bear and think about what others seem unable to. This 'holding' permits a transformative process to emerge so that seemingly unthinkable experiences

are turned into something bearable through the mutually reciprocal sharing of the group (Winnicott, 1982).

One very pragmatic example of such therapist activity is the telephoning of any absent member, who hadn't tendered a prior apology, to track what is happening and invite expression of ambivalence about the group experience. Patients are moved by this level of interest and helped to work through their concerns without avoidance dominating. Therapist encouragement of members' inclusive socialisation is another example of therapist activity that promotes a cohesive group. Finally, therapists' attendance at funerals supports grieving members, models openness to death and dying and comes to be expected quite naturally by mature groups. Although a variation of the regular patient-therapist boundary, we formed the view that such activity is vital to group wellbeing.

The social nature of the group process promotes a small yet sensitive degree of self-disclosure by therapists. We found the principle 'What will serve the interests of the group best?' a helpful yardstick in moderating the group's curiosity about therapists' lives. The reality of therapists having children and where they travelled to for overseas conferences were some examples of disclosure that would not be found in psychoanalytic groups.

While direct transference interpretations are less prominent in SEGT than psychodynamic therapy, making sense of the transference remains important. For instance, when a group is highly functioning and productive, an idealising transference towards its therapists will prove as problematic over time as a negative transference were the group to feel poorly contained. Seeing the therapist as a 'cancer expert' is one example of this idealising transference. Herein the task is to reflect cancer-related questions back for the group-as-a-whole to answer, rather than therapists 'becoming the expert'.

Negative or critical attitudes towards therapists are more often left unstated in SEGT, only to emerge destructively away from the group room. Therapists ignore any member's negativity at their peril.

Complacency is another challenge for a longer term cancer group, which collaborates well initially given the universality of the common journey. Alliances may become too comfortable, repetitiveness appears in stories, absences develop and momentum towards transformed living is lost. Ettin raises the question of 'which box to unpack' next as the necessary therapist response when an affiliative group starts drifting (Ettin, 2000). There will be previously acknowledged issues or concerns to which the therapist can re-direct focus so that the group's momentum is appropriately sustained.

Therapists are responsible for supporting group norms that will sustain a 'holding' structure and nurture an enabling culture. Can the transport of sick members be facilitated? Can a blood test or scan be arranged to avoid conflict with the meeting time of the group? Can the day for chemotherapy be re-negotiated with the oncologist so that it doesn't clash with the group? Except for medical crises, absences still have meaning, but SEGT therapists run the risk of not recognising ambivalence through over-compensation for illness.

THEMES WITHIN SEGT

David Spiegel, Jim Spira and Catherine Classen have described in detail the common themes that arise in SEGT groups (Spiegel and Spira, 1991; Spiegel and Classen, 2000). These will not be repeated here; rather the emphasis will be on issues that arise as a result of these themes when the model is applied in clinical practice. Particular attention is drawn to '*medicalization*' of the group's culture, maintaining a focus in their work, nurturing relationships and cultivating courageous acceptance of dying.

Health beliefs within the group culture

The regular exchange of information about recent medical consultations, results of tests, treatment experiences, side effects, and progress is the everyday work of SEGT groups. Movement occurs between the sharing of distress and grief at bad news back to optimism about the prospects of further chemotherapy and the hope for continued existence. The therapists' key activity in listening to this is to ensure that not only are feelings shared amid the biological data describing the disease, but also that key health beliefs influencing attitudes to treatment are discerned. Members' similarities through their treatment experiences will emerge alongside differences in each and every story. This diversity spans not only illness experience but also personality and coping style, providing the wherewithal to discover alternative approaches that could potentially enhance adaptation.

Some members will begin in the group with a mindset against conventional medical therapies for breast cancer. Such health beliefs may have arisen from difficult experiences during adjuvant chemotherapy for their primary cancer. Appropriate information from their oncologist about the potential benefits of treatment can fall on deaf ears because side effects become so feared. The group culture can empower gradual re-education, however, as members provide alternative information and model different coping approaches. Acceptance of anti-cancer treatment emerges with this new insight, the patient adopting the group's attitude with a fresh confidence.

