

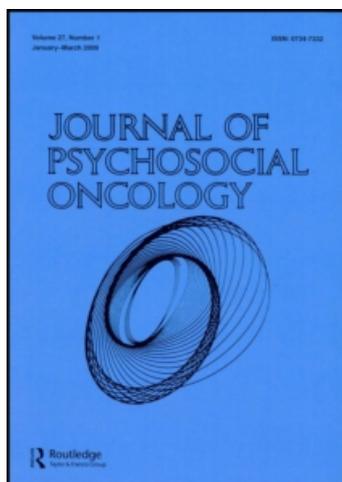
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### Is There an “Ideal Cancer” Support Group? Key Findings from a Qualitative Study of Three Groups

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## **Is There an “Ideal Cancer” Support Group? Key Findings from a Qualitative Study of Three Groups**

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*The objective of this study was to study differently composed cancer support groups to generate insights into what groups are attractive to the widest range of participants, and how they might be best structured and composed. This study applied a qualitative design utilizing participant observation at three cancer support groups (a group for women with metastatic cancer, a colorectal cancer support group, and a group for Chinese cancer patients) and in-depth interviews (N = 23) with group members as the primary data collection methods. Despite the diverse composition of the groups, their perceived benefits were similar, and informants highlighted the information, acceptance, and understanding they received in the support group environment. However, gender and cultural*

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*differences were found in attendance patterns and the desired content of group meetings. Importantly, participants' motivations for attending cancer support groups also changed as they moved through the treatment trajectory: over time the need for information was at least partially replaced by a need for support and understanding. This study supports prior research findings that there is no ideal support group, nor is there a "magical formula" for attracting and retaining a diverse audience. However, including an educational component in support groups may increase the participation of currently underrepresented populations such as men and patients from culturally diverse backgrounds.*

**KEYWORDS** *support groups, gender, diversity, ideal process and structure*

## INTRODUCTION

Over the past few decades, cancer support groups have emerged as a key mechanism for addressing the psychosocial needs of cancer patients and their families and provide an important means of helping patients cope with life during and after cancer diagnosis and treatment. Although increasingly common, such groups vary enormously in form and structure. They include open and closed formats, they may be peer led or professionally facilitated, and they may entail emotional sharing, psychoeducation, cognitive-behavioral therapy, and so on, or a mixture of approaches. Although professionally led groups have been the focus of considerably more study than self-help groups (Gray, Fitch, Davis, & Phillips, 1996), a meta-analysis of randomized controlled trials evaluating a variety of types of support groups for cancer patients found evidence that they improve emotional states, diminish depression and anxiety, and improve quality of life and marital relationships (Zabalegui, Sanchez, Sanchez, & Juando, 2005).

There is, however, evidence that psychoeducational groups may be more effective than groups focusing on emotional sharing alone (Fawzy & Fawzy, 1998), although one of the limitations of available evidence is the common failure to adequately describe and analyze the impact of demographic factors such as sex and socioeconomic status on patient outcomes (Bottomley, 1997). Moreover, though closed, time-limited, highly structured cancer support groups tend to be considered the "gold standard" in the field of psychosocial oncology, social workers and psychologists often find that open-ended, drop-in support groups are more feasible for patients because they offer a flexibility that other groups do not (Fobair, 1997). Although less well studied, these open-ended, drop-in groups have therefore become an

increasingly common mode of support group delivery for health professionals working in the area of psychosocial oncology.

Although cancer support groups have demonstrable benefits for those who participate, available evidence indicates that they enroll only a small minority of patients (Avis et al., 2008; Butow et al., 2007; Coreil, Wilke, & Pintado, 2004; Mathews, 2000). Moreover, participants tend to be White, middle-class females (Cella & Yellen, 1993; Docherty, 2004; Gottlieb & Wachala, 2007; Grande, Myers, & Sutton, 2006; Magen & Glajchen, 1999; Mathews, 2000; Taylor, Falke, Shoptaw, & Lichtman, 1986). Although cancer support groups are not universally attractive contexts for addressing psychosocial issues (Gottlieb & Wachala, 2007), the White, female, and middle-class composition of existing groups may serve to limit the participation of men, working-class cancer patients and survivors, and people from minority ethnic backgrounds who might otherwise be interested in attending. Indeed, U.S. studies of breast cancer support groups have found that Black women perceive such groups to privilege White women's experiences with the disease at the expense of their own (Mathews, 2000; Moore, 2001).

