THE EXPERIENCE OF CONNECTION IN GROUPS
FOR PEOPLE WITH CANCER

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ABSTRACT

This study reports on the experiences of nine individuals with cancer who were members of a weekly relaxation support group for people with cancer and their families/friends. It was posited that existential concerns such as suffering, isolation, meaning and death become essential when people are diagnosed with cancer, and as a result, they need to connect with others going through similar challenges in order to address these concerns. A modified critical incident technique was employed to identify experiences that either contributed to, or detracted from, a feeling of connection between or amongst group members, group volunteers and/or group facilitators. The modification of the method was the inclusion of a participant-observer approach in which the researcher both facilitated the relaxation groups and conducted research on the group. Two sets of semi-structured interviews were held with the participants, asking them about their perspectives on connecting with other group participants, and about how those connections were nurtured or curtailed. The study yielded thirteen categories. The first eleven categories described significant experiences that contributed to connection and were labelled: being with people like myself; expressing my thoughts and feelings; freedom to be myself; relating to other people’s cancer stories; knowing I can trust the people who run the group; helping others; experiencing care and touch from others; feeling that I belong here; sharing positive experiences around cancer; getting the help and support I need; connecting beyond the relaxation group. The remaining two categories described experiences that detracted from connection and were labelled: when I need to protect myself and aspects of the group that are not satisfying. Consistent with
other psychosocial oncology research, results indicated that group support is effective in assisting people with cancer in coping with the effects of their disease. Links made to existentialism included an emphasis on a need to feel less isolated; a need to laugh, even in times of distress; a need to openly address painful emotions, suffering and death; and a need to belong. Suggestions for counselling were based on these findings as well as the importance of expressions of caring and physical touch such as hugs, therapeutic touch; linking patients with other patients; and trustworthiness and openness in sessions.
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CHAPTER I

Introduction

The detection of cancer is one of the most frightening diagnoses for any individual (O’Connor, Wicker & Germino, 1990). The psychosocial stressors of a cancer diagnosis reflect, in part, the complex and unknown nature of the disease. While many environmental, genetic and behavioural factors have been identified as influences, the basic cause of cancer is as yet unknown. Thus, many patients are faced with the question, “Why me?” Additionally, people with cancer must deal with a multitude of unnerving possibilities including disfigurement, pain, disability and death.

A further stressor in the illness results from the ensuing treatment. Treatment generally involves a combination of surgery, chemotherapy and radiation therapy, all of which produce side effects that may be more unpleasant than the symptoms of the cancer itself. Even well established protocols of treatment will have widely varying degrees of effectiveness on the same disease in different patients; consequently enormous uncertainty is commonly experienced as to treatment outcome and prognosis. When cancer is curable, there is always a chance of recurrence; as a result most survivors feel that their lives have been inexorably altered. Despite the proliferation of advances in cancer treatment, the gloomy stereotypes associated with cancer continue to pervade the psyches of most patients diagnosed with a malignancy (Cantor, 1978).
These fearful stereotypes also pervade the general community with the result that cancer patients often experience a sense of perceived or actual rejection in their environments (Halldorsdottir & Hamrin, 1996). The myths around contagion, death, loss, and the anxiety of communicating with seriously ill persons can similarly affect relationships with physicians, nurses, friends and family (Stahly, 1985). The consequence for the patient is often a sense of isolation. The individual experience of cancer depends on a multitude of factors including type of cancer, site, and stage of the disease. These variables combine with age, gender, support systems, race and socioeconomic status to create a very different set of circumstances for each cancer patient (Dunkel-Schetter, Feinstein, Taylor, & Falke, 1992).

Despite the diversity of individual circumstances, the literature identifies several psychosocial commonalties in the cancer experience. Common experiences and themes include anxiety and depression; seeking meaning and explanations for the disease; feelings of isolation and helplessness; need for support; confronting death, and coping with physical limitations (Fawzy, Fawzy, Arndt, & Pasnau, 1995; Hegelson & Cohen, 1996; O’Connor et al., 1990; Schulz, Williamson, Knapp, Bookwall, Lave, & Fello, 1995). There is literature in psychosocial oncology that draws a close parallel between these themes and those of existentialism (Cohen, Mount, Tomas & Mount, 1996; Halldorsdottir & Hamrin, 1996; O’Connor et al., 1990). Because existentialism appears to offer a theoretical base for understanding commonalties in the cancer experience, I decided to pursue these linkages. Links between existentialism and the cancer experience can be seen in much of the
psychosocial oncology literature. Research involving groups designed for people with cancer and their families and friends often mention benefits including: diminishment of isolation; dealing with pain and suffering; feelings of belonging; increasing meaning in the individual’s cancer experience (Cunningham & Edmonds, 1996; Fobair, 1997). These themes suggest that it may be important for people with cancer to connect with other cancer patients in order to address these troublesome but essential themes. In surveying the existentialist literature, I found that most of the major existential thinkers discuss the themes noted above as relevant to psychosocial oncology. In exploring these parallels, I chose to focus on the works of existential psychotherapists rather than philosophers because my work emanates from the counselling psychology perspective. These parallels and themes will be described in detail throughout the thesis.

In reviewing the literature, it is evident that most existential psychotherapists make reference to the works of philosophers such as Heidegger, Husserl, Kierkegaard and Sartre, acknowledging that the origins of existential psychotherapy are derived from philosophy (Cohn, 1997, Van Deurzen-Smith, 1993). Existential counsellors may share a basic point of view, but their strategies and techniques are not standardized. Despite a shared belief system, existential counselling does not represent any particular methodology or treatment plan (Anderson, 1978).

Van Deurzen-Smith, in her chapter on existential therapy, explains that the existential psychotherapeutic approach is fundamentally concerned with understanding what it means to be alive. The approach asserts that we are all in a
constant process of becoming ourselves. In this process, we struggle with the physical, social, psychological and spiritual dimensions of life in an effort to find security, belonging, self-affirmation and immortality. Essentially, these struggles form our attitudes and experiences, and therefore shape our selves and our existences. The struggles are believed to stem from the anxiety which arises from the human being’s recognition of their inherent impermanence, insignificance, emptiness, isolation and mortality. The existentialist believes that every human being is ultimately responsible for creating themselves despite this emptiness, and it is this freedom to create and choose which makes us truly human (Van Deurzen Smith, 1993).

These large, philosophic themes provide the backbone for my belief system as a clinician and as a researcher. More specifically, I have chosen three existential psychotherapists who, I believe, focus on themes which closely parallel those found in the literature that links existentialism with the experience of cancer. Rollo May, Irvin Yalom and Viktor Frankl are examined because of their focus on themes relating to suffering, isolation and the need for relatedness, searching for meaning and value in one’s life. These themes correspond with the psychosocial experience of cancer as reviewed in the literature.

Rollo May stresses the importance of a willingness to face and struggle with one’s fears, pathology and troubles. May asserts that this willingness originates from love, courage, will and concern. He explains that, in a basic way, human beings get their original experiences of being a self from their relatedness to others; when they
are isolated, they fear the loss of themselves (1953). The particular experience of isolation for a person with cancer may necessitate a set of new original experiences from which to discover the new or changed self as a cancer patient.

Irvin Yalom asserts that the effectiveness of group therapy emanates from existential phenomena. He describes existentially run groups as a way to assist people with cancer in feeling valuable and useful to others during a period when they may be questioning the worth of their own lives (Yalom, 1985).

Viktor Frankl asserts that the search for meaning in life is the single most essential pursuit (1959). Frankl’s system of logotherapy asserts that death, isolation, meaning and suffering are implicit in all of human experience and can only be understood and validated through meaning. In the experience of a cancer patient, however, these themes quickly become explicit (Halldorsdottir & Hamrin, 1996, O’Connor et al., 1990). It is my contention that for the person with cancer, death, isolation, meaning and suffering become immediate and pressing concerns.

Psychosocial oncology attempts to address these pressing concerns through a variety of methods. The goals of psychotherapeutic interventions in oncology centre around the decrease in feelings of alienation, reduction of anxiety about treatment, clarification of misperceptions and misinformation, and the decrease in feelings of isolation and helplessness (Fawzy et al., 1995). There is considerable evidence that group interventions are effective in coping with the impact of having cancer (Fawzy & Fawzy, 1995; Fobair, 1997; Spiegel, Bloom & Yalom, 1981). Groups range from peer support designs to intensive psychotherapy formats which tend to include one or more
of the following: provision of information; emotional support; behavioural training in coping skills; and psychotherapy (Cunningham & Edmonds, 1996; Fobair, 1997).

There is a great deal of literature describing the goals as well as the importance of group work in psychosocial oncology (Spira, 1991), yet there appears to be no clear explanation as to why groups are effective. My belief is that cancer patients become members of an invisible / sometimes visible group and they need to connect with each other in order to counterbalance their perceived or actual rejection from the healthy community. Membership in this new community involves the possibility of serious, potentially imminent life changes, and therefore heightens the members’ needs and capacities for connection, belonging, understanding and compassion.

In my work as a clinician conducting relaxation and support groups for people with cancer, I have observed a constellation of interactions amongst and/or between participants that attends to the needs of this community. These interactions may be both therapeutic and unique to support groups for people with life threatening illness. While the literature has not described this constellation of interactions explicitly, I am choosing to identify it as connection. Connection includes a shared perception of existential themes as somehow life affirming, and an ability to develop intense and immediate intimacy through verbal, emotional, physical and spiritual contact. Connection will be defined as any experience which unites or links two or more individuals in a way that provides validation and affirmation for their sense of self as well as their life experience. In essence, this validation and affirmation effects an
abatement of the fundamental experience of human isolation that is exacerbated by having a life threatening disease.

In his treatise on love, Erich Fromm (1963) writes of human isolation:

This awareness of himself as a separate entity, the awareness of his own short life span, of the fact that without his will he is born and against his will he dies, that he will die before those whom he loves, or they before him, the awareness of his aloneness and separateness, of his helplessness before the forces of nature and of society, all this makes his separate, disunited existence an unbearable prison...The deepest need of man, then, is the need to overcome his separateness, to leave the prison of his aloneness....Man-of all ages and cultures-is confronted with the solution of one and the same question: the question of how to overcome separateness, how to achieve union, how to transcend one's own individual life and find at-onement. (pp. 7-8)

Martin Buber, in I and Thou (1923), echoes this existential theme of a basic human need for connection. He writes:

Man's unacknowledged secret is his desire to be affirmed in his essence and in his existence by his fellow men. He wishes that they, in turn, would make it possible for him to affirm them, and for both affirmations to be conferred not merely within the family, or perhaps at a party, meeting or in a bar, but also in the course of neighbourly encounters when perhaps the greeting with which they hail each other as they emerge from their houses or step to their windows is accompanied by a kindly look, a look in which all curiosity, distrust, or the routine has been overcome by mutual sympathy; by so doing, each would let the other know that he endorses his presence. It is this endorsement that constitutes the indispensable minimum of man's humanity. (pp.40)

I derive the premise of my research from these existential viewpoints. My assumption is that the human need for connection and contact is fundamental. In the case of individuals with cancer, this fundamental need becomes both more essential and more elusive. Thus, the purpose of this study is to identify the significant incidents that contribute to an experience of connection for participants in a relaxation support group for people with cancer.
Rationale

In Canada, it is estimated that approximately 132,100 new cases of cancer will be diagnosed in 2000 (Canadian Cancer Statistics, 2000). A further 65,000 deaths due to cancer are expected in Canada for the same year. Approximately one in seven women are expected to develop breast cancer during their lifetime and one in six men are expected to develop prostate cancer (CCS, 2000). These sobering statistics indicate the prevalence of cancer in our society. In order to attend to the vast needs of people with cancer, there are increasing numbers of both self-help and therapist-led groups (Gray, Fitch, Davis & Phillips, 1997; Cunningham, 1996)). This may be in part due to the cost effectiveness of running groups; however, there is more than ample evidence demonstrating that groups for cancer patients assist in improving their quality of life (Spiegel et al., 1989). Current research in the field of psychosocial oncology is also paying particular attention to the relationship between group attendance and the prolonging of life (American Psychological Association Monitor, 1999). More clinical research is needed, however, to clarify what aspects of group therapy are most effective (Cunningham, 1996). It is my contention that such clarification is important regardless of whether the groups are led by professionals or lay people and whether or not the groups assist in increasing survival rates.

From a counselling psychology perspective, group work involves itself primarily with an "interpersonal process that stresses conscious thoughts, feelings, and behaviour with aims of discovering internal resources of strength in an atmosphere of trust" (Corey, 1995). Working from this definition, it is important that counsellors
who run groups for cancer patients possess a comprehensive understanding of the interpersonal processes which occur amongst seriously ill people as well as their overriding thoughts, feelings, and behaviour. This study may contribute to this knowledge base by developing a more complete picture of the group process and the connections that participants make in groups for people with serious illness.

A further rationale for the study is to contribute to the translation of existential theory to applied technique and intervention. Existentially oriented therapists tend to label themselves as such because of their philosophical beliefs rather than a system of psychotherapy (May & Yalom, 1989). As a result, existential counselling may involve the use of techniques from any number of psychotherapy approaches as long as they are employed within an existential frame of reference (Anderson, 1978, May & Yalom, 1989). Frankl’s system of logotherapy and Yalom’s system of existential group psychotherapy stand out as rare delineations of applied existential technique. While a review of the psychosocial oncology literature reveals an emphasis on existential issues (Cunningham, 1996; Halldorsdottir, 1996; O’Connor, 1990), little is offered in the area of interventions and/or technique to facilitate this type of counselling. If this study demonstrates that there is a particular constellation of factors that cancer patients experience as beneficial in group work, a more in depth exploration of the links between these factors and existential theory may serve to provide guidance to practice. The exploration could then imply an emphasis on specific interventions or factors for professionals seeking to establish existentially oriented groups.
Approach to the Research

A qualitative approach to this study was most appropriate because of both the subject matter and the nature of the participants. First, notions of connection, meaning, isolation, and suffering do not lend themselves to quantification. While there are several relevant social support measures (e.g., Quality of Social Support Scale; Berkman Social Network Inventory; Coping with Cancer Scale), as well as tests which assess the existential realm (e.g., McGill Quality of Life Questionnaire; Purpose in Life Scale), the purpose of this study is an exploration, rather than a measurement of, these notions. Secondly, the participants in the study are people with cancer and it is important to me that the process of the research be non-pathologizing. Cancer patients are generally faced with a barrage of tests and numbers from health care professionals, and this data becomes associated with the progress of their disease. I did not want to participate in research which might have contributed to the participants feeling an increased sense of measurement, judgment, or pathology. Questionnaires and surveys were inappropriate because they denote distance and objectivity, and this research involves highly intimate, subjective matters. Individual interviews served to treat the material with its due respect by allowing the patients themselves to describe their experiences as well as elaborate on the themes that emerged.