For those ambivalent about its initiation, improved compliance with anti-cancer treatments is therefore a potential outcome of SEGT. More subtle, but just as relevant, is the emergence of burnout in patients as side effects and length of treatment generate exhaustion, leading them to cease permanently, or abstain for too long from further chemotherapy. Furthermore, this same demoralization about the benefits of further treatment can be recognised in the comments of a treating oncologist, who can be influenced by the patient's morale. Group members fighting to contain the growth of their own cancer prove adept at recognition of such burnout, offering understanding but also encouragement to persevere.

Such promotion of treatment adherence is a hypothetical mechanism to extend survival, but this, in turn, is dependent on a health promoting group culture. One study of patients with lymphoma and leukaemia that generated such a survival benefit placed considerable emphasis on structured education and enhanced treatment compliance (Richardson *et al*., 1990). In like manner, some further elaboration of the SEGT model to promote adherence with anti-cancer treatment may be warranted.

Only through reasonably detailed knowledge of the disease, its varied clinical presentations and course, and its potential management (including relevant indications, side effects and strategies for ameliorating the latter) can a patient be truly informed to choose appropriate anti-cancer treatments. Compliance with medical treatment is not only about initiating anti-cancer therapy but also adhering to it over time, especially when untoward effects have emerged that might lead some to abandon the approach. The expression of ambivalent feelings about these side effects in the group can provide the wherewithal to tolerate these and persevere with the treatment.

Generating a focus within the everyday session: the cancer illness

When a long term group proceeds with a flexible agenda, deliberately so to meet the needs of its members, a tension develops between social chit chat and the proper work of a group. There is a difference here between a member's news who has recently holidayed or witnessed important family events—surely a vital dimension of interpersonal connectedness—and aimless wanderings in conversation. If therapists allow the group to engage excessively in chatter, some members will quickly become bored or frustrated, recognising that they can relate to their friends thus at any time. The group's identity is formed around the shared experience of advanced cancer, and a therapist can safely return to this agenda should a group have momentarily lost its way.

Relationships

Another major agenda of SEGT is relational, so that issues and concerns about partners, offspring and friends are grist to the mill. The price of connectedness is the pain of grief at separation, yet the special meaning and joy in life derived from these relationships not only counters existential aloneness, but enriches living in the present (Leszcz, 1992).

Nevertheless, issues relating to hurts and perceived wrongs in the past, affairs and marital breakdowns, concerns about alcohol and substance abuse, conflict over money and wills, rivalries between children, and losses due to incidental life events appear in the long term life of every group. Ambivalence arises commonly from conflict, hurt, misunderstanding and difference; its resolution lies in fostering tolerance, forgiveness and acceptance of a goodness in life that is sufficient (Jaques, 1965; Strack, 1997). Personal fulfilment from accomplishment, proportional to each person's opportunity and endeavour, attenuates grief and promotes eventual acceptance of dying.

Accepting death alongside the pursuit of life

The agenda of the SEGT model is ultimately existential, in which members grapple with and

face the concerns that arise from the very givens of our existence (Yalom, 1980). Hence a search for meaning, clarification of role and purpose in life, and a review of what matters transforms the group from a focus on worry, anger, grief and distress into the pursuit of authentic living. However, before creativity, happiness and a genuine joy in life can truly emerge within the group, death and acceptance of mortality must be acknowledged and worked through.

This naming of existential ambivalence is fundamental to permitting the emergence of creative living. Therapists clarify the two sides to the predicament, the cost alongside the gain or the conflicting wishes about which the person must choose (Bugental, 1969). In so doing, the therapist takes care not to dilute the pain or autonomy of the patient; clarifying the ambivalence is sufficient to invite a search for an innovative solution.

Within each group, as some members succeed with disease control or stabilisation, others face progression and the knowledge that they are drawing steadily closer to death. Preparation for their death then becomes a worthy project. Tension will be evident between the seemingly eternal hope for cure of some members and an acceptance of reality in others, sometimes stoical or fatalistic, at other times heroic. Open discussion of death and dying is an imperative within the SEGT model. Therapists must accept responsibility for guiding the group towards this challenging agenda.