For immigrants from non-English speaking backgrounds, language issues also pose a barrier to participation in cancer support groups (Avis et al., 2008; Bui et al., 2002). However, even if patients are fluent in English, language and communication issues can still occur. Avis et al. (2008) found that participants from non-English speaking backgrounds felt that using English to discuss their experiences led to misunderstanding. Although support groups for specific linguistic and ethnic groups might increase their participation, it is unclear whether people from these communities wish to be segregated in this way (Butow et al., 2007).

Most of the research conducted on cancer support groups to date has been primarily on breast cancer (e.g., Cope, 1995; Coreil et al., 2004; Gray et al., 1996; Gray, Fitch, Davis, & Phillips, 1997; Mathews, 2000; Moore, 2001) and prostate cancer (e.g., Arrington, Grant, & Vanderford, 2005; Coreil & Behal, 1999; Gray et al., 1996; Oliffe et al., 2008; Thaxton, Emshoff, & Guessous, 2005) support groups. These studies have found that breast cancer survivors and prostate cancer survivors tend to be drawn to groups that look very different, with women preferring psychologically oriented groups and men leaning more toward educationally oriented ones (Bottomley 1997; Gray et al., 1996). However, it is unclear how readily these findings translate to other types of cancer support groups catering to a broader cross-section of patients.

Studying differently composed cancer support groups is an important first step in providing insights into what groups are attractive to the widest range of participants, and how they might be best structured and composed. Recent research that attempts to address this question is a study by Butow et al. (2007), who systematically recruited people from differently composed Australian cancer support groups to obtain their views on the ideal group.

They found that “support groups differ markedly in their content, process and structure and it is not clear which groups produce optimal outcomes” (p. 1039). They concluded that there is no “ideal” group and that individual assessment needs to be made in each group of members’ satisfaction and needs.

In another relevant study, Avis et al. (2008) focused specifically on ethnicity and participation in British cancer self-help groups. They found that time for sharing was an essential component of inclusive groups, although some participants expressed discomfort with the idea of groups confined solely to sharing of personal narratives. The researchers emphasized the importance of choice and argue that assumptions should not be made about the sort of support groups that attract minority ethnic patients. Thus, “Some may feel that their cancer experience can only be understood by someone who has a similar background in terms of age, gender, class or ethnicity, but this cannot be assumed” (pp. 945–946).

The current study takes up this idea of whether it is possible to formulate the outlines of an “ideal” group by examining three very differently composed cancer support groups that have been designed specifically around axes such as gender, ethnicity, disease stage, and disease type: a group for women with metastatic cancer, a colorectal cancer group, and a support group for Chinese cancer patients. These groups were also differently structured, allowing for comparisons between psychoeducational, self-help, and emotional-sharing formats.

## METHOD

The current study applied a qualitative design utilizing participant observation and in-depth interviews as the primary data collection methods. This methodological approach is consistent with a number of prior studies of cancer support groups, which have provided valuable insights into how such groups are formed, their dynamics, and functions they serve for participants (Arrington et al., 2005; Cope, 1995; Coreil et al., 2004; Mathews, 2000; Oliffe et al., 2008; Ussher, Kirsten, Butow, & Sandoval, 2006).

The research setting was three professionally facilitated cancer support groups connected with a cancer treatment centre in western Canada: a bi-monthly support group for women with metastatic cancer, a monthly support group for colorectal cancer patients and caregivers, and a monthly support group for Chinese cancer patients and family members (see Table 1). All of the three groups differed somewhat in structure, although each had a “drop-in” format, in recognition of the growing patient demand for flexible psychosocial support options. Importantly, all three groups were established in the context of clear patient demand and were, to varying degrees, community driven: all groups were created following expressions of interest

**TABLE 1** Composition of Support Groups

Characteristic	Metastatic Group <i>N</i> = 25 (%)	Colorectal Group <i>N</i> = 30 (%)	Chinese Group <i>N</i> = 96 (%)
Sex			
Male	0 (0)	14 (47)	35 (37)
Female	25 (100)	16 (53)	61 (64)
Age			
Range	30s-60s	30s-70s	20s-80s
Median	50s	50s	50s
Ethnicity			
White	22 (88)	27 (90)	0
Chinese	2 (8)	2 (6)	96 (100)
South Asian	0	1 (3)	0
Hispanic	1 (4)	0	0
Role			
Patient	27 (100)	21 (70)	59 (61)
Caregiver	0 (0)	9 (30)	37 (39)
Treatment stage <sup>a</sup>			
Pretreatment	0 (0)	1 (3)	5 (10)
In treatment	25 (100)	8 (27)	30 (60)
Post treatment	0 (0)	12 (40)	15 (30)

a. Treatment stage% based on *N* = 25 for Metastatic group, *N* = 21 for Colorectal group, *N* = 50 for Chinese group.

from patients in conjunction with a clinical recognition that their needs were presently underserved.