In the study, I endeavoured to find the common ground that exists between the existential experience of the person with cancer and the experience of participating in a group for people with cancer. This common ground and these connections are
difficult to quantify. Therefore, the qualitative approach served my purposes most appropriately.

I applied a qualitative field study that uses a modified critical incident technique. The modification incorporated the researcher, myself, as participant-observer as well as modifications to the data analysis. Because I conducted the relaxation group, which is the site of my research, I participated in the research as both a member of the group as well as an observer of the interactions therein. Implications and considerations for this dual role are addressed in the third chapter entitled Methodology and the fifth chapter entitled Discussion. The critical incident method was selected because it describes phenomena through a careful identification of factors which significantly contribute to an outcome (Woolsey, 1986). My research concerns itself with the factors (experiences, interactions and perceptions) which significantly contribute to an experience of connection amongst people with cancer. The critical incident technique comprises procedures for collecting direct observations of human behaviour in ways that facilitate their usefulness in solving problems as well as in developing psychological principles (Woolsey, 1986). The goal of this study is to contribute to the growing body of knowledge regarding what helps and what hinders the coping and psychological adjustment of people dealing with cancer. There existed also the possibility of developing a more clear delineation of existential psychotherapeutic principles that can be applied to group work for people with serious illness. Thus, the modified critical incident technique satisfied dual purposes that were ideally suited to my research goals.
Summary

My research was derived from two premises, one from existentialism and one from psychosocial oncology literature. Existential theory highlights universal human concerns such as the need to overcome separateness (May, 1963), the need to be affirmed (Buber, 1923) and the importance of recognizing death, suffering and pain as implicit in life (Frankl, 1967). Literature in psychosocial oncology indicates that the experience of cancer both makes these concerns explicit as well as more difficult to address because of societal anxiety around facing subjects such as isolation, helplessness, death and suffering (Stahly, 1985; Fawzy, Fawzy, Arndt & Pasnau, 1995; O'Connor et al, 1996). In response to the needs of people with cancer, medical and mental health practitioners have developed group interventions to attend to patients’ psychosocial needs. Research in this area cites existential themes as being primary elements in the struggles that people with cancer face (Cohen, Mount, Tomas & Mount, 1996; Halldorsdottir & Hamrin, 1996; O’Connor et al., 1990). The literature also suggests that these group interventions are effective (Spira, 1997; Fobair, 1997; Spiegel & Yalom, 1981).

Despite these consistencies in the literature, there are no well-defined links between the theoretical, psychological and philosophical models, and the design and implementation of group interventions for people with cancer. Therefore, the basic premise of my research was that a structured examination of the ways in which existential themes emerge in psychosocial oncology group work was needed. The intent was to check whether or not existential themes are reflected in the experiences
of participants in groups for people with cancer. Consequently, I took the term *connection* to represent a constellation of existential themes that seemed most relevant to psychosocial oncology group work. I investigated one group’s experience to determine whether there were: 1) actions, behaviours or experiences that could be identified as helping/hindering connection and 2) whether participants perceived these actions as relevant to the group effectiveness.

Given the centrality of themes such as isolation, need for support, searching for meaning and fear of death in the psychosocial oncology literature, I made the assumption that groups work because they combat these themes by providing connection. I believe there is sufficient evidence to indicate the effectiveness of group intervention in this area; thus, I did not investigate whether or not such groups are helpful. Instead, I focused on how connection occurs, and whether participants, themselves, cite it as an important element in group effectiveness.
CHAPTER II

Review of the Literature

The purpose of this chapter is to present existing research that pertains to the experience of connection in groups for people with cancer. I will review theoretical and empirical literature that serves to elucidate how groups attend to the psychosocial needs of the cancer patient and how existential theory explains the psychosocial needs of the cancer patient. Throughout this process, I will attempt to demonstrate how connection is implicit in both group work and existential psychotherapy. Finally, methodological considerations for this study will be addressed in the literature.

Group Work in Psychosocial Oncology

“It is one of the most beautiful compensations of this life that no man can sincerely try to help another without helping himself”

Ralph Waldo Emerson

The need for mental health counselling in cancer care is fairly self-evident. Patients face enormous challenges in adapting to a disease that usually causes significant psychosocial stressors across the spectrum of physical, emotional, and existential experience. Spira (1997) asserts that group psychotherapy designed specifically for persons with cancer may offer patients the most powerful psychosocial intervention available. I believe that groups give people with cancer the opportunity to communicate, celebrate, and cope with their experiences by both giving and receiving support to others who share and understand their plight. Groups give new patients the opportunity to receive support from others undergoing similar challenges as well as be educated regarding effective coping skills and information about what to expect both
during and following treatment (Spira, 1997). Regularly attending group members find that they are encouraged to examine personal choices; increase emotional expressiveness; improve relationships with family members and health care providers; and work through grief issues (Fobair, 1997). With the unceasing development and improvement of medical technology and treatment, cancer patients are living longer and may require continued connection with other survivors in order to explore the ways in which cancer is changing their lives (Fawzy Fawzy, Arndt & Pasnau, 1995). This too, can be facilitated in open, ongoing, weekly group support programs.

Research on support groups for cancer patients began to emerge in the 1970’s and has been growing ever since (Fawzy, Fawzy, Arndt & Pasnau, 1995). In a study by Wood et al. (1978), 11 out of 15 patients who attended eight 90 minute weekly meetings of an open-ended support group reported they felt less isolated, and appreciated the support and education provided through participation. In 1997, Fobair reviewed the use of groups for people with cancer, and found that a broad range of applications and theoretical perspectives are being used in psychosocial oncology groups. She relates that at least 10 studies within the last 20 years indicate that group interventions improve patients’ mood, provide information, encourage active coping and increase health-enhancing behaviours. These positive results seem to occur whether the group is educational-cognitive, self-help, or supportive-expressive (1997).

Many studies have been conducted, however, in an attempt to compare group intervention styles and approaches. Spira (1997) cites two studies which suggest that cognitive-behavioural groups are more beneficial than unstructured support groups
that focus primarily on emotional expression. In their often cited intervention study, Spiegel and Yalom (1981) demonstrated the benefits of more in-depth psychological groups for patients with metastatic breast cancer. Explorations of death, relationship problems, and living life to the fullest were focused upon and facilitated in a group context which emphasized support, sharing, self-disclosure, and interaction outside the group. After a year, participants showed a decrease in tension, fatigue, and confusion as well as more vigor than the control group (Fawzy, Fawzy, Arndt, & Pasnau, 1995). A 10 year follow up of these patients showed an increased survival rate of 18 months longer than the non-intervention group.

Several studies claim that support groups led by para-professionals or lacking in psychotherapeutic intervention were found to be of less value than professionally led groups (Spira, 1997; Cunningham & Edmonds, 1996). In their qualitative study of breast cancer self-help groups, Gray, Fitch and Phillips (1997) found, however, that participants reported that group involvement was extremely helpful in coping with the effects of breast cancer. None of the women interviewed considered the absence of a professional leader to be problematic. In fact, the sharing of experiences and bonding with other women who had breast cancer were described to be the core benefits of participating in the group (1997). It is this type of bonding which may factor in to the definition of connection for my study. There is no conclusive argument for a particular approach or intervention in group work for cancer patients. What does emerge, however, is ample evidence for the effectiveness of groups in general for
cancer patients as well as a need for more applied clinical research (Cunningham & Edmonds, 1996).

**Existential Theory Applied to Psychosocial Oncology**

"Take away love and our earth is a tomb"

*Robert Browning*

Almost all of the literature surveyed on psychosocial issues in cancer care mentions the term *existential* somewhere in the text. This is not surprising because of the obvious existential implications of a cancer diagnosis. Notions of death, isolation, meaning, and suffering are seemingly unavoidable considerations for an individual diagnosed with a life threatening illness. In their phenomenological study designed to explore the lived experience of nine individuals with cancer, Halldorsdottir and Hamrin (1996) found the overriding theme expressed by the participants was “experiencing existential changes” (1996). Five subthemes were identified: uncertainty, vulnerability, isolation, discomfort, and redefinition. Cunningham and Edmonds (1996), in their proposal that group psychological therapy be included as part of the standard treatment for cancer patients, conclude their article with a reminder that “for many people with cancer and other life-threatening disease, existential concerns are much more salient than the details of biological breakdown and medical treatment.” While this is a strong and controversial statement, it is echoed, in many ways, in other parts of the literature. Cohen Mount, Tomas and Mount (1996), developed the McGill Quality of Life Questionnaire (MQOL) specifically because they found that the existing quality of life instruments neglected the existential domain, and as such were not suitable measures for patients with life
threatening illness. In their study (1996), which attempts to show construct and concurrent validity for their measure, this hypothesis was supported. Multiple regression showed the existential subscale to be at least as important as any other subscale in predicting the single item scale measuring overall quality of life. Furthermore, the existential subscale played a greater role in determining the quality of life of patients with cancer than in patients with no diagnosed disease (Cohen, Mount, Tomas & Mount, 1996).

Existentialism, however, is a broad category that exists in both philosophy and psychology, and is accompanied by a vast body of literature that is too large to represent respectfully in this review. A brief description of three existential psychotherapists and their views relating to isolation and connection follows.

Rollo May

The following quote from Rollo May’s Love and Will (1969) illustrates what may be at the root of the phenomenon of connection that I seek to explore: “This is the mythos of care. It is a statement which says that whatever happens in the external world, human love and grief, pity and compassion are what matter. These emotions transcend even death” (p. 302). May speaks of care as central in psychotherapy as well as in all meaningful relationships. He describes care as “a state in which something does matter; care is the opposite of apathy” (p.289). In the case of people with cancer, it may be fear rather than apathy which causes friends, family and professionals to avoid subjects such as death, suffering and pain. This avoidance, may, however suggest to cancer patients that fears of death, suffering and pain do not
somehow matter. May defines the aim of existential psychotherapy as “that of helping the patient experience his existence as real” (1958). This aim may be a source of explanation for the therapeutic connections that occur among people with cancer in support groups. Perhaps, the opportunity to talk openly about their suffering and fears renders their experience real, and therefore valid, and therefore surmountable.

May contends that the threat of death is the most common reason for anxiety (May, 1953). If this is true, then people facing cancer live with enormous anxiety because, despite the development of cancer treatment, there still remains a widely held belief that cancer will always be fatal (Saleeba, Weitzner, Meyers, 1996). Many people with cancer describe their anxiety in terms of an image of time running out (Cantor, 1978). In a study on the quality of life in breast cancer survivors, however, Ferrell, Grant, Funk, Otis-Green, and Garcia (1997) found that two of the major themes associated with psychological well being focused on openly facing the possibility and overcoming the fear of death. Participants in the study expressed that it was not possible for them to fully embrace life or re-enter into daily activities without an awareness of the possibility of dying. While death remains a difficult topic for many people to address, an openness to discussions of mortality may be an important source of connection for people with cancer.

**Viktor Frankl**

Frankl’s system of logotherapy involves the attribution of meaning to life and all of life’s experiences. He believes that an individual’s behaviour is determined by the degree to which he/she sees his/her life as having personal, social, or universal
value and meaning. The individual is inherently responsible for both creating and actualizing this meaning. O'Connor, Wicker, and Germino (1990) focused their study on the development of an understanding of the cancer patient's search for meaning because of the importance that meaning in life takes on following a diagnosis of cancer. They explain that the struggle to discover and understand one's personal significance in life is heightened by a diagnosis of cancer. They hypothesized that an individual's belief that their own life is purposeful and meaningful facilitates psychosocial adjustment to negative life events such as life threatening illness (O'Connor, Wicker, Germino (1990). In logotherapy, love is considered to be one of the truest and most spiritual routes to meaning (Frankl, 1965). In its broadest definition, love may be a healing factor in cancer support groups. It is often the sense of compassion, understanding, empathy and concern which participants cite as the reasons they continue to attend their groups (Fobair, 1997). Those four components are surely factors in love (Fromm, 1963).

Suffering and death are also essential components of Frankl's theory perhaps, in part, because of his own experiences as a prisoner in a concentration camp during World War II. I am reminded of the striking parallels between the terms holocaust survivor and cancer survivor in reading Frankl's quote: "Whenever one is confronted with an inescapable, unavoidable situation, whenever one has to face a fate that cannot be changed, e.g., an incurable disease, such as inoperable cancer, just then is one given a last chance to fulfill the deepest meaning, the meaning of suffering" (Frankl, 1963). Logotherapy views the transitoriness of life as a source of strength and responsibility.
Thus, Frankl’s approach might redirect the cancer patient’s intrinsic fear of death toward a reflection upon the fullness of the life he/she has been afforded to live.

Finally, logotherapeutic counselling reminds the patient of his/her freedom to change at any moment (1963). Frankl would insist that the freedom to face difficult conditions in an individual way is something that can never be taken away. Attention to this particular freedom may be a point of connection for people with cancer. Amongst each other, cancer patients can explore the ways in which they wish to cope with their illness. Those who are not facing suffering in such a direct way do not easily grasp the details of such an exploration.

Irvin Yalom

Irvin Yalom’s book Theory and Practice of Group Psychotherapy (1975) attempts to explain the benefits of group psychotherapy via existential theory. Through both theoretical and empirical study, he explains the phenomenon of therapeutic change in group work within twelve categories, which he terms “curative factors” (1975). These factors occur through group interaction. They are: altruism, group cohesiveness, universality, interpersonal learning (input and output), guidance, catharsis, identification, family re-enactment, self-understanding, instillation of hope, and existential factors. I propose that there may be an unique combination and experience of these factors that is particularly beneficial for groups of patients with life threatening illness. In the book, Yalom describes research he conducted with Tinklenber and Gilula studying the categories of curative factors in successful long-term group therapy participants. They applied a Q-sort with 20 patients which was
comprised of sixty items (5 per curative factor) and asked participants to rate the helpfulness of each item on a 7 point Likert scale. The sort was followed by individual interviews with the patients expounding upon their reasons for their choices. It was noted that 'existential factors' was ranked even higher than commonly valued modes of change as universality, altruism, family reenactment, guidance, identification, and instillation of hope (Yalom, 1975).

Yalom points out that many support and psychotherapy groups make a mistake in avoiding the existential realm, and focus exclusively on interpersonal interactions. He explains that groups conducted from an existential perspective choose not to "water down the tragedy of life" (1975) and are able to bear the weight of "extreme experience" such as the death of a group member. He makes a point of distinguishing social isolation from existential isolation, and comments that groups can attend to the former but are remiss in trying to soothe the latter. I believe that this may be an important factor in what is experienced as connection in the relaxation support group.