The well functioning group will discuss concerns about both the process of dying and what it means to be dead. A therapist's medical knowledge of dying is invaluable in order to guide discussion and foster comfort with the topic. More apt still is the recognition of ambivalent members who consider talk of death or dying taboo (Hyland *et al.*, 1984). Provision of sensitive assistance to draw out their fears and to generate group support proves worthwhile. Longer-term members are wonderful allies in sharing memories about the courageous deaths of former participants. Spiegel has termed this process 'detoxifying death' (Spiegel, 1993).

The group also provides a safe place to review conversations with spouses, children, extended family and friends as the final farewells begin.

One challenge for longer surviving members (and potentially for some therapists) is coping with multiple, and sometimes horrible, deaths. Across any 5 year period, most of our groups have experienced between 15 and 20 deaths. Patients who joined such a group at its beginning express survivor guilt at their good fortune. Unless a healthy adaptation to dying is realised, patients will not tolerate continuing in the group. We will have more to say about the negative aspects of group life later, but first, let us explore the maturation of a group.

GROUP TRANSFORMATION AS IT MATURES

Life's fundamental existential challenges include mourning its many losses (the biggest of which is death), coping with its essential aloneness, discovering meaning in what we do, and responding to freedom with responsibility in the choices we make (Yalom, 1980). The process of confronting these challenges has the potential to help the group mature, transcending the limitations of humanity, grieving loss and emerging with renewed spirit. This authenticity is evident in the group through humour, celebrations, assertiveness, pursuit of creative activities, loving relationships and an outward looking generosity towards the broader community.

Humour

SEGT groups prove to be enjoyable and can be approached with anticipation and enthusiasm. Humour in the well functioning group constitutes a hallmark of its emerging maturity. Thus Freud identified its liberating function for a person 'refusing to be distressed by the provocations of reality' (SE XXI, p. 162). Therapists must nevertheless reflect on laughter, assessing whether it is a manic defence against unrecognised ambivalence, or truly signifying confidence and contentedness. When ambivalence is evident, active questioning seeks to understand it. In contrast, when the humour is genuine, therapists can be reassured about the healthy functioning of the group.

Celebration

The culture of the group develops to embrace the celebration of birthdays and other festive occasions in a genuine and spirited manner.

Enjoying life becomes tremendously important to individuals who know that their future is necessarily limited.

Assertiveness

Group confidence about authenticity and the enjoyment of life leads to optimisation of relationships, including those with treating clinicians. Members rehearse questions they might ask their doctors and set goals for what they want from a medical consultation. A basic understanding of their disease and its treatment empowers their selection of helpful questions, their growing assertiveness leading to improved relationships with their care providers and better health outcomes.

Creativity

Some group members will be artists, painting the beauty of the feminine form despite mastectomy; others writers, generating poetry and prose; yet others musicians, creating lyrics and harmony. Community activities such as participation in public seminars about breast cancer, 'dragon boat races' and 'fields of honour' ceremonies, or fundraising through 'pink ribbon' sales constitute creative endeavour. In the process, the group models the pursuit of authentic living. Psychoanalytic theory reminds us that only when mourning and ambivalence are dealt with successfully does such creativity emerge (Pollack, 1989).

Altruism

Within the microcosm of the group, caring for each other is exemplified through transporting sick members to sessions, providing meals for their family, expressing concern for relatives, and even remembering each others' dates of medical appointments and tests. As the group looks outwards, members get to know the spouses and family of other members. Loving relationships are valued. Bereaved relatives also return to group activities for continuing support.

Courageous dying

Acceptance of dying with courage can be viewed as a mature outcome of the group process. As sad news is shared of disease progression, and frailty develops gradually, members come to accept their limited future, recall the heroism of former group members, and prepare for their dying with dignity. '*We know that we will die, but our hope is that we do so peacefully, serenely and accepting when the time is right*.' No greater poignancy is felt within the group than when a member is describing their preparation for dying, taking leave of family and friends, creating memories for their children . . . saying goodbye.