The metastatic group was open to women with metastatic cancer, and its format included a meditation period followed by open sharing among members guided by the group facilitator. The colorectal cancer support group took the form of a professionally led self-help group open to colorectal cancer patients, survivors, and their family members. Meetings consisted primarily of open sharing with occasional speakers invited to meetings to talk on topics of interest to the group. The Chinese group, on the other hand, was facilitated in Cantonese and had a psychoeducational format consisting of a lecture on a specific topic (regular speakers were invited to the group) followed by open sharing and group discussion. This group was also open to patients and family members.

A cancer treatment agency research ethics board provided approval for the current study. In light of the groups' drop-in format, obtaining informed consent from the group participants was an ongoing challenge throughout the 8-month fieldwork period (September 2007–April 2008). To facilitate the consent process, a number of measures were undertaken. First, during each meeting, the researcher (K.B. in the metastatic and colorectal group & J.L. in the Chinese group) introduced herself and her role in the group. Second, the researchers made an effort to approach new participants at group meetings to explain the project and give them written information about the study.

During the fieldwork period, 8 colorectal group meetings were held, 7 Chinese group meetings, and 14 metastatic group meetings. In group meetings, the researcher observed without participating unless asked a direct question. However, these venues provided numerous opportunities to converse and interact with group participants informally. More active participation occurred at other events connected with the groups, such as a retreat, a colorectal cancer forum, and so on. Because of the groups' drop-in format, the researchers and the facilitators (S.F., S.K., and J.C.) decided it would not be appropriate to record the meetings. Rather, observational data were recorded in a notebook during the group meetings and written up into full field notes directly afterwards.

### Key Informant Interviews

Aside from the participant observation at the support group meetings, key informant interviews ranging from 1 to 2 hours were conducted with 23 group members (see Table 2) to seek further "clarification, explanation and validation" (Cope, 1995, p. 473) of the participant observation field notes. Participants in the groups were invited to take part in an individual interview after fieldwork had been underway for several months. This helped to maximize the validity of the research because interview questions were generated through the participant observation itself, rather than in a laboratory or office (Sanjek, 2000). It also served to reduce participants' anxiety about being interviewed, as they were familiar with the researchers by the time of interview (cf. Ussher et al., 2006). Key informants received a nominal honorarium (a \$20 gift card) to acknowledge their time and contribution to the study.

Open-ended interview techniques were applied (Fetterman, 1989), inviting participants to tell their story of being diagnosed with and treated for cancer, how they came to the group, and their overall views on the group. For members of the Chinese group, the informants' views on cultural issues for Chinese cancer patients were also elicited. Interviews were primarily conducted in the researchers' office located on site at the cancer treatment agency or participants' homes. With the consent of the informants, written notes of all interviews were taken. The primary researcher (K.B.) conducted interviews with the metastatic and colorectal group members, and all were recorded and transcribed. The research assistant (J.L.) conducted interviews with the Chinese group members in Cantonese; only four of the seven interviews were recorded, in keeping with the stated preferences of interviewees.

Nvivo software (version 8) was used in the initial stages of analysis to facilitate coding of the data. K.B. and J.L. coded the data using ethnographic coding processes (Emerson, Fretz, & Shaw, 1995), involving open coding to identify any and all ideas and themes in the material and focused coding