In the group, careful attention is paid to respecting participants' struggles. Group members are encouraged to witness and respect expressions of grief and sadness rather than attempt to soothe and intervene during cathartic expressions. Yalom describes a support group that he led for metastatic cancer patients in which issues of death, pain, and suffering were explicitly confronted. He notes extraordinarily deep levels of support between group members as well as the importance of members being useful to someone else. Yalom concludes that the members of the group who confronted their challenges most deeply came to
experience a richer existence than that prior to their illness (Yalom, 1975). He also suggests that, in the case of running a group for seriously ill patients, the roles of both facilitator and other group members shifts from one of trying to mediate better interactions to simply being present with others' experience. I believe that this notion of presence may be another aspect of the connections that participants experience in groups for people with cancer.

**Methodological Considerations**

"In the human sciences theoretical interest is directed exclusively to human beings as persons"  
*Edmund Husserl*

Given the prevalence of cancer in our society, it seems most helpful to nurture our understanding of the cancer experience from people with the disease itself. In their article, Waxler-Morrison, Doll and Hislop (1995) note the prevalence of quantitative research methods in psychosocial oncology. They argue for an increase in research which combines qualitative and quantitative methods in order to establish certainty that the data produced from quantitative research is accurately representing the phenomena it seeks to explain, namely the psychosocial experience of cancer. The authors report that social scientists and patient interest groups are now encouraging funding bodies to give greater consideration to qualitative research so that patient’s experiences can be heard (1995). This is consistent with a general shift in health care toward increased patient involvement in their own care.

Waxler-Morrison et al. review two of their own studies and show how their qualitative research produced surprising findings that merited further study. In the first phase of a prognostic study of breast cancer patients, a large epidemiological
survey was followed by a small qualitative study. Data from the initial survey involving the women's social support system and network was analyzed after a four year follow up period. From a sample of 133 women, it appeared that women with high survival rates shared certain characteristics. They had more contact with supportive friends; larger social networks; were employed; and were either single, divorced, or widowed. Due to these unexpected discoveries, a set of open-ended ethnographic interviews with some of the breast cancer survivors was developed to further inform the findings. Informal interviews with the participants focused on the role of work, family, friends, and social support in their cancer experience. A qualitative analysis of the responses produced new hypotheses which are relevant to counselling. Waxler-Morrison et al. found that having a job may be helpful for breast cancer patients/survivors because women tend to work with other women and a patient may find themselves becoming the center of a network of information of support in the employment setting. Also, survivors tended to be women who fostered their ability to continue to give support to others in community, family, or other social settings. Thus, an element of connection may include the opportunity that participants are given to display and act upon their concern for others. This display of concern is a healthy, normal aspect of social interaction (Yalom, 1985). Such caring may also serve to remind cancer patients that they are still able to care for others, and not only be recipients of care.

In Easton's (1986) study on helpful behaviour for assisting bereaved widows, the critical incident technique was employed to discover what factors are helpful or
harmful during the experience of grief. Easton conducted interviews and collected data from fifteen widows who had participated in group therapy. Two hundred and forty-one experiences were collected and categorized according to which factors were considered helpful and which factors were considered harmful. The study yielded ten categories: five categories of helpful incidents which were labeled taking action, receiving support, sharing the grief, verbal reassurance and physical comfort, and five categories of hindering incidents which were labeled inability to act, lack of support, feeling alone, verbal criticism and physical distress (Easton, 1986). In this case, the critical incident technique assisted the researcher in specifying behaviours which help or hinder the process of emotional stability for widows. In my study, I utilized a similar approach to the material by looking at factors that were helpful or harmful to the connection experience in the relaxation support group.

While the sample size of Easton’s study (1986) was small and does not provide an accurate representation of widows in general, the study provided a very in depth exploration of the participants’ experiences of grief. The themes that were derived from this exploration can both serve as useful guidelines for caregivers involved with the bereaved as well as provide significant topics for future quantitative research.
CHAPTER III
Methodology

In order to study the experience of connection in a group for people with cancer, I utilized a modified critical incident approach that incorporated myself as a participant-observer. The critical incident technique is an exploratory method which “has been shown both reliable and valid in generating a comprehensive description of a content domain” (Andersson and Nilsson, 1964). In this technique, data is collected through interviews that centre on people’s direct observations of themselves and/or other’s behaviour. These observations are made in circumstances where the aim or task is fairly well understood by both the observer and the observed (Flanagan, 1954). The method focuses on the identification of those behaviours / incidents (experiences, interactions) that significantly contribute to an aim / identifiable outcome (Woolsey, 1986).

My study considered the events, feelings and interactions that significantly contribute to an experience of connection between and amongst participants in a relaxation support group for people with cancer. From the outset, it felt essential to me that this experience be elucidated by the group members themselves. I believed, also, that a better understanding of the experience of connection would likely emanate from a fairly complex set of phenomena in the group member’s experiences. I chose the critical incident technique because it offered a structured yet flexible method for gathering and organizing information from such a rich source.
Critical Incident Technique

The critical incident technique was developed by John C. Flanagan (1954) through studies in the Aviation Psychology Program of the United States Army Air Forces in World War II. The technique assisted in the development of procedures for selection and classification of pilots and other air crew members and candidates. Flanagan sought to establish a basis for pilot selection and performance that relied on the observation of specific behaviours rather than vague comments such as “lack of inherent flying ability” which had previously been used. Flanagan’s procedures were found to be very effective in developing a systematic analysis of successful and unsuccessful performance in aircrews. From these origins, Flanagan and other psychologists developed and expanded the application of the critical incident technique into other areas. Numerous studies were carried out in order to determine the critical requirements for specific occupational groups or activities, such as dentistry, industrial foremen, bookkeeping, sales clerks and instructors of psychology courses (Flanagan, 1954). The technique has since been used in diverse fields for a variety of purposes. Its flexibility is due, in part, because of its basic, fundamental approach to research. Flanagan states: “People have been making observations on other people for centuries...what is most conspicuously needed to supplement these activities is a set of procedures for analyzing and synthesizing such observations...” (Flanagan, 1954).

There are five steps which comprise the critical incident technique. These are: 1) determining the aim of the activity to be studied, 2) setting plans, specification and
criteria for the information to be obtained, 3) collecting data, 4) analyzing the thematic content of the data, and 5) reporting the findings (Woolsey, 1986). Step 1 refers to the definition of connection as it has been presented in the introduction and rationale of this paper. Flanagan and Woolsey both recommend the usage of simple language and/or simple phrases or catchwords in a statement of aims, with the intent of providing a “maximum of communication with a minimum of misinterpretation” (Flanagan, 1954). The term connection satisfies this requirement, as it denotes the possibility of verbal, physical, spiritual, emotional and cognitive elements, but clearly communicates an alliance, relationship or bonding that occurs between and amongst people. Steps 2 and 3 refer to the planning and the process of data collection and their description follows. Step 4 refers to the process of data analysis, also discussed in this chapter. Step 5 is addressed and described in detail in the Results and Discussion sections of this thesis.

Participant Observer Considerations for Research

The participant-observer role exists when the researcher is both “near and distant from the social phenomenon being studied” (abstract: Savage, 1984). Because I conducted the group that was being studied, I was an intimate participant in the group. On the other hand, I was not a cancer patient and therefore experienced the group from different perspectives, both as a non-cancer patient and as group facilitator. The latter is the more problematic due to the issues of power that naturally arise between therapist and client/patient. An awareness of these considerations was made explicit both within the data collection process as well as the data analysis and
reporting stages. Throughout the information meetings, interviews and member checks, I repeated to the participants that this study was intended primarily to reflect their experience, and that for this report, they were the ‘experts.’

The critical incident technique is founded upon the value of observation (Flanagan, 1954). I assumed that as a researcher, I could be as credible a source of observation as any other participant, given that the difference in our roles is made explicit. Generally, participant observation has been applied to ethnographic studies where the researcher was present, but his/her presence was intended to go unnoticed. This is exemplified in the case of Muzafer Sherif, a researcher who observed the group dynamics of boys at a summer camp by occupying the role of janitor and part-time maintenance person (in 1961). By being present in a non-invasive form, Sherif was able observe the boys in their naturalistic setting while eliminating any reactivity on their part since they did not know they were being observed for research purposes (Palys, 1997). My role as group facilitator in the group being studied differs quite dramatically. I had to be very explicit about my goals, my subjectivity, my data collection methods and data analysis.

**Confirmability and Credibility**

It is evident that my subjective experience and values affected both the data collection and theory development. Rather than attempt to create a sense of objectivity which I do not believe is entirely possible, my involvement in this study emanated from an interpretivist / constructivist paradigm rather than the traditional empiricist perspective (Smith, 1989). I approached this study with a belief that the
reality I would report is a constructed reality, “based on the meanings that I, and the other study participants give to our own intentions, motives, and actions as well as to those of others around us” (Smith, 1989). This belief, however, does not diminish the truthfulness of the results. Objectivity is replaced by confirmability: the knowledge that the data, interpretations and outcomes of the research are rooted in the source of the participants, and thus are not figments of the imagination (Mertens, 1998). The verbatim participant quotes which represent each subcategory developed in the study combined with the member checks served to attend to this consideration as well as to increase credibility (Guba and Lincoln, 1989). Additionally, I incorporated any and every change suggested by the participants in regards to the categories and subcategories. This affirmed my commitment to the statement I made to each of them: “This report has to reflect and represent what you said and felt about being connected in the group, whether or not anyone else agrees.”

In order to assure for authenticity and accuracy, I kept a journal of my reactions to all the components of the study. Mertens (1998) explains that the qualitative researcher should monitor his/her process from the beginning of the study right through to the end and share this process with someone who has an open mind and can challenge the researcher’s beliefs. I utilized the journal by reflecting upon assumptions and choices, and attempted to incorporate them fairly in this report. I also relied upon my thesis supervisor for objectivity, and had many discussions with Dr. Beth Haverkamp regarding outstanding interpretations and biases. As a source of credibility, Mertens (1998) cautions against making conclusions without sufficient
observation. In combination with the validation interviews, I believe that my prolonged contact with the group members over time increases the credibility of observations and interpretations made from the data. Upon completion of this report, I still maintain that the study was enhanced, rather than distorted, by my prior knowledge and familiarity with the group members and their group experience.

Site

The research was conducted at a major cancer centre that will henceforth be referred to as the “Agency.” The Agency is a medical treatment facility for people with cancer that offers Patient and Family Counselling Services (PFCS) in both individual and group forms. The director of the PFCS and the principal Research Consultant of the Agency agreed to participate in the study as it was outlined in the proposal, and both were consulted regarding the U.B.C. Ethics Review and any procedures that involved patient contact.

At the time of data collection, I was employed as a permanent part-time music therapist at the Agency. I saw individuals and families as well as co-facilitated two weekly relaxation programs for people with cancer and their families and friends. These relaxation support groups were the specific site of the research and group members were invited to take part in the study as outlined below. Please refer to Appendix A for a description of the format, purpose and operation of the relaxation support group.
Preparations and Procedures

The members of both weekly relaxation groups were invited to participate in the study, and were provided with information regarding the purposes and expectations of involvement in the research. The relaxation group is a drop-in format, and has a weekly attendance of between 10 to 25 participants. It was hoped that a heterogeneous sample that included participants of both sexes; a range of ages; differing tumour sites and stage of disease; and cultural background would be formed. This heterogeneity, however, was not a criterion for participation. The criterion for participation in the study included people with cancer who have attended the relaxation support group at the Agency at least 5 times, were able to express themselves comfortably in English and were interested in communicating about their experience of the group.

The relaxation group is made up of both people with cancer as well as their families and friends. The ratio of people with cancer to caregivers and friends/family in group attendance is approximately 3:1. My reason for including only those individuals with cancer was because of the vast amount of literature on the caregiver experience. This literature generally exists as distinct from the ‘patient’ experience and I felt that I could not fairly represent both bodies of literature in this study. It seemed appropriate to limit the scope of my study to either the ‘patient’ or ‘caregiver’ experience. I chose the ‘patient’ experience because it incorporated the larger portion of the group membership. Please see the section on Limitations and Implications for Future Research sections in Chapter 5 for further discussions on this matter.
At the conclusion of both relaxation groups on Tuesday, January 25, 2000 and Thursday, January 27, 2000, I briefly mentioned that I was conducting a research project involving the relaxation program at the Agency. I stated that information notices about the project would be available at the front desk if anyone was interested. I made every effort to keep the research project completely separate from the group sessions themselves so that group members knew there was no pressure to participate. This in fact was stated explicitly. The information notices were posted throughout the Agency as well as communicated to staff via internal e-mail (See Appendix B). Interested individuals were invited to attend one of two information meetings held after group sessions. Because a different cluster of people tend to attend Tuesday and Thursday groups, I held one information session on a Tuesday and one on a Thursday to provide equal opportunity to group members. Following the information sessions, interested individuals were invited to contact me or my thesis supervisor for any additional information and/or to schedule an initial interview.

The information meetings were intended for interested persons to develop an awareness of the parameters of the study, and to decide whether or not they wished to participate. In the information sessions, I outlined both the purposes of the study and the participant commitment by reading a prepared statement entitled Project Description (see Appendix C) to ensure that both groups were exposed to the same information. It was explained that participant commitment consisted of: 1) attendance at the information meeting, 2) an one hour audio-taped interview, and 3) one half-hour member check / validation interview to confer regarding themes that emerged from the
data analysis. Interested individuals who were too ill to attend the meeting were
provided with the option of a private information meeting in a location of choice, but
this did not occur. Following the reading of the Project Description, everyone was
invited to ask questions. Eleven group members attended the information meeting and
nine of them decided to participate in the research.

Data Collection

Data were generated through three sources: individual oral interview; member
check/validation interview; and a journal of my thoughts, observations and
perceptions. Obtaining the data from multiple sources provided a triangulation of data
that is consistent with responsible and credible qualitative research. Triangulation of
data involves the use of multiple data sources and methods to support the strength of
interpretations and conclusions (Mertens, 1998). The objective of the interviews was
to obtain a comprehensive description of the critical factors that contribute to an
experience of connection in the relaxation support group. The member checks were
intended to establish credibility for the results by verifying the analysis and
interpretations with the participants. The objectives of my observations and journal
were to develop and enhance my understanding of the connections that occur in the
group as well as to keep my personal biases and perceptions in check.