Group-as-a-whole activities

Cohesiveness through shared purpose and activity fosters group maturation. This was well exemplified in one of our groups by the members writing a book about their experience of advanced breast cancer. More than a compilation of stories, this represented an altruistic wish to help others better understand the journey, while also creating a memorial for family and friends. Therapists do well to support such endeavours and recognise them as signs of the emergence of the mature, creative and nurturing group environment.

ANTI-GROUP PHENOMENON

Not all groups mature as described. The presence of anti-group phenomena assists recognition of negative group experiences. Given the flexibility of its framework and the existential concerns that it brings, our therapists and supervisors concur that SEGT is more difficult to facilitate than psychodynamic or psychoanalytic group therapy. Some form of supervisory process proves invaluable to reflect on the challenges and identify problems before they become too entrenched. Notwithstanding this, and in keeping with the long recognised rate of negative consequences from psychotherapy of approximately 10% (Gurman and Kniskern, 1978), SEGT has had its failures in our hands.

Transference issues

Negativity to therapists usually emerges subtly, couched perhaps in criticism of treating oncologists, and is rarely shared openly with the therapists. When taken up by some group members but not others, the potential for splitting of

the group develops, as conversation about the lack of understanding of therapists occurs outside the group. Looser boundaries make recognition of such phenomena more difficult.

On other occasions, therapists are directly split, one being praised for kindness while the second is criticised in their absence. Points of tension include therapist's absences from funerals, perceived neglect of the group when attending conferences or taking holidays, confrontation of difficult members, stylistic differences or a relative lack of knowledge about breast cancer. Envy at therapists having normal breasts, or normal health, can also lead to angry members attacking them. Furthermore, the therapeutic work of such groups is challenging and difficult. Members are asked to confront their own mortality and live in the face of it. One form of resistance to this is a counter-challenge to the therapists: can they face the loss of their identity as therapists through group members' criticism of their skill and commitment? Do the therapists know what they are doing in asking so much from group members? Can the therapists face a similar challenge to their self-knowledge and courage?

These examples of negative transference challenge co-therapists to understand the group and contain its distress. Key strategies include identifying differences (reframed as diversity) within the group, drawing out expressions of ambivalence, nurturing inclusiveness and cohesiveness, and facing (rather than avoiding) existential issues.

When anti-group phenomena are expressed, members withdraw [unless a strong therapeutic alliance has already been established], often taking others with them and causing some fracturing of the membership. Therapists feel they have failed the group, and if the surviving numbers are few, the viability of the remaining group is problematic. Sometimes unhealthy memories of what has occurred make it wiser to start a fresh group, rather than contaminate new members with an unhelpful past.

Countertransference issues

When therapists develop negative feelings about group members, sharing these with their co-therapist improves understanding and ensures that respectful tolerance is sustained. Standard principles to contain difficult patients have been well enunciated elsewhere (Yalom, 1985). Therapists model adaptive responses to nurture the ethos of the group-as-a-whole.

Just as common as negative responses, the idealising of group members' courage or the minimisation of non-attendance can lead therapists to miss emerging issues and fail to recognise evidence of the ailing group. A reflective stance is crucial to fully understand the meaning of behaviours.

Ambivalence also finds expression within the co-therapy couple, sometimes about interventions, differing views and choices, and invariably based on projections from the diverse membership of the group. We have noticed ambivalence emerge between each of the co-therapy couples. As one therapist is idealised and the other possibly criticised, or more commonly bypassed, the potential for conflict can emerge. The capacity for therapists to talk about their ambivalence with each other is crucial to the maintenance of mutual respect, the latter dependent, in turn, on tolerance, compromise, compassion and care for all. Genuine harmony between therapists creates an enabling environment for the group, which permits creative energy to emerge as banter, humour, play and generativity. As therapists sustain respect and value each other's contribution, so too will members derive benefit from the rich diversity of the group, adding their own originality in an engaging and facilitatory manner.