**TABLE 2** Overview of Informants

Informant <sup>a</sup>	Age Range	Support Group	Treatment Stage	Time Elapsed Since Diagnosis	Time in Group <sup>c</sup>	Frequency of Attendance in Group
F1	50s	Metastatic	In	1.2 yrs	7 mths	Regular
F2	50s	Metastatic	In	1.5 yrs	8 mths	Sporadic
F3	50s	Metastatic	In	4.75 yrs	4.3 yrs	Regular
F4	50s	Metastatic	In	2.75 yrs	1.2 yrs	Regular
F5	40s	Metastatic	In	2.5 yrs	2 yrs	Regular
F6	60s	Metastatic	In	2.25 yrs	1.5 yrs	Regular
F7	60s	Metastatic	In	8 yrs	6 mths	Regular
F8	50s	Metastatic	In	2 yrs	2 yrs	Sporadic
F9	40s	Metastatic/Colorectal	In	1 yr	.75 yrs	Regular
F10	40s	Colorectal	In	4 mths	3 mths	Sporadic
F11 <sup>b</sup>	50s	Colorectal	n/a	n/a	6 mths	Regular
F12	50s	Colorectal	Post	2.75 yrs	1.5 yrs	Regular
F13	60s	Colorectal	In	.75 yrs	n/a	One-timer
M1	60s	Colorectal	n/a	n/a	n/a	One-timer
M2	50s	Colorectal	Post	2 yrs	1.5 yrs	Regular
M3 <sup>b</sup>	50s	Colorectal	Post	1.25 yrs	1 yr	Regular
F14 <sup>b</sup>	20s	Chinese	n/a	n/a	5 mths	Sporadic
F15	60s	Chinese	Post	2.5 yrs	1.25 yrs	Regular
F16	60s	Chinese	Post	2.5 yrs	1.33 yrs	Regular
F17	70s	Chinese	Post	4.5 yrs	1.5 yrs	Regular
F18	40s	Chinese	Post	1 yr	1 yr	Sporadic
F19	50s	Chinese/Metastatic	In	6 mths	1 mth	Sporadic
M4	50s	Chinese	In	3 mths	3 mths	Regular

Note: a. F = female, M = male.

b. Caregiver.

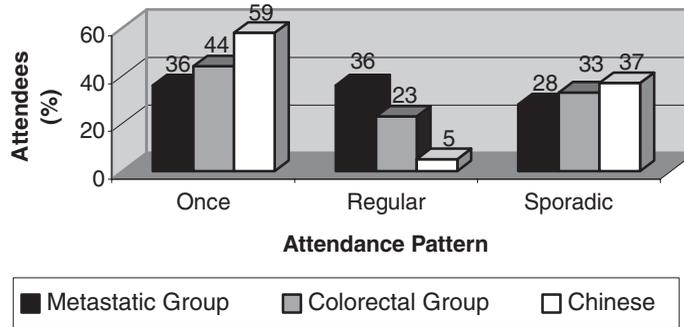
c. These numbers are based on informants' own estimates, and it is unclear how accurately people remembered their date of entry to the group as there were some discrepancies in the estimates several informants gave.

as the fieldwork progressed, whereby the transcripts and field notes were subjected to a line-by-line scrutiny on the basis of topics that had emerged as of particular interest. Field notes and interview transcripts/notes were then analyzed using ethnographic content analysis techniques (Altheide, 1987). Ethnographic content analysis draws on numerical and narrative data to develop a systematic and analytic understanding of the data. Like grounded theory (Strauss & Corbin, 1990), it is embedded in the constant discovery and constant comparison of situations, settings, images, meanings, and nuances (Altheide, 1987).

## RESULTS

### Attendance Patterns

Although support group attendance patterns have not been well studied (primarily because most of the available research has been conducted in



**FIGURE 1** Attendance patterns at support groups.

closed groups), these patterns differed markedly in each of the three groups (see Figure 1), providing important insights into how participants use such groups and who receives most benefit from them.

*Metastatic group.* In the metastatic group, one third of the women attended meetings on a regular basis, with another one third attending sporadically. There was a clear pattern in the people who attended the support group once. All one-timers ( $n = 9$ ) had been diagnosed with metastatic cancer in the previous 6 months: on average, these women were only 3 months postdiagnosis. This contrasted starkly with the regular members of the group, who on average had been diagnosed with metastatic cancer  $3\frac{1}{2}$  years earlier.