Interviews

The first interview was considered to be a pilot interview. I discussed the
process and the results of this meeting with Dr. Beth Haverkamp, who recommended a
small modification to the wording of the questions in order to better discover what
promoted connection rather than what connection felt like. The interview, however, was considered to be appropriate for inclusion in the data analysis. Next, a convenient interview time for the remaining 8 participants was established. The meetings were scheduled on site at the Agency to ensure for privacy and professionalism. I conducted the interviews, as per the participant-observer approach. The initial part of the interview consisted of: 1) reading of the orienting statement (see Appendix D), 2) issues of confidentiality and signature on two copies of the Informed Consent form (see Appendix E) and 3) a reminder that termination of participation in the study was an option at any point in the development of the research. Basic biographical information was collected (see Appendix F) for descriptive purposes so that the parameters of the sample would be clear. The option of not filling out the biographical information sheet was offered, but no participant chose this option.

Once a reasonable comfort level was achieved through casual conversation, a discussion of the participants’ general perceptions of the research led in to the interview questions (See Appendix G). Because I worked with the participants on a weekly basis, the comfort level was established fairly quickly, but the closeness of these relationships also demanded an extra emphasis on confidentiality. Participants were reassured that any matters discussed in the interview would not be brought up by me in future individual discussions or groups. I explained to each participant that I would utilize some prepared questions but would not be following a fixed list. I expected that the participants themselves would generate areas of interest that would serve as my guide.
The interview focused on events that occurred while attending the relaxation support groups. Because some participants had been attending regularly for 2 years and others had attended 15 times in recent months, I did not restrict the time frame for incident occurrence. At times, participants spoke of incidents or experiences that occurred outside of the group, i.e. lunch in the cafeteria, phone calls with group members from home. It turned out, in fact, that these experiences ended up forming a category of their own, because they involved a sense of connectedness to the group even though they did not necessarily occur during the group session. This is not uncommon in qualitative research where the details of a method are modified during the research to attend to issues that arise throughout the process. It is referred to as emergent design.

Flanagan (1954) and Woolsey (1986) explain that significant incidents are indicated by full and precise details. Because the observers were reporting on themselves, I assumed that full and precise observations would be reported for incidents that participants considered to be most noteworthy to them. Participants were also asked for their definitions of connection as well as whether connection was an important or unimportant part of their reason for coming to the group.

Throughout the interviews, I tried to remain open to all the information that was brought up by participants. This was tempered with an understanding, however, that "the researcher is the instrument for data collection" (Mertens, 1998). There were a few occasions where I felt it was important to guide the interviewee back to the subject of group connections. I was careful to add that we would/could return to other
topics after the interview. On two occasions, this led to a joint decision that the participant write or speak with someone in Patient Family Counselling Services for further discussion. Generally, the interview questions easily expanded into discussions around experiences that contributed or detracted from connection.

Throughout the interviewing process, I employed empathy, perception checking, paraphrasing and clarification, along with other basic interviewing skills. This was to insure for comprehensive descriptions of incidents, for the participants to know that their input was being valued and not judged, and to keep researcher biases and perceptions in check. I took notes while participants talked, particularly when I had questions, required clarification or was struck by statements that sounded like significant incidents or descriptions of connection. During several of the interviews, participants became teary while discussing experiences that were particularly tender to them. When this occurred, I offered the participants the option of shutting off the audio-tape to respect their privacy. Generally, people chose to do so and we spent some time addressing their emotions. This break in taping did not last beyond 5 or 10 minutes and during that time I reminded them of their option to discontinue the interview if they felt uncomfortable. No one chose this option, however, and each person remarked that it felt good to be able to talk about their experiences in the group because it felt very important to them. At the conclusion of each interview, I summarized what had been said and checked if my notes accurately reflected the participant’s viewpoint. This served to establish an initial credibility of the results.
(Mertens, 1998). The interviews were terminated when participants felt that they had given a full description of their experiences of connection in the group.

**Rigor: Member Checks / Validation Interviews**

Mertens (1998) states that the member check is the most important criteria in establishing credibility. Following the initial analysis of the data, I contacted each of the participants to schedule individual validation interviews. These were held approximately four months after the first interviews. Six of the nine member checks were held at the Agency, two were held in the members' homes due to time constraints or increased illness and one was conducted over the telephone due to time constraints.

During the member checks, I gave an explanation of the process I used to establish the categories as well as a written summary of the thirteen categories and their subcategories. I asked the participants to examine and comment upon and/or write down any aspects they a) did not completely agree with, b) did not completely understand and c) felt strongly about for any reason, positive or negative. I explained that not every participant cited every theme and disclosed the number of participants who mentioned each one. After each participant read through the categories, we reviewed and discussed any of their questions and comments. I wanted to discover whether or not the categories resonated with their own experience to assure that the analysis was not purely my interpretation. I found that the level of intersubjectivity was high. Participants often nodded their head, pointed to subcategories and expressed an affinity to them. All suggestions and changes were noted and
incorporated into the categorization system. I also presented any quotes that I had chosen to represent subcategories and asked for permission to include them in the report. All quotes were accepted for inclusion; however, two individuals requested a slight modification in wording. I made these changes as neither modification significantly altered the meaning of the statement.

The member checks took longer than I had anticipated. As in the initial interviews, a few of the participants became teary while reading and discussing the subject matter within the categories. For some of the participants, this study coincided with re-entry into the ‘non-cancer world’ because they had finished treatment. For others, a recurrence or progression of the cancer brought increased sensitivity. The meetings also may have had new meaning because I had recently moved from Vancouver and left my position as group leader. As a result, I had discussions with most of the participants that lasted well over an hour. For me, the member checks were one of the most interesting and rewarding aspects of the research process. I had involved myself heavily in the data during the initial process of analysis so it was very satisfying to discuss the results at length with others who had a full grasp of the information. It was very interesting to hear comments of both recognition and surprise in response to some of the categories. In particular, participants reacted to some of the incidents cited as disconnecting experiences. Several members felt that this was too strong a term and suggested something less negative, namely experiences that detract from connection. For the most part, the participants exhibited a very keen interest in
the content of the categories. They also expressed a sense of satisfaction and pride in being involved in the study, stating that they felt it could be of use to future groups.

Data Analysis

Data analysis was conducted by combining guidelines from the Critical Incident Technique outlined by Woolsey (1986) and Flanagan (1954) with modifications informed by McCormick (1994). Analysis consists of the three steps: 1) selecting a frame of reference, 2) forming categories and 3) establishing the level of specificity-generality to be used in reporting findings. These steps were applied and modified as needed following data collection as per emergent design. The content of the interviews was listened to as well as transcribed in order to consider changes in inflection and voice tone which can sometimes make the content of the incident more clear (Woolsey, 1986).

Unfortunately, one of the tapes did not record properly and at the time of transcription, I was unable to access the interview. I discussed this problem with my thesis supervisor and we considered the options. Because I was leaving Vancouver, I could not re-interview before my departure. From Toronto I called the participant whose interview did not record and explained the situation. We held a briefer version of the interview on the telephone that was partially guided by the notes I had taken during the first interview. I took extensive notes during the phone conversation. In combination with my notes from the interview and the second conversation, Dr. Haverkamp and I decided that it would be acceptable to incorporate the data in the analysis.
Existentialism as a Bias

Woolsey (1986) explains that the selection of a frame of reference is based on the intended use of its results. My intent is that the results of this study serve to inform counselling and lay practice for those working with and caring for people with cancer. The frame of reference for my study is psychosocial oncology, and how connection in group work impacts the coping experience of people with cancer. Existentialism provided a hypothesis for my assumptions about the definition of connection, but did not restrict the frame of reference for interpreting the results. In other words, I did not select and report only those critical incidents that represented existential themes. In fact, early on in the category formation phase, I recognized that a subcategory entitled Dealing with issues of mortality had probably been formed as a result of this bias. Upon closer observation of the data, I was able to report the incidents more clearly and accurately, as Hearing about recurrences, relapses and deaths (See Chapter 4, Category 4). The journal and my discussions with my supervisor, Dr. Beth Haverkamp gave me a continuing opportunity to critically reflect my interpretations and biases throughout the process of data analysis.

Category Formation

Incidents were considered to be critical when the participant could recall specific details about the event, and explain what it was about the event that made them feel connected or not connected to the group or someone in the group (Easton, 1986). Themes were extracted from the taped interviews and transcripts by grouping the reported incidents into clusters that seemed to share unifying concepts. I did this
by listening to the tapes and highlighting and coding phrases with thematic material within the transcripts. I placed all the themes and phrases on index cards and looked for potential systems of organization. This was a repetitive and long process, one that quickly dissolved my early excitement over how obvious the themes seemed to be! I tried several different organizing models before deciding on the one that was most comprehensive. After this lengthy process, I was able to return to a model that seemed basic and comprehensive. Woolsey (1986) describes this as an “aha response” that occurs when the data and the categories seem to suddenly fit together.

My guiding principle for the material became centred on data that answered the thesis questions: *What contributes to an experience of connection in the group?* and *What detracts from an experience of connection in the group?* I formed initial categories that were worded as direct responses to these questions. This was an important step in the process because it was, at times, very challenging to distinguish between the incidents that fostered connection and the effects of those incidents on the person’s experience. The incidents were then sorted into piles for which I generated descriptive, self-explanatory labels. This entire process was repeated numerous times until a fairly refined set of categories and subcategories emerged. This set was intended to provide both general and specific delineations of experiences that either fostered or detracted from connection amongst the participants in a way that was true to the data, easy to understand and potentially useful to psychosocial oncology practice.
Validation of the Categories

The formulation of categories is a very subjective process. It is important to check that the category scheme developed is both sound and trustworthy (McCormick, 1994). These categories are intended for use or consideration in the application of groups for people with cancer. This is work with vulnerable people. It is essential that anyone who utilizes these categories in a psychosocial oncology context is quite certain that the categories are complete and well founded. I utilized several measures to ensure for soundness and trustworthiness.

Participation Rate

One method to determine whether a category is well founded is to look at the level of agreement amongst participants in the study (McCormick, 1994). In my study, themes were developed based upon significant similarities amongst the reported experiences. The participation rate for the categories ranged from 67% to 100% (see Tables 2A and 2B in the Results section) representing a high level of agreement on the thematic material. Only one category out of 13 was rated at a 67% participation rate while all the others ranged from 78% to 100%. The subcategories have a wider range of participation. I made a concerted effort to form comprehensive categories and this sometimes meant reporting an incident or experience that was related only once. This did not strike me as unusual for a study that involved only 9 participants.

Independent Judges / Expert Commentary

Other tests for soundness include the use of independent judges and expert validation. In my study I combined the two. I felt strongly that the true experts in this
research were the participants themselves, and yet I knew I had to have some outside consideration of the categories for validation purposes. For this reason, I submitted these categories and subcategories to two colleagues for review. The first was a fellow counselling psychology student familiar with group work and the second was a former volunteer and caretaker of a family member with cancer who had attended the relaxation groups. Initially, I provided each with index cards that stated each subcategory and asked them to organize the cards in groupings that seemed to share a common theme. The nuances in the themes, however, required that we shift the focus. We entered into a lengthy discussion that resulted in a good comfort level regarding the final groupings. The second assistant expressed concern that there was no mention of the family member / caregiver experience in the group (see Limitations section in Chapter V). I explained to her the reasons why I chose to focus on the ‘patient’ experience and noted her concerns. In combination with the feedback from the member checks, I felt confident that I had reached a comprehensive, credible and confirmable set of categories and subcategories.

Support of Related Literature

The soundness of categories can also be considered within the realm of related research. Categories that disconfirm previous research might have to be questioned more closely, while categories that are consistent with related research may be used more confidently (McCormick, 1994). New categories would need to be subjected to more research. In my study, the categories were found to be consistent with the work of Irvin Yalom, who provides a comprehensive description of existentially based
psychotherapeutic group work in the text *The theory and practice of group psychotherapy* (1985). The categories in my study can be paralleled with what Yalom refers to as the “curative factors” in group therapy (see Table 3 in the Discussion section for greater detail). Along with the other contributing factors, these parallels suggest that the categories are both sound and well founded.
CHAPTER IV

Results

Both in conducting and analyzing the interviews, it quickly became apparent that the term *critical incident* as defined by Flanagan (1954) did not accurately represent the nature of the data collected. Participants reported a combination of events, feelings, thoughts and auras that fostered connection in their group experiences rather than observable incidents. This occurred despite the fact that the interview questions were worded in a way that specifically requested behaviours and events that enhanced connection. Participants explained that there were many ‘nebulous’ qualities and ‘auras’ that contributed to connection. It seemed that the term *critical incident* could not reflect these qualities. Woolsey (1986) reported a similar experience in her self-actualization study in which she had to categorize descriptions of relationships rather than incidents in order to demonstrate what was reported as meaningful to the respondents. Similarly, Mauchan, (1999) utilized the term *factors* rather than *incidents* to report the experiences which adolescents found to enhance their involvement in an outdoor experiential education programme. Both Woolsey (1986) and Flanagan (1954) stress the importance of creating categories which “increase the usefulness of the data while sacrificing as little as possible of their comprehensiveness, specificity, and validity” (Flanagan, 1954). Woolsey (1986) acknowledges the subjectivity of category formation but reminds the researcher to focus on the basis of the intended use of a study’s results: the frame of reference. Because my frame of reference serves to inform counselling and lay practice for those
working with and caring for people with cancer, I have chosen to report the data as groupings of *significant experiences*. These experiences are best viewed in the group context in which they were described but can also be understood as basic human experiences outside the realm of psychosocial oncology practice.

While some of the data could be expressed as critical incidents, I believe that the participants reported contextualized experiences rather than isolated incidents. I was concerned that a division of the data in two sets of categories (critical incidents and significant experiences) would detract from the comprehensive representation of the results. I also felt that such a division might suggest that either the incidents or the experiences could be applied separately from the other. It seemed that the incidents derived their meaning from a context of experiences (such as trust and safety). I would not be comfortable in recommending that group interventions based on only the incidents be encouraged outside of such a context.

**Participants**

Participants were all people who have or have had cancer and have attended the relaxation group at least five times in the two years before the study was conducted. In fact, all the participants had attended the group at least 15 times in that period. The nine participants were asked eight demographic questions which serve to reflect the parameters of the results and contribute to a more careful description of the time, place, context and culture of the data (Mertens, 1998). Guba and Lincoln (1989) refer to this as “thick description” in their treatise on qualitative research methods. Thick description assists the researcher and the reader in establishing
whether or not they believe the results may be transferable to contexts other than the one specifically studied. Table 1 summarizes the demographic attributes of the participants.