Thus the working through of ambivalence in the group is mirrored at some level by the experience of ambivalence between therapists. A facilitatory environment is nurtured by these therapists tolerating existential uncertainty, death anxiety, a lack of clarity about the meaning of life or suffering and respect for the freedom of choice of members such that an unconditional regard is always maintained. This group culture will then have the capacity to transform fear and distress into creativity and worthwhile living.

Systemic influences on both individuals and the group culture

The group is not the sole system influencing choices such as anti-cancer treatment adherence over time. Medical and family input are two subtle, yet powerful, confounding influences. Sometimes the treating doctor runs out of commitment to a patient judged to have had 'a good innings'; at other times relatives become

exhausted. There is a real risk that the group also withdraws as frailty and increasing physical dependence limit a member's access and attendance. The therapists' interest and inquiry are vital reminders to ensure that the group remembers all of its members, including those ill and repeatedly absent. Throughout this endeavour, both members and therapists inevitably have mixed feelings about treatments, care systems and death itself. This can be a truly challenging predicament, especially when these outside influences are powerful and the group may not be able to intervene, merely understand.

What needs to emerge ultimately in the group is acceptance of a goodness that is sufficient—lives lived imperfectly, yet gracefully (Jaques, 1965). Death eventually brings closure to these lives, seemingly prematurely, but optimally with continued creative living expressed through families and relationships, until life is able to continue no more.

Winding up—death of the group

Sometimes for service reasons, realignment of a program, retirement of a therapist or for want of sufficient members, groups close. This loss is a metaphor for personal death and needs to be mourned accordingly. Adequate warning and working through of related feelings is vital.

The death of a group has proved particularly challenging for our program and highlighted our therapist's inherent desire to avoid death. Nevertheless, the reality is that some groups must close. While the group's myth of ever-continuing support reinforces each woman's expectation that she will be accompanied unto death, mourning the loss of a group brings the potential for greater personal maturity. A risk exists for those close to death—that perceived abandonment will increase their cumulative grief. This risk will be countered by the social support from survivors, who will continue to meet together, albeit without their therapists. This begs the philosophical question: can a group ever fully die?

DISCUSSION: EFFICACY AND UTILITY OF SEGT

The key questions that arise in any consideration of the role of SEGT in routine clinical practice have to do with its efficacy and utility. The improvement in quality of life from SEGT has been clearly demonstrated (Spiegel *et al*., 1981; Kelly *et al*., 1993; Goodwin *et al*., 2001; Classen *et al*., 2001). Professional leadership enriches group experience, while SEGT optimises adaptive adjustment and creative living during what is potentially one of life's most challenging transitions. The translation of the model used in research into regular clinical service remains a current developmental agenda for most countries. We hope that the experience reflected upon in this paper assists its adoption.

Whether SEGT has the capacity to enhance survival is doubtful—certainly any positive effect size will be small. The Canadian multi-site replication study failed recently to confirm Spiegel's originally reported survival advantage (Goodwin *et al*., 2001; Spiegel *et al*., 1989). The outcome of further replication studies in Stanford and Melbourne is awaited.

The concept of 'compliance enhancing' SEGT proposed in this paper calls for further elaboration of the model to ensure that an adequately health promoting group environment is established. Within such understanding, any survival benefit would be mediated less by psychoneuroimmunology and more by attitudinal and behavioural change in both the initiation of and perseverance with anti-cancer therapies. However, an analysis after randomisation in Spiegel's original study failed to identify subsequent differences in medical treatment that could account for the observed survival advantage (Kogan *et al*., 1997). This contrasts with our clinical experience in Melbourne, which is more consistent with the findings of Richardson's team identifying compliance as a key survival promoting mechanism (Richardson *et al*., 1990). We hypothesise that while anti-cancer therapies [for instance, chemotherapy] have the potential to prolong survival, the psychological care received from SEGT creates the environment in which greater compliance with anti-cancer therapy occurs. Future research in psycho-oncology could well explore models that optimise treatment adherence.

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