F19, a member of Chinese support group newly diagnosed with metastatic disease, attended one meeting of the metastatic group, and her comment that she found the metastatic group to be too “depressing” may shed light on why other newly diagnosed patients fail to return to the group. The comments of F10, a member of the colorectal support group recently diagnosed with metastatic cancer, are also instructive. F10 made a decision not to attend the metastatic group and had the following to say about her choice:

All I could think of was that’s the worst name for a group! Like, why do I want to—just the sound of—it’s like “Oh my God, I can’t handle it! I wish you’d change the name!” Like the “M” word I can’t stand. So I don’t know, I think that was it. It was just like “Oh, I don’t want to be a person with metastatic cancer.” I don’t even want to admit it.

These comments suggest that many women recently diagnosed with metastatic cancer may find the group too confronting and need time to adjust to the diagnosis before attending on a regular basis. The fact that the majority of the group regulars (seven of nine) started attending the group at least 6 months after their diagnosis would appear to support this

hypothesis. Importantly, even those women who had had some time to adjust to their diagnosis highlighted how confronting their first meeting was and how ambivalent they initially felt about returning to the group. As F4 noted, "I started going in November of 2006, I think, and I met this gal, and she was quite ill and she died like a month later, and I was just a mess. So I just thought 'Oh I'm so not going to this,' you know."

*Colorectal group.* The colorectal group had a lower proportion of regulars and a higher proportion of one-timers than the metastatic group. In this group, the regulars were primarily patients in the post-treatment or "survivorship" phase (see Table 1). Indeed, patients who had completed treatment dominated the group overall, a phenomenon that has also been witnessed in other support groups (Schnipper, 2001) and may relate to the fact that the completion of treatment generally coincides with a dramatic reduction in other forms of support for the patient (Stanton et al., 2005).

Several patterns were evident among the one-timers in the group. First, the majority of patients who attended only one meeting (five of eight) had very specific questions that could not be answered by group regulars (e.g., dealing with ostomies and permanent bowel obstructions). Second, they were also more likely to be male (six of eight patients). Thus, though the total numbers of males and females attending the group in the 8-month period were almost equal, there was generally a higher proportion of females present at any given group meeting. A separate study exploring patients' level of interest in a colorectal cancer support program (Bui et al., 2002) highlights similar gender differences. The researchers found that gender did not relate to the level of interest in the support program offered, but actual attendance appeared to be gender related, with fewer men actually turning up to the meetings. In the case of the current study, male patients were almost as likely to attend the group meetings but were less likely to return.

Family members and caregivers were also more likely to be one-timers, with five of nine family members/caregivers attending on one occasion only. Three of the remaining four members attended sporadically, and generally only appeared on special occasions, such as when "potlucks" were held at meetings. Many of these sporadic and one-time attendees appeared to view their role in the group solely as supporters (and, in some cases, transporters) of patients; thus, their attendance was directly linked to that of the patients. However, for caregivers interested in receiving support in their own right, the group did not appear to meet these needs, as two caregivers interviewed (a one-time attendee and a group regular) suggested:

M1: I was a bit surprised there was only one other caregiver there. I thought there would be more. . . . I can see the point like caregivers shouldn't be there. . . . Like [if] I went there, I wouldn't say [what he was feeling] because Z's [his wife] there. You know, I could say, "Oh my God,

when she did this it was so horrible, and then she did that.” Why would she want to hear that?

F11: As a caregiver I would prefer to have more caregivers. If I had to choose between one or the other, if there were an “only caregivers” [group], I would probably attend the caregivers. . . . So it [the colorectal support group] doesn’t completely meet my needs. . . . It [a caregivers’ group] would meet the needs of really wanting to be amongst caregivers, and perhaps there would be maybe more emotional content, perhaps . . . caregivers have different needs.

The different support needs of caregivers and patients have been highlighted in several studies (DuBenske et al., 2008; Hauser et al., 2006; Hodgkinson et al., 2007) and suggest the potential benefit of a separate group for caregivers interested in receiving support.

*Chinese group.* In the Chinese group the proportion of regulars to one-timers was most extreme: 5% of the total attendees during the fieldwork period came to meetings on a regular basis and 59% came to only one meeting. However, the Chinese support group was also more than twice the size of the other groups, with an average of 21 people present at each meeting. Another important difference between the Chinese and colorectal support group was that the proportion of family members and caregivers at group meetings remained consistent over the fieldwork period (60% patients, 40% family members). Also notable was the fact that more than one family member of the cancer patient was often present at the meetings (e.g., a spouse and a child, or both parents-in-law). Interestingly, the core group members in the Chinese group were primarily cancer patients in the survivorship phase (80%), whereas the majority of one-timers (79%) were in treatment.