**TABLE 1: DEMOGRAPHIC DESCRIPTORS OF THE PARTICIPANTS**

<table>
<thead>
<tr>
<th>Demographic Variables</th>
<th>Range of Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sex</td>
<td>6 women and 3 men</td>
</tr>
<tr>
<td>Age</td>
<td>Ages ranged from 39 to 64, mean age of 51 and median age of 53</td>
</tr>
<tr>
<td>Occupation</td>
<td>2 self reported as disabled, 2 as nurses, 1 as retired, 1 teacher, 1 engineer, 1 therapist, 1 artist</td>
</tr>
<tr>
<td>Type of Cancer</td>
<td>5 self-reported as breast cancer, 2 as lymphoma, 1 as brain tumour, 1 as colorectal cancer</td>
</tr>
<tr>
<td>In treatment or Post Treatment for Cancer</td>
<td>6 self reported as post treatment, 3 as in treatment</td>
</tr>
<tr>
<td>Nationality</td>
<td>4 self-reported as Canadian, 1 German-Polish, 1 Japanese, 1 First Nations, 1 American, 1 “none”</td>
</tr>
<tr>
<td>Marital Status</td>
<td>7 self-reported as married, 1 as common law, 1 as single</td>
</tr>
<tr>
<td>Number of Children</td>
<td>Ranged from 0 to 3, with a mean of 2</td>
</tr>
<tr>
<td>Religious Affiliation</td>
<td>3 self-reported as Protestant, 2 as “none”, 1 as Christian, 1 as Roman Catholic, 1 as First Nations / Evangelical, 1 as Buddhist</td>
</tr>
</tbody>
</table>

**Significant Experiences**

The nine participants who took part in this study reported a total of 318 experiences that either enhanced or detracted from a sense of connection in the relaxation support group. Of these 318 experiences, 283 (89%) were enhancing experiences and 35 (11%) were detracting experiences. Based on my qualitative analysis of these experiences, numerous themes emerged. I have organized these themes in a set of 13 categories, each with representative sub-categories that are more specific and can be seen in the context of interactions. Eleven of these categories...
represent enhancing experiences while the remaining two categories reflect the
detracting experiences. An explanatory paragraph and a prototypical incident reported
in the exact words of one of the participants represent each sub-category. The number
of participants who cited experiences as well as the number of experiences cited for
each subcategory is also reported. Tables 2A and 2B show the distribution of incidents
within each category and the rate of participation for each. An in depth description of
the categories and subcategories follows Tables 2A and 2B.

**TABLE 2A: DISTRIBUTION OF SIGNIFICANT EXPERIENCES THAT
CONTRIBUTE TO CONNECTION**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Experiences</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Being with people like myself</td>
<td>36</td>
<td>100%</td>
</tr>
<tr>
<td>Freedom to be myself</td>
<td>21</td>
<td>100%</td>
</tr>
<tr>
<td>Helping others</td>
<td>26</td>
<td>100%</td>
</tr>
<tr>
<td>Relating to other people’s cancer stories</td>
<td>37</td>
<td>100%</td>
</tr>
<tr>
<td>Sharing positive experiences around cancer</td>
<td>18</td>
<td>100%</td>
</tr>
<tr>
<td>Knowing I can trust the people who run the group</td>
<td>24</td>
<td>89%</td>
</tr>
<tr>
<td>Experiencing care and touch from others</td>
<td>32</td>
<td>89%</td>
</tr>
<tr>
<td>Feeling that I belong here</td>
<td>23</td>
<td>89%</td>
</tr>
<tr>
<td>Expressing my thoughts and feelings</td>
<td>17</td>
<td>78%</td>
</tr>
<tr>
<td>Getting the help and support I need</td>
<td>34</td>
<td>78%</td>
</tr>
<tr>
<td>Connecting beyond the relaxation group</td>
<td>15</td>
<td>78%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>283</td>
<td></td>
</tr>
</tbody>
</table>

**TABLE 2B: DISTRIBUTION OF SIGNIFICANT EXPERIENCES THAT
DETRACT FROM CONNECTION**

<table>
<thead>
<tr>
<th>Category</th>
<th>Number of Experiences</th>
<th>Participation Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Aspect(s) of the group or session that are not satisfying</td>
<td>17</td>
<td>78%</td>
</tr>
<tr>
<td>When I need to protect myself</td>
<td>18</td>
<td>67%</td>
</tr>
<tr>
<td>TOTAL</td>
<td>35</td>
<td></td>
</tr>
</tbody>
</table>
CATEGORIES AND SUBCATEGORIES

Experiences that Contribute to Connection

1. BEING WITH PEOPLE LIKE MYSELF

"Man wishes to be confirmed in his being by man, and wishes to have a presence in the being of the other”

Martin Buber

This category refers to the experience that all participants had regarding the knowledge that people in the group shared one or many of the same attributes as themselves. This knowledge seemed to be a comfort to the participants, particularly in the area of their experience of cancer. The perception of shared experience had the effect of making participants feel safer in terms of self-expression and self-acceptance. In many ways, this category lies at the root of many theories of group effectiveness (Corey, 1995, Fobair, 1997, Yalom, 1985). The individual can learn to cope with his/her circumstance when s/he perceives there are others in the “same boat”.

Subcategories

A) Being with other people who have cancer
8 participants, 11 experiences

"...it's I guess that automatic closeness because we're in the same boat together, you know. A leaky boat too, you're going to patch it up quick or you're going to sink, right."

B) Being with people with similar attitudes and/or interests
4 participants, 5 experiences

"...would be the same if you were meeting people outside of the group, you make a connection because of the way they look at the world...I think probably the strongest connection is an attitude type thing. And I can think of the people that I've connected to most, and they're people who tend to be positive and a bit outgoing..."
C) Being with others with the same diagnosis and/or treatment  
6 participants, 7 experiences

“...you just feel more comfortable, either it’s because you’ve shared similar type of treatment or the same stage of your treatment and you can do comparisons”

D) Knowing we are all vulnerable and need help  
7 participants, 13 experiences

“You really don’t know much about yourself, how you are and your situation until you’re amongst people like yourselves, seeing them, listening to how they’re as shaky as you are, and so you feel close knowing that, and then you get to know yourself too.”
2. EXPRESSING MY THOUGHTS AND FEELINGS

"The meeting of two personalities is like the contact of two chemical substances: if there is any reaction, both are transformed." Carl Jung

This category refers to the importance that participants placed on open expression of thoughts and feelings. This importance centred on an awareness of a need for expression and a feeling that they could not comfortably be sad, scared or angry around family members or friends. In this way, these experiences are linked to a feeling of comfort, acceptance and connection that probably already existed in the group. The open display of a range of emotions only seemed to enhance and increase this comfort and connection in the group experience.

Subcategories

A) People letting me cry

5 participants, 7 experiences

".... And to know it's okay to cry in front of people, or to completely break down ... and when you come back the next time, somebody's not going to say to you... well, what happened to you?"

B) Talking openly about distressing thoughts and feelings

6 participants, 7 experiences

"... everything that you're going through, I was scared, I mean, they all realize that you're going to be scared, and it's on the surface and then it breaks through. I think that's what the group means to me."

C) Being listened to

3 participants, 3 experiences

"they look at you and, you know, you could see that they're listening to you and they care for you"
3. FREEDOM TO BE MYSELF

"Beyond the element of giving, the active character of love becomes evident in the fact that it always implies certain basic elements, common to all forms of love. These are care, respect and knowledge."

Erich Fromm

This category represents experiences where participants felt connected to the group as a result of feeling accepted and validated as an individual therein. This category emerged from poignant and often lengthy descriptions of the relief and gratitude that participants felt as a result of an immediate sense of acceptance in the group environment. Like the preceding category, this sense of acceptance was sometimes explained as palpably distinct from outside environments (such as work, home, grocery shopping) where participants felt boxed in or misunderstood. Participants described a discomfort in outside environments in still being themselves, only now with cancer. This seemed to relate to a perception that outside the group, others could not cope with the reality of their circumstances. As a result, the acceptance and validation from the group fostered an experience of connectedness that was most welcome.

Subcategories

A) Being accepted for who I am
8 participants, 8 experiences

"Right from the beginning, I felt very secure in the room as far as being yourself is concerned, whatever someone - anyone said or even that I made a statement or comment, it would be viewed as that's the way I feel and there wouldn't be anything derogatory attached to it. If you had any opinions, you just voiced them and they would be accepted as something said by myself. Other patients or people in the group, they'd either comment on it or accept it just say nothing...Because every one of us is unique in our own way... just by talking to friends of ours...that as soon as I'd mention to some of our friends that I've got cancer, there seemed to be a hesitation in the dialogue, and then they'd kind of steer away as if I had some sort of formidable plague"

"Nobody here says 'hey, I don't agree with what you're doing'..."
B) Freedom to deal with things in my own way  
5 participants, 7 experiences  

“The next time I came, I spent the whole time crying, but it was the same sort of feeling that you had that you could talk, or not, and there was no negative feelings from anybody”

C) Feeling understood  
5 participants, 6 experiences  

“...And I love the understanding..like ‘okay that’s just him, he’s doing his thing..he’s having a bad day, a hormone thing, or a brain tumour day or whatever. People give me that break, they give me that understanding, and I love that”
4. RELATING TO OTHER PEOPLE'S CANCER STORIES

"The human being gets his original experiences of being a self out of his relatedness to other persons."
Rollo May

This category relates to incidents where participants felt a link to the emotional, social and/or medical experiences of other participants. These incidents occurred primarily during the sharing portion at the beginning of each session. This part of the group is characterized by a 'witnessing' of other people's stories without verbal reactions and/or comments. Relative to this, participants explained that it was often quite powerful to listen to other people's experiences. Much of this power was attributed to the learning, validation and normalization that came from hearing things that they could relate to in their own experience. This act of witnessing called out to parts of the participants that were tender and at times, unexpressed. Some of these experiences were amongst the most painful for participants to describe.

Subcategories

A) Remembering the trauma of being diagnosed
7 participants, 10 experiences

"One of the bonds is that everybody knows that panic feeling when you can't even take a deep breath when you're first diagnosed, and we all hate that. It's such a horrible place to be, and I think that's why everybody comes at the beginning, so they can get their breath back. So there's that understanding amongst the group members when you're listening to a new person talking."

B) Relating to other people's emotional experiences
6 participants, 11 experiences

"I can remember feeling a strong connection with somebody who talked about wanting to see their grandchildren grow up, and that is hard for me, because that's really dealing with the future, so I could just feel that same strong feeling inside in connecting with that person"
C) Finding my place in the cancer world:
4 participants, 5 experiences

“And you know that there’s people in there worse off than you and people in there not as bad off as you, so you’re somewhere in the middle, and everything fits, so yeah that’s a connection”

D) Hearing about recurrences, relapses and deaths
4 participants, 4 experiences

“...if the group was all survivors, and the stories were all successful, you don’t really appreciate or comprehend until you hear the other side of a story like a death or a relapse, where the situation got worse. An analogy of this is like you just didn’t know how white, white really is, until you see black.”

E) Normalizing my cancer experience
4 participants, 4 experiences

“You keep thinking, why did I get this disease, did I do something wrong?..the whole group is so diverse, all ages, all walks of life, all socioeconomic, all nationalities, that it sort of gives you a bit of sense of ‘this is just something that happened’. It wasn’t something that I did, it happens to the best and worst of us..so as a group, together that gets communicated to you.”

E) Hearing someone vocalize a thought or feeling I couldn’t/wouldn’t articulate myself
3 participants, 3 experiences

“...it was vocalising a thought or a fear of mine that you don’t want to put into words and that was a strong connection”
5. KNOWING I CAN TRUST THE PEOPLE WHO RUN THE GROUP

"The warm subjective encounter of two persons is more effective in facilitating change than is the most precise set of techniques" Carl Rogers

This category refers to experiences of connection with, or nurtured by the volunteers and facilitators of the relaxation support group. Several participants said that they believed these were the people who established the sense of safety, openness and warmth in the group environment. Once this comfort level was established, participants felt they could begin to benefit from and expand upon the healing quality of their relationships in the group. Participants speculated it was critical that everyone attending the group feel a sense of connection to the facilitator but not necessarily to every group member.

Subcategories

A) Knowing that the volunteers are there out of the goodness of their hearts and have problems just like we do
7 participants, 10 experiences

"The volunteers are absolutely wonderful, they're a really important part of making you feel comfortable... the people that are volunteering, they have this compassionate type of personality and caring, and their intent is to be helpful. I think intent is very powerful"

"The volunteers themselves had their own problems, so by helping us it was therapeutic to them, so they were very much a part of us"

B) Knowing that the facilitator(s) genuinely cares
7 participants, 9 experiences

"The facilitator, I think is a key, key part of the group. The group of people really has to feel a connection to them. They need to feel that there's a compassion and caring, and they need to know there's going to be no judgment"

C) Being told every week that I am safe here
4 participants, 5 experiences

"It's the way when (the facilitator) talk with the group and explains it to everybody, especially the new people, but even for us who have been quite a few times...to hear it again, just reinforces it. To let people know this is a safe place, you can say or do anything, if you want to cry, cry... and as I say, week to week you come to hear the same thing... it's a safe place, there's no right, there's no wrong"
6. HELPING OTHERS

“If I am not for myself, who is for me? And if I am only for myself, what am I?...”  Hillel, the Talmud

This category reflects the sense of satisfaction and closeness that participants experienced as a result of being helpful to others. All the participants expressed that their desire and ability to meet others’ needs greatly contributed to a sense of being connected to other individuals as well as to the group. Similar to the experiences in the first two categories, the ability to help others felt precious because participants felt they could not express this side of themselves in outside environments. There, participants felt primarily like ‘patients’ who needed caretaking and assistance rather than people who were capable of being useful to others.

Subcategories

A) Reaching out to others when they're in need
8 participants, 18 experiences

“When you stop worrying about yourself and you start worrying about somebody else, you’re expanding that border beyond yourself, and that’s the best connection”

B) Feeling that my experience can be inspiring and helpful to others
6 participants, 8 experiences

“Every week there’s some sort of connection, I find myself talking out to somebody across the circle or just a little bit of a hint here or there... and it feels good to help”
7. EXPERIENCING CARE AND TOUCH FROM OTHERS

"Now join your hands, and with your hands, your hearts"  Shakespeare

This category represents the connecting effects of receiving care, touch and kindness from other group members. Participants expressed numerous experiences where they felt instantly connected to another group member after they bestowed upon them a touch, a hug, a smile, a warm look across the room or simply a feeling of genuine concern. This category included experiences which most closely resembled critical incidents as defined by Flanagan (1954) and Woolsey (1986) because they were observable behaviours and/or events that elicited an outcome of connection.

Subcategories

A) Feeling cared about
5 participants, 9 experiences

“I just really got relaxed, and then someone opened the door and I opened my eyes, and there was this lady standing right there, right beside me, looking down at me with a nice smile, and I felt really good. So there’s always this caring and nice people”

B) Warm smiles and eye contact across the circle
4 participants, 6 experiences

“you could see from them looking across at you, so you knew they were listening, and they made you feel they were interested in your feelings or understanding and that warmth, you could see it and you could feel it...”

C) Holding hands, being touched, warm greetings and hugs
6 participants, 11 experiences

“the first couple of times I came, I think all I did was cry and the people just sit there and hold your hand, it felt so good”

D) Therapeutic touch from the volunteers
5 participants, 6 experiences

“... but the touch of somebody, I think it’s because it feels like they care about me, will trigger the tears. That somebody actually cares and is doing the therapeutic touch and volunteering their time...”
8. FEELING THAT I BELONG HERE

"You don't live in a world all alone. Your brothers are here too."  
Albert Schweitzer

This category refers to experiences where participants felt a sense of being part of the group in a way that was personally meaningful. Inherent in this category is a sense of connection because the sense of belonging could not occur without feeling connected to others. Participants expressed a sense of satisfaction and pride in regards to their membership and belonging in this group. There was no mention of a regret that they could only belong here because they had cancer. In fact, membership in this community seemed to be a welcome and gratifying experience.

Subcategories

A) Looking forward to seeing people I've connected with in past sessions  
6 participants, 9 experiences

"when I come here also, I'm wondering how she's doing, how he's doing. You know, if they're not here, I might ask about them or have you heard from her..."

B) Feeling that I am amongst family / friends  
6 participants, 8 experiences

"it feels like they're all your friends, even if you don't see them until the next week"

C) Being invited to the group by someone I met because I have cancer  
3 participants, 3 experiences

"the physician had got me in touch with J which was really nice 'cause her story and my story were exactly the same...she actually came and visited me on my first chemo day, it was wonderful...so she highly recommended coming to the relaxation group...so it was right from the very beginning...and then you start to meet other people and make other connections"

D) Being recognized each week  
3 participants, 3 experiences

"And you walk in the door and people will, 'How are you?!' and give you a hug. It's just a welcoming place that people are coming together with."
9. SHARING POSITIVE EXPERIENCES AROUND CANCER

"We must laugh and we must sing. We are blest by everything" Yeats

This category includes experiences where participants felt a sense of joy, pleasure, humour and/or personal growth during the group sessions, which they experienced as a source of connection to others. These experiences were characterized by a particular sense of satisfaction that occurred because the pleasure was being shared with people who were also going through the arduous challenge of a cancer diagnosis. Certain key group members who had particularly positive outlooks on their cancer and/or warm and humorous dispositions were referred to as inspirational in this area. Participants expressed feeling particularly connected to them because of their positive, inspirational attitudes.

Subcategories

A) Laughing and enjoying being together
7 participants, 11 experiences

“But you can say anything you want in there, and I often laugh because where else could I have said, a year and a half after my surgery, ‘Hey! I did my bra up all by myself today!’ You know, because my shoulder had been frozen and I could finally for the first time reach around...and everybody hooted. But there’s nowhere else you could say that for a laugh.”

B) Seeing myself in a new, more positive light because of my cancer
4 participants, 4 experiences

"I wondered how could they be so happy and how could he say that this was the best thing that ever happened to him. And then later on as I progressed in my treatment and coming more and more to these sessions, I began to appreciate exactly what he meant by that...”

C) Seeing the best in people
3 participants, 3 experiences

“Because when they’re talking to somebody, I can see they’re really trying to give their best and their understanding, and I can see it. It’s so obvious, because they’re open. And it’s a connection, transference of energy, of love, of caring.”
10. GETTING THE HELP AND SUPPORT I NEED

Oh, I get by with a little help from my friends”  Lennon and McCartney

This category incorporates experiences in which participants felt that getting the help and support they needed contributed to their sense of connection and trust in the group and to the people therein. Participants expressed that the benefits of group attendance were characterized by two distinct factors. One factor was the opportunity to be proactive in their healing process through relaxation, healing imagery, therapeutic touch and therapeutic music. The second was opportunity to develop and foster connections and relationships with others going through a similar process.

Subcategories

A) Getting inspiration and hope
9 participants, 19 experiences

"It absolutely astounds me, the courage and the dignity of these people that come. It is just awe inspiring, and you get a lot of strength from that”

B) Knowing the group is there for you when you need them
5 participants, 5 experiences

"I think that’s part of the connectedness of the group, because I think they seem to be able to pick up on when I’m a little more needy”

C) Relaxing together
5 participants, 6 experiences

"...well we’ve often joked, that it’s like being at Brownie camp or something. You know, you get your blanket and your little pillow and lie down together and someone is singing to you. I feel very safe here”

D) Live music
4 participants, 4 experiences

"It’s a whole difference having the music therapist doing live music and singing... they’re there because they care rather than listening to a recorded tape”
11. CONNECTING BEYOND THE RELAXATION GROUP

"To know of someone here and there whom we accord with, who is living on with us, even in silence – this makes our earthly ball a peopled garden"  Goethe

This category introduces elements of connections to the group which actually occurred outside of the group sessions. Participants explained that their group experience and their relationships with group members continued to have an impact on their lives outside of the sessions. Experiences such as: thinking of the group when you’re having a bad day, calling a group member from home, bumping into someone from the group outside and having lunch together after sessions exemplify this category. Participants explained that these experiences deepened their sense of connection to the group because they expanded into their everyday lives.

Because of this, I would regularly pass around a sheet of paper in group for those who wished to include their name on a telephone list. This was optional, for group members who wished to be contacted outside of the sessions. This list seemed to be well utilized, however, the facilitator or volunteers were not included.

Subcategories

A) Having lunch together in the cafeteria after the group
6 participants, 6 experiences

"The connection is there in that room, but since we started, and it just grew and grew... Going for lunch, it didn’t matter who came and who didn’t and you would talk about all kinds of things and that was really nice too”

B) Ongoing inspiration from the group
5 participants, 5 experiences

"...looking back on the group, whenever I do, I do it with a feeling of appreciation and thankfulness ...and if I didn’t feel good that day I thought about those guys and how they’ve supported me and I felt really good about myself”

C) Seeing and speaking to people on other days than the group is held
4 participants, 4 experiences

"...you do feel connected to people and you’re so glad to see them wherever you go... because you feel like they know who you really are.”
Experiences that Detract from Connection

“There is hunger for ordinary bread, and there is hunger for love, for kindness, for thoughtfulness: and this is the great poverty that makes people suffer so much.” Mother Teresa

1. ASPECT(S) OF THE GROUP THAT ARE NOT SATISFYING

This category refers to experiences in group sessions that participants felt were unsatisfying. Most of the participants explained that these experiences were not the norm, but that they did happen from time to time and were not just isolated events. Participants explained that they would either shut down temporarily, do something to modify the situation or simply try and ignore the source of their dissatisfaction. None felt that the issues were severe enough that they would consider not returning to the group. Some participants offered suggestions regarding solutions to the problems. These were discussed following the interviews and referred to the Director of Patient and Family Counselling.

Subcategories

A) Group is too big
4 participants, 6 experiences

“When there are ten or so people, the intro and sharing of experience part of the program...in regards to that, I felt more comfortable in sharing and relating and I noticed that we took the same time, just as long as the large group...It's just like classroom, there are 30 people, if there's 60, you just can't deliver...”

B) People talking for too long about things unrelated to cancer
3 participants, 5 experiences

“Just when someone goes on about other things that you kind of want to tune them out, so in a way you do disconnect there. I know they have to talk about these things, but it's not related to their illness or anything.”
C) Some facilitators are too clinical or inflexible
3 participants, 3 experiences

"because sometimes when other people have taken the group over, and have
done a fine job, but it feels very clinical... it just doesn't have the connectedness."

D) When there is a fake or phony quality to a hug or touch
2 participants, 2 experiences

"And there are people in the group who will give me a hug and it's, I don't
know, fake. They're just giving a hug, but it doesn't appear that they actually care or
understand."

E) When I don't know anyone there
1 participant, 1 experience

"...there have been days that I have come and thought, what am I doing here,
I'm the only person that I know in this room. And that feels very strange."
2. WHEN I NEED TO PROTECT MYSELF

This category refers to experiences where participants explained that they needed or wished to protect themselves from connecting with others because they perceived a connection would be counterproductive. This generally occurred when participants were feeling particularly vulnerable: physically, emotionally or mentally. On these days or during these periods, participants explained that they came to the group for relaxation, therapeutic touch and music, and for connection only with those individuals who could provide a positive influence.

Subcategories

A) When someone is extremely ill or dying
4 participants, 6 experiences

"Sometimes when there’s people in the group who are very sick, I don’t connect with them, because I’m afraid. And when people are really really down, it’s hard to connect too sometimes, and it’s a fear... like you don’t want to go there almost, and it’s a self protection thing”

B) When I’m extremely down or feeling unwell
4 participants, 7 experiences

“When you’re not feeling as good yourself, I think maybe you shut down a little, you’re not as intuitive or open”

C) When others are extremely down or negative
4 participants, 5 experiences

“I can only understand so much, and when that person goes beyond the understanding and started bringing out the trash, I don’t have time for that then... There’s a limit if they’re going to try and put some negativity on you or against you or the group or even to themselves... I don’t come here for that.”
Participant Perceptions of Connection

At the outset of the study, I made the assumption that connection was an important part of the relaxation support group. I also created my own definition for connection and presented it to the participants. I felt it was important to check on these assumptions with the participants, so I asked them directly. What follows are the verbatim responses to these questions. I feel that the responses indicate support for my initial assumptions.

1. “How do you define connection in the group?”
   - Feeling accepted, feeling comfortable
   - The opportunity to get together with people who are going through the same thing
   - Companionship of people, safety, and the camaraderie
   - To unite, a feeling of belonging
   - It feels like love, an emotional thing, a healing thing
   - Being part of a community
   - A combination of gentleness and patience with where you’re at
   - We’re all together, feeling very secure
   - Validation of where you’re at and how you’re feeling, it’s a strong feeling, you realize you’re surrounded by people in the same boat which you’ve been isolated by yourself, and it causes you to cry

2. “Is connection important, unimportant, neutral or not really a factor in why you come to the group?”

All participants said it was an important reason why they attended the group.
CHAPTER V

Discussion

In this chapter I will discuss my ideas about the results and the findings of this study in relation to: literature on group work in psychosocial oncology, literature on existentialism, counselling psychology practice and future research in related areas. Other noteworthy findings and limitations to the study will bring this report to its conclusion.

Any links made to the existing literature as well as any inferences about the results are done with the knowledge that the categories yielded from this study reflect, primarily the experiences of the 9 participants. It is important that the reader consider whether or not these categories resonate with the experiences of other people who face cancer and other life-threatening illnesses. While I am confident that the categories can be tracked to the participants themselves and that the results are credible and authentic, I am aware that any transferability of these results is a subjective act. It is incumbent upon myself and the reader to judge whether or not these categories can be seen beyond the context of the nine people who were interviewed.

Despite the limited number of participants, I was pleased that the biographical descriptions of the participants yielded a relatively generous mix of sex, age, occupation and cultural origin. The group was diverse. It also included a combination of people in treatment and post-treatment, as the literature suggests there is a difference in the psychosocial experiences and needs of treatment and post-treatment cancer patients.
I have run relaxation support groups for seven years, and have observed the interactions amongst group members as well as listened to participants' preferences and complaints about the sessions. As a result, I feel capable of assessing whether or not the categories that emerged from the interviews represent what I have heard and observed throughout those seven years. Other than the marked absence of the caregiver experience (see Limitations to the Study and Implications for Future Research), I believe that the categories and subcategories of experiences that contribute to connection in this study portray a comprehensive delineation of the group experience. I do not feel, however, that the area of detracting experiences is complete. Therefore, as the researcher, I am comfortable with transferring the first set of results to the larger context of group experiences for people with cancer, but exercise much greater caution with the latter.

**Links to Group Therapy in Psychosocial Oncology**

Spira's (1997) assertion that group therapy may be the most powerful psychosocial intervention available to people with cancer is supported by the findings of this study. Participants felt that they relied heavily on the group for support, education and coping as well as for the opportunity to be proactive in their healing process. Several participants stated that the group was their main source of support throughout their cancer experience and referred to the group as *therapy*.

Fobair (1997), in her review of group work in oncology, posited that the benefits of group attendance were experienced regardless of whether the group was educational, self-help or expressive. The results of my study may suggest that an ideal
group environment may be one that incorporates more than one treatment modality. Participants remarked that they found that there were two distinct aspects of the group, both of which they found to be beneficial for different reasons. These factors were described in the "Getting the help and support I need" category. They are: 1) the experience of being proactive in their healing process through relaxation, imagery, therapeutic touch and music and 2) fostering connections and relationships with people who are going through a similar experience. These two factors seemed to both result from the other as well as be enhanced by the other. Participants commented for instance, that they wouldn't be able to relax or visualize alone or with people that they didn't trust, nor were they seeking a straight verbal support group. Perhaps a combination of therapeutic interventions that are behavioural (i.e. relaxation and visualization) with interventions that are emotionally / socially focused provides the most effective and expedient group approach for oncology work.

Some participants also noted an increased sense of personal awareness around their cancer experience in that they felt they could begin to see beyond the challenge of cancer into the positive psychological effects of having the disease. This was often referred to as an increased appreciation of what was formerly considered to be mundane (i.e.: working, gardening, walking, eating, spending quiet time with friends and family). Such an increase in self-awareness is consistent with the expected benefits of group therapy as defined by researchers and theoreticians such as Cunningham and Edmonds, (1996), Corey (1995) and Yalom (1985).
The relaxation support group is also distinguished by the gestalt of people who attend. Volunteers, caregivers, people with cancer, families and friends, and professional facilitators come together in the groups in a way that is very special. There seems to be an immediate equalization process that occurs within the session’s time and space boundaries. Everybody reports a feeling of transformation in that room, including myself. Perhaps this occurs because the awareness of our own mortality is before us in a way that, at once, makes it very important and also very unimportant. The cancer experience is the focus but it seems to take on larger human themes that transcend even the disease. Participants are present as caregivers, care recipients and simply as people seeking and offering love and compassion. They are all there as part of the group’s unit of care and assist in forming the complete circle that is representative of the cancer experience. It does not only happen to the patients and everyone is aware of this fact.