One possible explanation for the large number of one-timers is that a certain proportion of people came to the group not because they were seeking a support group per se, but because they were seeking information and there are few culturally and linguistically appropriate resources available for Chinese cancer patients (Chan, Law, & Leung, 2000). The fact that so many of the participants who attended the group were currently in treatment, rather than in the survivorship phase, also suggests that their needs were primarily informational rather than support oriented. Thus, such patients may have been attracted by the lure of a Chinese-language information resource but turned off by the reality of the support group environment. As B. H. Mok (2001) noted, for many Chinese people, coping with illness is largely a private and family affair and such patients may have seen this as a public airing of their “dirty laundry.” However, this is not to suggest that Chinese patients are “culturally” incapable of finding benefit in support groups—indeed, support groups for Chinese cancer patients in Hong Kong have proven beneficial and effective (Chan et al., 2000; E. Mok, 2000; B. H. Mok, 2001).

**TABLE 3** Most Common Topics and Subtopics of Discussion in Support Groups

Metastatic Group	Colorectal Group	Chinese Group
1. Family issues: – Family difficulties in coping – Impact of illness on family – Dealing with children	1. Treatment side effects: – Peripheral neuropathy – Fatigue, chemobrain – Hair loss	1. Interactions with health care – Professionals: – Language barriers – Quality of health care services
2. Responses to the cancer: – People not knowing how to deal with it – People being patronizing/trivializing experience	2. Interactions with health care professionals: – Comparing notes on oncologists – Misdiagnosis of cancer	2. Coping with treatment & recovery: – exercise (qigong, yoga) – Importance of information – Being “self reliant”
3. Interactions with health care professionals: – Bad bedside manner – Doctors not being open – Doctors giving survival estimates	3. Posttreatment follow-up: – Updates on checkups – Who should conduct it & where – How often & what form	3. Family & friends: – Support from family – Worries about family – Impact of illness on family
4. Unreliable body: – Not being able to do things – Not looking like “myself” – Feeling disconnected from body	4. Employment issues: – Returning to work – Access to long-term disability	4. Treatment side effects: – Pain – Eating issues
5. Meaning of life: – Searching for purpose – Letting “little” things go – Focusing on what you can change	5. Financial issues: – Financial struggles – Cost of drugs	5. Fear & anxiety: – Fear of unknown – Anxiety re: asking for help – Anxiety while waiting for treatment

### Content of Group Meetings

*Metastatic & colorectal groups.* The content of the group meetings differed dramatically from group to group (see Table 3), with the greatest contrast apparent between the metastatic and colorectal group. In the metastatic group, the focus of discussion was on relationships and the physical, emotional, and spiritual changes wrought by cancer. Group members commonly asserted that people who have not experienced metastatic cancer simply could not understand what they were going through. Women also expressed distress about the bodily changes produced by the cancer and its treatment, and many felt alienated from their bodies, which they perceived to have “failed” them.

In contrast, colorectal support group meetings remained confined almost exclusively to emotionally “neutral” topics and treatment side effects dominated discussion. Participants also spent considerable time talking about their interactions with health care professionals and comparing notes on their oncologists. Given the high prevalence of posttreatment “survivors” in the

group, there was also regular discussion of posttreatment follow-up and ongoing work and financial issues connected with cancer treatment. Discussions of the emotional impact of cancer were very rarely raised in group meetings. When such conversations occurred, participants were generally unsure of how to respond and conversation quickly moved towards “safer” topics.

The unwillingness of members of the colorectal group to delve into the emotional impact of cancer may have been partly due to the gender composition of the group. A number of researchers have observed gender differences in cancer support groups. Based primarily on research with breast and prostate cancer support groups, they have found that men in cancer support groups tend to value information and education over personal experience and emotion sharing, whereas women place more emphasis on precisely these dimensions (Bottomley, 1997; Coreil & Behal, 1999; Gray et al., 1996, 1997; Hitch, Fielding, & Llewelyn, 1994; Steginga et al., 2001; Thaxton et al., 2005).