**Links to Existentialism**

There is an aspect of the categories and subcategories, which, to me, seems universal and self-explanatory. Themes that emerged from the data such as belonging, being cared about and expressing feelings are not exclusive to the needs of the cancer community. My main impression of the results is that the experiences of people with cancer are very much like the experiences of people in general. People typically need to be cared about; to be touched; to express themselves openly; to be accepted for who they are; to trust those in positions of authority; to be useful to others; to feel like they belong; and to laugh. Essentially, people with cancer experience these needs more
sharply, and may have more difficulty getting these needs met because of the fears of people around them. This is what emerged from the interviews. The resultant categories reflect the aforementioned needs, and parallel the basics of existential thought. In particular, the categories that emerged relate closely to the “curative factors” in Yalom’s Theory and Practice of Group Psychotherapy (1985).

In Table 3 I have mapped out potential points of correspondence between Yalom’s 13 curative factors and the first 11 categories that emerged from my data referring to experiences that contributed to connection.

**TABLE 3: YALOM’S CURATIVE FACTORS PARALLELED TO CATEGORIES**

<table>
<thead>
<tr>
<th>Curative Factors (Irvin Yalom, 1985)</th>
<th>Parallel Category in Experiences that Contribute to Connection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Altruism</td>
<td>Helping others</td>
</tr>
<tr>
<td>Group Cohesiveness</td>
<td>Feeling that I belong here</td>
</tr>
<tr>
<td>Universality</td>
<td>Being with people like myself</td>
</tr>
<tr>
<td>Interpersonal Learning (Input)</td>
<td>Getting the help and support I need</td>
</tr>
<tr>
<td>Interpersonal Learning (Output)</td>
<td>No parallel category</td>
</tr>
<tr>
<td>Guidance</td>
<td>Present in the subcategories of: Getting the help and support I need</td>
</tr>
<tr>
<td>Catharsis</td>
<td>Expressing my thoughts and feelings</td>
</tr>
<tr>
<td>Identification</td>
<td>Relating to other people’s cancer stories</td>
</tr>
<tr>
<td>Family Re-enactment</td>
<td>No parallel category</td>
</tr>
<tr>
<td>Self-understanding</td>
<td>Present in the subcategories of: Relating to other people’s cancer stories</td>
</tr>
<tr>
<td>Instillation of Hope</td>
<td>Sharing positive experiences around cancer</td>
</tr>
<tr>
<td>Existential Factors</td>
<td>Present in most categories</td>
</tr>
</tbody>
</table>

These parallels became apparent only after the data analysis. Family Re-enactment was not found as a theme in the data, perhaps because it is more consistent
with group psychotherapy. Interpersonal Learning (output) is also not seen in the categories derived from my study. This refers to the need for group members to generalize the interpersonal learning they experience in the group to their personal relationships in their outside life. The absence of this factor may exemplify a special quality in groups for people experiencing cancer. For a period of time in the cancer experience, people may find that their relationships undergo a great deal of change. I have often heard group members tell me that the network of support they perceive to be genuine becomes very small, even if many people are calling them. They also say that, for a time, the relaxation group becomes a major part of their support system. Perhaps then, the need for generalizing interpersonal learning to the outside world is not necessary during this crucial time in group attendance. At some point, however, it would seem important that people expand their support system beyond the scope of the group. Despite the fact that some of the participants call themselves "groupies," I have not come across any situation where I perceived that a group member was unhealthily attached to the group and/or had damaged or neglected outside relationships because of the group.

Four of the categories in my study are not explicitly present in Yalom’s curative factors. They are: Freedom to be myself; Knowing I can trust the people who run the group; Connecting beyond the relaxation group and Experiencing care and touch from others. Each of these four will now be addressed. Yalom discusses the importance of the facilitator in group work but it is not considered to be one of the essential factors. The participants in this study considered the trust and care they
experienced from facilitators and volunteers to be significant to their group experience. *Freedom to be myself* may actually be implicit in a number of Yalom’s factors, though the language used doesn’t address this explicitly. *Connecting beyond the relaxation group* may be specific to certain types of groups where it is useful for participants to continue to foster their relationships outside of the group. In many psychotherapy groups, this type of connection outside of the group is not encouraged. In the case of groups for people with cancer, as previously outlined, this expansion of relationships beyond the group sessions seems to be a helpful component.

The fourth category absent from Yalom’s work may be one of the most specific and salient to the cancer experience. It involves the reception of care and touch from others. Because people with cancer often experience a perceived or actual rejection in their community environments (Halldorsdottir & Hamrin, 1996) and because the myths around contagion and repulsion to cancer are prevalent, people with cancer may have a significant need for human contact that is warm, physical and caring.

Consistent with other works based on existential themes cited in the literature review, the results of my study support the contention that existential matters are a very real part of the cancer experience. Participants cited *being with others* and *feelings of belonging* as central to the benefits of group experience. This suggests a need for an abatement in feelings of isolation, a main tenet of existential thought.

Participants also reported that freedom to be themselves and permission to express distressing thoughts and feelings assisted them in coping with the emotional
effects of having cancer. These themes are reflected in the works of the existentialist, Viktor Frankl. He posited that a person's attitude and freedom to live by that attitude, regardless of the circumstances, was a major factor in determining their survival and quality of life. Participants in this study made it clear that it was precious to them that they were afforded the freedom to deal with their disease and the resultant emotions in their own way. This was also evident in the first category of experiences that detracted from connection. Participants described an awareness that at times they needed to protect themselves emotionally from connecting to people who were very ill or very negative in attitude. Some participants expressed an element of guilt regarding their reticence to connect with these people. Nevertheless, they explained that their internal decision was almost automatic and unconscious. Participants felt that they must have known instinctively that connections with certain people at certain times would be damaging. Frankl, in describing the experiences he had and observed in Auschwitz, highlights this knowledge.

Frankl (1963) writes:

"Those who know how close the connection is between the state of mind of man – his courage and hope, or lack of them – and the state of immunity of his body will understand that the sudden loss of hope and courage can have a deadly effect. The ultimate cause of my friend's death was...his faith in the future and his will to live had become paralyzed and his body fell victim to illness..." (p. 120)

Perhaps, participants knew that when they were feeling vulnerable, the presence of very ill or very negative people could decrease their sense of hope and courage, thereby damaging their attitude and potentially harming their psychic and physical state.
Other Findings

A salient factor that emerged for me relates to the phenomenon of connection as being at once a source or cause and an outcome or effect, the combination of which seems to be circular and cyclical in nature. Sometimes it was difficult to tell the difference between experiences that contributed to connection and experiences that were descriptions of what it felt like to be connected. For instance, participants who described a feeling of belonging to the group as contributing to a sense of connection also described the connection experience, in part, as a feeling of belonging to the group. While this absence of a fixed operational definition for connection may be considered to be one of the limitations of the study, I choose to view it as an indication that connection is probably not a linear experience. People come into the group with needs and hopes. Some of these needs are for healing and for connection with others. These same people are particularly open to having these needs met because they are vulnerable and feel isolated. They are, however, willing and proactive enough to come to a group to try and have these needs met. This combination then results in their needs for connection and healing being met. Further to this, their needs having been met increases the opportunity for their needs to continue to be met. In other words, the moments of connection and healing in the group continue to foster more connection and more healing. In this way, an ongoing need for connection is fulfilled by ongoing experiences of connection. It is not unlike the building of intimacy that occurs over time as relationships deepen. Perhaps, the process occurs more quickly for people with cancer because the need is greater and the time is perceived to be
shorter. This is seen in crisis situations, where, for instance, neighbours who share an experience like a hurricane, rise to the occasion and assist one another quite instantly because the need is so immediate and obvious.

**Implications for Counselling**

Counsellors, therapists and other professionals working in the field of oncology may find this research useful in developing a better understanding of the interpersonal needs of people with cancer, particularly as these needs are met in a group setting. The participants’ reports indicated some of the crucial aspects that both help and hinder productive relationships for people who have cancer. Of particular note is the possibility that people with cancer are especially impoverished in the area of physical warmth, touch and caring. Hugging, therapeutic touch, warm greetings and gentleness were experienced as particularly therapeutic for the participants in this study. The relaxation support group was developed with a consideration of these specific needs. Volunteers trained in Therapeutic Touch, handmade pillow cases, blankets and eye covers; and a warm, caring approach to patient contact are all part of the standard format of the sessions. Needs that involve warm and close contact can probably best be met in a group format as the increased sensitivity to the ethical dimensions around physical touch between counsellor and client may prevent this essential need from being met in individual work. Expressions of warmth and care, even when counselling people with cancer individually, however are recommended.

One of the themes that emerged in almost all the categories involves the comfort that participants got from being around other people who are dealing with
cancer. Over and over, participants described sensations of relief, gratitude and friendship as a result of feeling comfortable, understood and emotionally free with other cancer patients and their families or friends. Perhaps one of the tasks of psychosocial oncology is to link people with cancer with other patients and families who have undergone or who are experiencing similar circumstances. This undoubtedly would involve an organized and ethical set of standards for making certain that both parties are interested in meeting each other before it is suggested. I have heard of several situations where physicians recommended that a patient get in touch with another patient who the physician knew had experienced some similar challenges. On these occasions, the connection was perceived as very helpful. A type of buddy system might be implemented where people who are post-treatment and willing to assist someone newly diagnosed can sign up to volunteer. Again, restrictions due to boundaries of confidentiality may make it difficult for a counsellor to link up two specific individuals. At the very least, however, counsellors should encourage their clients to reach out to groups or to other individuals they know who have cancer so that they can make that important connection.

Counsellors who have an interest in the existential realm of psychotherapeutic group work may also benefit from the information gleaned from the study. The results showed that dealing head on with isolation, suffering and meaning were important factors in the participants’ experiencing the group as beneficial. This may imply that counsellors can feel more comfortable incorporating those sensitive topics in a direct way into their work. When counselling people with serious illness, it may be
important to be direct about clients’ perceptions of death, isolation and suffering. While it can be valuable to follow the lead with clients on these sensitive subjects, some patients may need an ‘invitation’ to talk about mortality with their counsellor because it is probably a taboo subject for the client in their family/social network. The results of this and other studies indicate that people with cancer are often very open to discussing mortality issues, and that they find these discussions to be helpful in developing coping mechanisms for their fears around pain and death.

Working with existential issues individually or in a group context demands a high level of personal and emotional awareness on the part of the counsellor or facilitator. The results of this study indicate, also, that group participants rely on the warmth, trustworthiness and care of the facilitator for the establishment of warmth, trustworthiness and care in the group itself. I believe that it is essential that counsellors who work in the field of psychosocial oncology devote a generous amount of attention to their own feelings and perceptions around existential issues, as well as their personal experiences involving death and loss. This may include personal counselling, supervision, journalling, autobiography and any other methods that encourage self-awareness and self-care. The work is draining, and I believe that a counsellor working in cancer care who has unresolved grief or loss issues will quickly ‘burn-out’ or inhibit their clients from exploring the full dimensions of their own suffering or pain.

The results also showed the importance that participants placed on laughter and pleasurable experiences shared with other group members. The shared experience of
laughter and joy seemed to deepen a feeling of connection to the group. It does not strike me as unusual that participants felt that a combination of attention to both issues of suffering and issues of rejoicing was experienced as gratifying. This is exemplified in Bertrand Russell’s adage: *Laughter does not cease to be important when someone is dying anymore than crying ceases to be important when someone is living.* Perhaps, counselling in cancer care should exercise a healthy combination of the two.

The results of my study also suggest that a fundamental humanistic approach to psychosocial oncology group work is effective. My personal and professional philosophies in this vein are as one. The basic principles of respect, trustworthiness, listening and caring lie at the root of how I wish to conduct myself clinically and personally. It can be hard enough to maintain these ethics in everyday life. Perhaps it is even more difficult to do these things when the person we are interacting with has a serious, life threatening illness that we know can happen to anyone at any time. So many people come to counselling and to their friends with problems of being isolated, lonely, misunderstood or treated poorly by others. I know that these same difficulties plague those with cancer, and often do so to a devastating extent. One of the tragedies is that when people have cancer, their need for connection is increased while their opportunity to obtain connection is frequently decreased.

Rollo May (1953) posited that the self is derived from relating to others. He suggests that isolation leads to the fear of the loss of self. I could see elements of this fear in the participants’ descriptions of the enormous relief and gratitude they
experienced as a result of feeling united with people who understood, empathized with and related to their experience. In a related study, Gray, Fitch and Phillips (1997) explain that participants reported the sharing of experiences and bonding with other women to be the core benefits of participating in a group for women with breast cancer. May contends that a diminishment in feelings of isolation is the single most important goal in counselling. The results of this study and the repetition of themes that focused on relating, understanding and caring in personal interactions may suggest that in part, a Rogerian approach to counselling would be effective. Qualities like empathy, trust and unconditional positive regard seem particularly significant when working with vulnerable individuals such as those with serious illness.

**Implications for Future Research**

The results of this study suggest that future research in the field of oncology group work is needed to elaborate upon the ways in which group leaders can facilitate the presence of connecting experiences such as those outlined in the categories. The categories serve as useful descriptors but do not necessarily offer explicit techniques. This kind of work would probably combine theory and practice, and could be useful for the field of psychosocial oncology. For instance, some of the categories suggest helpful group characteristics that are not well researched. This includes: a need for cancer patients to be helpful and useful to others; the benefit of listening to other people’s stories without commenting on them; the factors that contribute to a facilitator being perceived as trustworthy and caring; the benefits or positive aspects of a cancer diagnosis; and the benefits of group members nurturing and developing their relationships outside of group sessions.
In my opinion, research is definitely needed regarding the experience of open groups that entail personal involvement from patients, caregivers, volunteers and facilitators. This study focused on the patient experience but the group that was studied is very much influenced by the presence of both people with cancer and their families and friends. Additionally, future research on the impact of therapeutic touch (T.T.) for people with cancer would seem appropriate. This is due to the strong corroboration from participants about the value that T.T. had in their group experience.

The participant-observer approach to research is something that also deserves more attention. I found the experience to be both ethically challenging and enriching. I believe that a person unfamiliar with the participants might not have been able to achieve the richness of the reports in the interviews. I also believe that my experience with groups afforded me better comprehension of the material. I did worry, however, that the participants wished to please me and was glad when they felt comfortable in relating negative or disappointing aspects of the group or the group leadership. I propose that an excellent methodological research team might consist of a participant observer and an objective expert paired up for optimum comprehension and dependability.

Finally, a different kind of research or data collection approach is required to get a better picture of the experiences that detract from connection and group satisfaction. This study called upon participants who continued to attend the group so they clearly were experiencing some benefit from attending. In my years of running the groups, I have seen a number of people attend only once and not return. As well, the group has been described and recommended to many others who never attend. While I have some theories about the reasons why people discontinue attending or
never attend at all, it would seem quite important to discover these things from the people who experienced it themselves.

**Limitations to the Study**

One of the main difficulties I experienced throughout the study was my decision to include only those individuals who actually had or have cancer. I believe that the healing nature of the relaxation group's culture results from the joint involvement of people with cancer, family members, friends, caregivers, volunteers and facilitators. The group simply would not be the same without this constellation of people. As a result, by looking only at the experience of the people with cancer, a complete picture of the group experience was not drawn.

Another obvious limitation of the study is the fact that I facilitated the group as well as conducted the research and the interviews with group participants. While I believe this also functions as one of the strengths of the study, it does present a very subjective, individual viewpoint of this group. Researcher bias is present in this study, but the biases have hopefully been made explicit. It is true, however, that another researcher working with the same participants, or for that matter, working with the same data, may have arrived at different categories and different interpretations.

Finally, there exists a limitation because the participants in the study volunteered to participate, and therefore may neither represent shy group members nor those who have not experienced a feeling of connection in the group.
Conclusion

It is my hope that the results of this explorative study will contribute meaningful and practical additions to the body of psychosocial oncology literature. I have deep beliefs in the power of interpersonal caring and sharing as well as the usefulness of bringing relaxation, music and touch into group work. What is most clear to me is the natural ability and expertise that people with cancer have to help one another. It is the group members themselves who do the work that is most therapeutic. As a group leader and clinician, I believe that one of my primary responsibilities is to facilitate participants in finding a balance between supporting, caring and comforting one another and bringing these same gifts to themselves. I sincerely hope that this project will bring a sense of increased respect to the healing nature that exists amongst people with cancer and their families and friends.
References


Appendix A

Relaxation and Support Program

Statement of vision

All people affected by cancer will have the opportunity to be proactive in their healing process through the experience of relaxation, music, imagery and touch in a supportive and hopeful environment.

Program Delivery

Equipment: Spacious room which is quiet and relatively warm with doors that can close
CD/Cassette player
Relaxation music recordings (classical, nature, etc.)
Guitar/Piano
Chairs
Mats for lying down (and recliner chairs if possible)
Blankets and Pillows (handmade by local community agencies)
Leg bolsters
Woolen sockettes and Eye coverings (handmade by local agencies)
Pitcher of water and disposable cups
Box of tissues
Scented candles and dried/fresh flowers (optional)

Staffing: One music therapist and one social worker or counsellor trained in guided relaxation, group dynamics & therapeutic touch:
Facilitators One (or more depending on the size of group) volunteer trained in therapeutic touch.

Format: 2 hour session

A. Set-Up: Chairs are set up in a circle for initial part of session. Mats, pillows, blankets, sockettes are brought into the room in preparation for the relaxation component. Fresh water, sockettes and tissues are placed in the centre of the circle for participants to help themselves.

B. Introduction: Facilitator gives brief explanation of the relaxation response, general benefits of support group and relaxation, and a description of the format of the
session. Participants are invited to remove their shoes and choose a pair of sockettes to wear.

Facilitator asks a volunteer to briefly describe the method and rationale of the gentle touch (leg stroking) offered to enhance the relaxation experience. Participants are reminded that the touch component is optional. Facilitator invites the participants to introduce themselves one by one around the circle. Each person is asked to say their name, but are assured that any more information is optional and confidential. Typical sharing includes: personal circumstances which brought the person to the group, i.e.: diagnosis, treatment, fears and concerns; family member’s situation; personal preferences regarding significant images and/or music to be included in the session; what the individual needs out of the program/group. Facilitator or participant response to personal sharing is not encouraged. The introductions are characterized as a witnessing time. Sometimes when a participant is visibly upset, tissues are brought to them and their situation is briefly addressed. Individual contact and/or referral to counselling is addressed privately between the facilitator and participant after the session. Participants are given the time they require to introduce themselves. Introductions are completed with a summarizing statement by the facilitator.

C. Relaxation Component: Volunteers, staff and participants assist (as per physical ability) in moving the chairs to the sides of the room, and setting up the mats on the floor. Mats are placed next to each other or in the shape of a circle, always with enough room at the foot of the mat for a volunteer to sit down and provide gentle touch on the feet. Upon each mat and/or recliner is placed: one bolster, one pillow, 2 small blankets. Participants lie down on mats or on a chair if it is too difficult to lie down or if they are receiving treatment. Volunteers assist participants in getting comfortable, covering them with blankets, offering eye coverings, etc. Lights are dimmed and relaxation music recording begins play.

The facilitator leads the group in a guided relaxation which begins with suggestions for increased comfort; reminders that mistakes can’t be made; and an initial focus on relaxation breathing. A combination of autogenic and progressive muscle relaxation can be used to attend to different styles of relaxation. After the first five minutes of guided relaxation, the volunteers move toward the participants and provide gentle touch (usually leg stroking, but also may include brow stroking). Depending on the number of participants, each is allotted equal time for touch.

Following the initial relaxation exercise, the facilitator moves into guided imagery and visualization, incorporating suggestions from the participants in the opening circle and drawing together themes that were brought up during the introductions. The imagery is followed by a few minutes of silence, as well as positive affirmations repeated several times by the facilitators. The relaxation component is followed by ten to fifteen minutes of soothing live music, which may combine voice, guitar, gong, piano.
A five to ten minute guided closing and return is essential. Participants are 'brought back' from their relaxed or altered state slowly, using imagery, breathing and stretching exercises. Ample time is then given for people to open their eyes and sit up when they feel ready.

D. Closing Circle: A twenty minute de-briefing time is given for participants to share any significant aspect of the relaxation session. The session is completed with a closing circle. Participants stand and hold hands in a circle and are guided by the facilitator to squeeze the hand on their right, sending a 'little sense of hope or wisdom from themselves' around to each person, and congruently, receiving 'a little sense of hope or wisdom from each person' in through their left hand. Participants are asked to say aloud the name(s) of any person(s) who need some healing, blessings, or attention. This circle lasts a few minutes and heralds in the end of the session.

Often, some of the participants go off following the group to have coffee or lunch together, and are encouraged to use this time to talk further about questions that arose during the introduction stage.

The group is a drop-in format so attendance is not taken. If there is some news about a regular participant who is absent from the group, participants are encouraged to let the facilitator know beforehand and the information is shared with the group where appropriate. A short moment of silence or tribute is generally given to honour a group member who has died.
Appendix B

Recruitment / Information Notice for the Study

A RESEARCH PROJECT EXPLORING:

THE EXPERIENCE OF CONNECTION IN

RELAXATION SUPPORT GROUPS

FOR PEOPLE WITH CANCER

The purpose of this study is to develop an understanding of the connections that participants make with each other in the relaxation support group. I am interested in talking to people who have attended the relaxation group at the Agency who would be willing to discuss their experience as a member of the group.

IF YOU:

- have attended the relaxation program at the Agency at least 5 times in the last two years;
- are a person who has cancer or has been treated for cancer;
- would be willing to talk about your experience as a member of the relaxation group

THEN PLEASE ATTEND THE FOLLOWING INFORMATION MEETING ON TUESDAY, JANUARY 25TH OR THURSDAY, JANUARY 27TH FROM 12:30 – 1:00 PM TO FIND OUT MORE....

This master’s thesis research is being conducted under the supervision of Dr. Beth Haverkamp, Dept. of Counselling Psychology at U.B.C.

Participation in this study will include two audio-taped interviews of approximately one hour in length each.

Participation in this study will be completely confidential.

If you would like further information about this research study, please contact Patricia Nitkin at 822-4919 (UBC) or Dr. Beth Haverkamp at 822-5259 at UBC’s Department of Counselling Psychology.

Thank you for your interest
Appendix C

Project Description: Information Meeting for Individuals Interested in the Study

The following was read aloud by me at the information meeting:

Thank you for your interest in this research project. Because I know all of you, I want to begin by stating some very important things. It is not common that someone does research on a program that they run themselves. (This is a newer approach to research that demands very high ethics because I certainly can’t be objective about the group, since I’m intimately involved with all of you.) Please know that your participation in this study is in no way related to your participation in the relaxation group. My commitment to providing the best possible service for you as facilitator of the relaxation group is first and foremost. Whether or not you would like to participate in this study is entirely your choice, and it is most important that you know that I honour and respect whatever choice you feel is best for you. There will be absolutely no prejudice or judgment made should you choose not to participate.

For the past 7 years, I have been running relaxation support groups, both here at the Agency, and at Lions Gate Hospital. I have always been struck by the powerful relationships and connections that people make while participating in this group. It has always been an honour to be a part of these groups, and I find myself very interested in what makes the group ‘tick’. Now that I am completing a master’s degree in counselling psychology, I wanted to pursue my interest in this area through my research project.

I believe that you can help me develop a better understanding of how people make connections, don’t make connections and generally relate to the group. It is my hope that a better understanding of these things will contribute to groups and interventions that better assist individuals who have cancer.

Participation in this study would entail 2 one-hour interviews that would be audi-taped and transcribed in writing. The interviews would be held in a place of your choice and would be completely confidential. Information would be discussed only with my thesis supervisor, Dr. Beth Haverkamp. The first interview would be a discussion about your experiences in the group, and the second would be asking you to check the analyses and interpretations I have made from the information that all the participants provided. The information would be presented in categories of common themes that people brought up in their discussions, but would have no identifying information whatsoever.

If you decide you want to participate in the study, and then change your mind at any point in the process, you can withdraw your participation without explanation. The conduct of this research is under the auspices of both UBC and the Agency.

Please take some time to think about the project and whether or not you might be interested. If you would like to know more, you can call me or my supervisor at UBC at the following numbers

Patricia Nitkin: 822-4919 Dr. Beth Haverkamp: 822-5259

DOES ANYONE HAVE ANY QUESTIONS?......
Appendix D

Orienting Statement for Individual Interview

The following was read aloud at the beginning of the interview, and was followed by signing of the informed consent form.

As I explained in the information meeting, I want to remind you that anything we discuss here is completely separate and apart from the groups that you attend for relaxation, and if at any time, you don't feel comfortable participating in the project, just let me know, and you can withdraw without having to explain. Also, there is no obligation to discuss any questions or subjects that you don't feel comfortable talking about. Please keep me informed about this if anything comes up for you.

The purpose of this research is to find out about the connections that people make in the relaxation group. In the study, I have defined connection as: “any experience which unites or links two or more individuals in a way that provides validation and affirmation for their sense of self as well as their experience of cancer”. The definition of connection may be different for you, and I would like to understand what the notion of connection means to you. I am interested in learning about your experience of feeling connected to the group, to some person or persons in the group. This sense of connection may have been at any point in the relaxation session and may involve another group member, a volunteer, a facilitator or the group in general. I’d like to understand why you felt connected and what specifically happened that brought this sense of connection to you. I also would like to understand about experiences where you didn’t feel connected to anyone, or when someone did or said something that actually made you feel disconnected from them or from the group. During the interview I will be asking you questions and may ask you for more information or clarification about something you have said so that I feel sure that I understand your experience.

Please take all the time you need to respond to questions, and please speak as freely as you wish about anything relating to your experience in the group. Do you understand what I’m hoping to learn from you? Do you have any questions before we begin?

The first step we need to take is to read and both sign an informed consent form to assure that you understand the details of your participation, and your rights as a participant.
Appendix E

Participant Informed Consent Form

What are the significant incidents that contribute to an experience of connection for participants in relaxation support group for people with cancer?

Principal Researcher: Patricia Nitkin (Tel: 822-4919)

Faculty Advisor: Department of Education and Counselling Psychology
Dr. Beth Haverkamp (Tel: 822-5259)

This research is being conducted by Patricia Nitkin as one of the requirements for a Master of Arts Degree in Counselling Psychology and is supervised by Dr. Beth Haverkamp. This study examines the experience of connection for participants in relaxation support groups for people with cancer.

The researcher will meet with you individually on two occasions for a total of approximately 2-3 hours in order to document your experience of feeling connected or not connected to members in the relaxation support group. The second interview will be in order for you to check on the development of the report and share any concerns, questions, additions or deletions before the report is completed. The data that will be reported involves descriptions of experiences and events categorized by theme.

The interviews will be audio-taped and transcribed, but the identity of each participant will be kept confidential. No one, except myself and Dr. Haverkamp will have access to the tapes or transcripts, and they will be destroyed and/or erased within 5 years. Any personal references or identifying information will not be included in the final report. Each participant will receive a summary of the report upon completion. Copies of the report will also be provided to the Agency.

Your participation in this research is voluntary. If at any time, you wish to withdraw from participation in the research, you have the right to do so without prejudice of any kind. You also have the right to refuse to answer any question asked.

If any aspect of this research or your involvement remains unclear, or if you have questions about the study, you may contact myself or Dr. Haverkamp at any time. If you have concerns about your treatment or rights as a research participant, you may contact the Director of Research Services at UBC, Dr. Richard Spratley, at 822-8598, or the Director of Patient & Family Counselling at the Agency.

I understand that my participation in this research is entirely voluntary and that I may refuse to participate, or withdraw from the study at any time. I have received a copy of this consent for my personal records.

Signature of Participant: ___________________________ Date: _________________________
Signature of Researcher: _________________________ Date: _________________________
Appendix F

Biographical Information Sheet

Age:

Sex:

Occupation:

Type of cancer:

In treatment or
Post treatment:

Nationality:

Married / Single / Divorced:

Children?:

Religion:
Appendix G

Interview Questions

Highlighted questions were utilized in each interview.

Please focus on your experiences in the relaxation group... Think of a time when you felt really connected (disconnected or less connected) to the group or to someone in the relaxation group....

What were the general circumstances leading up to this experience?

Tell me exactly what this person did that made you feel connected/disconnected?

When I say "connected" and "disconnected, what do the terms mean to you?

What role does connection in the group have for you?

OPTIONAL / ADDITIONAL QUESTIONS

Did you experience a sense of feeling connected to another person in the group or to the group itself at any time during your attendance?

What helped or hindered this sense of connection?

What did someone do, or say that made you feel connected/not connected in the group?

What happened to make you feel connected/not connected in the group?

What subjects that were touched upon or discussed that made you feel a sense of connection/disconnection with another group member or within the group?

What does being connected feel like?

What does being disconnected feel like?

When did you feel most connected with another member or with the group?

When did you feel most unconnected with another member or with the group?

What have been the most meaningful/significant aspects of the group for you?

What else would you like to tell me about connections in the group?
Certificate of Approval

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CERTIFICATION:

The protocol describing the above-named project has been reviewed by the Committee and the experimental procedures were found to be acceptable on ethical grounds for research involving human subjects.

Approval of the Behavioural Research Ethics Board by one of:
Dr. I. Franks, Associate Chair
Dr. R. Johnston, Associate Chair
Dr. R. D. Spratley, Director, Research Services

This Certificate of Approval is valid for the above term provided there is no change in the experimental procedures.