These findings suggest that the presence of men and women in the colorectal support group may flatten the “gendered” dimensions of typical support groups; instead, members bonded around those aspects of their identity that were shared (i.e., experience of colorectal cancer). However, there were indications that at least for some group members, there was less emotional sharing than might appeal to women, and less formal provision of information than might appeal to men. Thus, when asked how the group could be improved, M2 noted, “I’d say that you need to have more educational component.” Elsewhere in the interview he made his views on emotional sharing clear when he noted that pushing from his wife led to his initial involvement in the group, “even though I had that guy’s reluctance—I don’t want to get involved in some touchy feely exercise, you know, the way most guys feel.”

Although all of the female participants made suggestions for improving the group, none of them highlighted the need for an educational component, stressing instead the need for a more intimate atmosphere, the importance of gaining other patients’ perspectives, an interest in “buddies” with whom they could communicate with outside of group meetings, and a desire for more emotional sharing in group meetings. One woman explicitly highlighted what she perceived to be a gender difference between men and women’s involvement in the group:

F9: Some of them [men] are there really for medical, they’re not there for the emotional. They want to know how the chemo going to work, what things to do, what kind of drugs are you on, what kind of protocol you’re on. It’s more that kind of thing. . . . Now if you were a woman who’s sort of more in touch with this “I’m on a journey” thing and you’re stage 3 then you wouldn’t get your needs met there.

*Chinese group.* The Chinese support group covered the most wide ranging content of the three groups. The primary issue raised in meetings related to participants' interactions with health care professionals and the substantial language and communication barriers they experienced. The group members also spent considerable time discussing practical tips and pointers for coping with treatment and the recovery process, although there was also some discussion of the emotional impact of cancer and the fear and anxiety it generated. Interestingly, there was a temporal dimension to the topics discussed in meetings: more pragmatic and practical issues (e.g., communication, coping) were raised initially and conversation moved toward discussion of more emotionally loaded topics over the course of the sharing.

As Chan et al. (2000) noted, expressing emotional issues to strangers is a phenomenon many Chinese cancer patients are unfamiliar with. Therefore, in the context of the support group these issues were broached indirectly, after the provision of information and practical coping tips. F18 made some interesting observations regarding this phenomenon. Although F18 did not want her interview recorded, her interview notes provide a general record of the content of the interview:

F18 also finds the participants in the English group tend to be more willing to talk about their emotions. She recalls a woman in the Chinese group who was silent throughout the meeting. She also speaks of a man in the Chinese group, who took great courage to express his perspective on cancer only toward the end of the meeting.

### Commonalities Between Groups

*Perceived benefits of groups.* Despite the very different composition of the groups, one notable similarity between them was the benefits informants derived from group membership. These individual reflections all pointed to the role of the group in providing information, acceptance, and understanding, views expressed most explicitly in the following selection of comments:

F4: We all speak the same language. . . . Whatever your story is, that's a good place to tell it, and, you know, we're not there to help or give advice, I mean, or anything like that. . . . And you take away, you know, something that you might want to try or check on or find out about or a different medication], you know, you're different, you have, like, side effects and, you know, so you kind of compare notes, I guess is what I'm saying.

F11: I get out of the group other people's experience which I can bring home, which I can relate to. . . . [I]t sounds probably cliché but there is

an element of not feeling completely alone. Because it's a pretty lonely experience, you know, being at home. . . . And neighbors don't want to hear about it, they really don't. Some of them, it's "How are you doing? Oh great. You're going to be just fine!" . . . Some of them [group members] really are willing to listen, probably because they've been there; they probably know what you're talking about.

F15: A curious phenomenon is that when a cancer patient shares with another cancer patient, there is less concern, feeling that the person can understand him/her. Like, even now, when I talk to my family/relatives, they may not understand what I have said. But in the support group it will be understood. This is very important, the issue of understanding.

These views are consistent with findings from other studies of support groups and seem to constitute a benefit of support group membership, regardless of the ethnicity of the participant (Avis et al., 2008) or whether the group is professionally facilitated (Cope, 1995; Gottlieb & Wachala, 2007; Ussher et al., 2006) or peer led (Arrington et al., 2005; Coreil et al., 2004; Docherty, 2004; Gray et al., 2007; Yaskowich & Stam, 2003).

*Differing motivations based on treatment stage.* It is sometimes implicitly assumed in the literature that people's motivations for attending cancer support groups remain constant over time. However, one commonality between the three groups in the study was the different function they served depending on where participants were in the cancer trajectory. For people in treatment (or new to metastatic cancer in the case of the metastatic cancer support group), their needs appeared to be connected with information more than emotional support. This was reflected in meetings in all three groups, as patients in or new to treatment generally had many questions about treatment procedures and outcomes, to the point that they would sometimes monopolize meeting discussions.

For those who had completed treatment or whose cancer had become a long-term, chronic disease, their motivations for attending connected more with the friendships they had developed (M2, M3, F3, F4) and a desire to "give back" (F3) and support others:

M2: X said at one of the very, in fact it could have been the first meeting, she said, and I always remember this, she said "I want to see people in this group that have been around for a while" . . . And we all wanted that when we first joined; we did. We wanted to see survivors. There weren't any. . . . So now I like to think that I'm one of those people, and I think it's really important for new people to come and talk to people that have been through the treatment and got out the other end safe and sound.

F5: I think it's—that the people come in with a, you know, again a different stage. They're confused, they're scared, they're, you know, and

I think for them to sit around with a bunch of old-timers, you know old hat with this [metastatic cancer], I think that's really reassuring for somebody, you know. . . . That also feels good, too, knowing that you've participated in maybe helping somebody.

F15: When I remember [the difficulty of treatment], I will understand others' situation more. If I want to help others, this is very important. . . . I am just a single person. If I don't care about the support group, and if everyone thinks in that way too, then, the group will be gone.

E. Mok (2000) also observed a similar phenomenon in a Chinese cancer support group in Hong Kong, noting "the needs of the cancer survivors are different, depending on their stage of the illness. The old-timers, instead of getting more information, treasure the friendship that has developed in the self-help groups" (p. 210). Similarly, Krupnick, Rowland, Goldberg, and Daniel (1993) also highlighted the differing needs of cancer patients attending support groups based on their stage in the treatment trajectory. They suggest that newly diagnosed patients are best served by a structured group educational format, whereas after patients have accepted their illness and made initial decisions regarding treatment options, support for emotional concerns and development of specific coping skills is appropriate.

## CONCLUSIONS

The comparative focus in the current study along with the research methodology, which allowed the groups to be followed over time, provides important insights into who attends cancer support groups and how the groups' composition affects the content of meetings. Attendance patterns reveal that the groups benefited some patients more than others—particularly patients who were in the "survivorship" phase, or those for whom cancer had become a long-term, chronic disease. The differing content of group meetings illustrates the specific issues patients in each group face but also illuminates how the gender of participants and their cultural background influenced what was and was not discussed in meetings and how such discussions unfolded.

Interestingly, despite their diverse composition, the benefits accrued through participation in the cancer support groups were very similar, and informants highlighted the information, acceptance, and understanding they received through group membership. However, informants' motivations for attending cancer support groups did not stay constant over time. Their movement through the treatment trajectory was accompanied by changing needs, as the thirst for information was replaced by a focus on support, friendship and a desire to "give back" to others.

The findings of the current study support Butow et al.'s (2007) conclusion that there is no ideal support group. Nor is there a "magical formula" for attracting a diverse audience. As Thaxton et al. (2005) noted, cancer support groups should not be developed from an overarching template but must take into consideration gender-based and cultural differences in needs and preferred format in order to be effective and appealing. Study findings also support Avis et al.'s (2008) position that assumptions should not be made about whether cancer patients prefer cancer support groups organized around age, gender, class, or ethnicity. However, the lines along which support groups are organized do have important implications for who attends and what is discussed—something that needs to be explicitly recognized and taken into account by clinicians running these groups.

### IMPLICATIONS FOR CLINICAL PRACTICE

As the current study is based on research at only three cancer support groups, it is unclear how generalizable findings are beyond the context of the groups examined. However, the study findings tentatively indicate that offering a tangible product at the start of support group meetings such as an education or coping skills component might increase the attractiveness of support groups to men and patients from cultural backgrounds where group sharing is a somewhat unfamiliar concept (Cella & Yellen, 1993). Offering separate caregiver support groups may also increase the participation of those caregivers who are seeking support to deal with their distinctive needs.

The study also suggests that language-specific groups such as the Chinese cancer support group are attractive to patients. However, though some patients are clearly seeking and benefit from group support, the demand for such support groups may relate partially to a general dearth of culturally and linguistically appropriate resources for such patients. Finally, study findings indicate that in the case of metastatic cancer support groups, referral to such groups might be best timed after patients are at least 6 months postdiagnosis, when they have had more time to adjust to the diagnosis and its implications.

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