Group Therapy for Patients With Medical Illness

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This article aims to review the expanding role of group psychotherapy in the treatment of individuals with medical illnesses, an area that has expanded dramatically during the past 30 years. The fundamental principles of adaptation of group therapies for specialized clinical populations are articulated. Clarity of goals and thoughtful alignment with patient interests and needs are at the heart of building a strong therapeutic alliance and potentiate the effectiveness of group therapy. This article also discusses the conceptual underpinnings of group therapies and the ways in which group therapeutic factors gain expression with these clinical populations. This article also focuses on breast cancer, in light of its clinical prominence and the development of group therapies for individuals with the disease. These therapies address clinical concerns for women along the continuum of the disease, including familial and genetic predisposition, primary breast cancer, adaptation to illness and its treatment, metastatic disease, and dealing with mortal illness.

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Contemporary health care is moving toward greater integration of medical and psychological care, recognizing the likely co-occurrence of both dimensions of illness and the compounding effect this has on patients. Clinical work has accordingly expanded, building upon the early roots of group therapy for individuals with cancer, HIV, or AIDS. The presence of medical illness does not reflect psychological homogeneity; not all patients who have medical illness are psychologically distressed. It is therefore most relevant to focus group interventions on those who experience higher levels of psychological distress and to create a range of treatment options tailored to patient need (1). Moreover, there is growing appreciation of the need to modify group interventions to be culturally adaptive to ensure that groups are sensitive to, and inclusive of, the needs of patients of diverse racial-ethnic backgrounds.

SCOPE OF GROUP THERAPY

Group therapy methods have proved useful in many different clinical contexts. Groups may meet both face-to-face and online. The COVID-19 pandemic has fueled utilization of online group therapy options, with synchronous, interactive group interventions as well as asynchronous groups, which operate like chat groups. Group therapies aim to provide information, psychoeducation, support, and opportunities for self-expression. This type of clinical work can be expected to grow in light of the evidence of its effectiveness. Growing patient awareness and interest and the potential to reduce allied health care costs (2) are also important drivers. Psychological care has moved from peripheral and adjunctive considerations to a position of centrality in integrative care.

Breast cancer is an exemplary focus because of its clinical prominence. Breast cancer is the most common cancer among women, with 268,600 new cases in the United States in 2018 (3). One in nine women in North America will be diagnosed with breast cancer during their lifetime, and the clinical concerns surrounding breast cancer can progress from genetic or familial predisposition to primary breast cancer, adaptation to illness, and potentially reconstructive surgery, to the existential confrontations that individuals with metastatic breast cancer face. Notably, the original work on the survival benefits of group therapy for women with metastatic breast cancer published by Spiegel and colleagues (4) 30 years ago sparked a significant advance in interest in group therapy for those with medical illness. Practitioners were encouraged

HIGHLIGHTS

- The use of group therapies for patients with medical illnesses has expanded greatly over the past 30 years.
- Group therapies are effective in improving patient coping and adaptation, reducing psychological distress, and increasing social support and social integration.
- Effecting a good fit between patient and group demands thoughtful attention to patient needs, stage of illness, and group therapeutic mechanisms.

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that psychological care could not only improve quality of life but also potentially prolong life.

A comprehensive review of the entire field of group therapy for patients with medical illness is beyond this article's scope, but a brief survey of some clinical applications with proven and statistically significant impact, as noted by the American Group Psychotherapy Association, may be illustrative (5). For example, group therapy has demonstrated the following: improved pain ratings, psychological distress, and quality of life among patients with irritable bowel syndrome (6); improved pain management, mood, and functional impairment among patients with chronic pain (7); improved clinical and patient-reported outcomes and significantly reduced glycated hemoglobin among primary care patients with diabetes (8); and improved pain, self-care, self-efficacy, psychological distress, and quality of life among patients with chronic medical illnesses (9).

In addition, 20% of patients present to family physicians with unexplained medical symptoms, causing significant distress to patients and frustration to care providers. Collaborative care, delivered through a brief integrative group intervention by psychosomatic specialists linked with primary care physicians, has shown significant impact with regard to reducing health anxiety, psychological distress, health care visits and associated costs, and improved health-related quality of life (10). Group therapy has been shown to improve psychosocial functioning and well-being of men with HIV in diverse cultural settings (11), and supportive-expressive and coping-focused group therapy, delivered by phone to older adults with HIV, has demonstrated significant improvements in treating depression (12).

Meaning-centered group psychotherapy has significantly improved the sense of personal meaning in life, personal effectiveness, and psychological well-being among patients with cancer (13), and participation in a brief group intervention using expressive guided imagery (14) has demonstrated significant reduction in body image concerns and breast cancer worry among participants.

A narrative approach to group therapy delivered through the Internet has also illustrated the benefit of asynchronous groups for adult survivors of pediatric cancers, where outcomes included reduced posttraumatic stress symptoms and anxiety and reduced fear of cancer recurrence (15). In particular, Internet and telepsychiatry groups may, importantly, be accessible for those who are too unwell to travel or who live long distances from psychological care (16).

ADAPTATION OF GROUP THERAPY FOR PATIENTS WITH MEDICAL ILLNESS

Yalom and Leszcz (17) articulated five key principles in adapting group therapy for specialized clinical populations: assess the unique clinical situation, formulate appropriate clinical goals, modify techniques to fit the clinical situation and related clinical goals, evaluate the effectiveness of the model, and plan for the next iteration. Clarity of goals increases the therapy's effectiveness by strengthening engagement with patients, making them informed collaborators in the therapeutic process. It is at the heart of building a strong therapeutic alliance (18).

Two more considerations are important for group therapists working with patients with a medical illness. Group leaders must be familiar with the clinical condition and the special problems faced by patients with that illness. Group therapists must immerse themselves in the specific clinical area to understand the unique problems patients face. Second, regardless of the format of the group or the degree of structure used in the group, therapist understanding of core group therapy processes and group therapy leadership skills is essential; this understanding will have a significant impact on the effectiveness of the group therapy (19). The recent determination by the American Psychological Association (20) that group therapy is a specialty with requisite training and clinical practice standards, underscores these principles.

Groups for the self-management of chronic medical conditions may be heterogeneously composed (21) or may consist of patients with the same medical condition. Groups address the gamut of major medical illnesses, including cancer, cardiac disease, renal disease, Parkinson's disease, obesity, lupus, inflammatory bowel disease, transplantation, diabetes, HIV and/or AIDS, and somatization disorder (4, 6, 8, 9, 22–27). Groups may be open-ended for those with chronic and life-threatening illness or, more typically, may be limited to four to 20 sessions. The group is typically used as a setting to deliver the intervention, rather than as an agent for deep personal change, as is the case for traditional group therapy. Groups for patients with medical illness de-emphasize interpersonal processes or here-and-now work. Instead, the group's focus is on coping and enhancing quality of life where possible.

A useful way to conceptualize group interventions for patients with medical illness builds upon Folkman and Greer's (28) tripartite model of coping: emotion-based coping, problem-based coping, and meaning-based coping. Virtually all groups for patients with medical illness emphasize one or more of these coping paradigms. These three dimensions gain expression in supportive-expressive group therapy, cognitive-existential group therapy, cognitive-behavioral group therapy, psychoeducational groups, and self-management groups. A review of the literature demonstrates that, regardless of the type of group intervention, many groups integrate aspects of these coping paradigms (29). Group leaders must understand the needs of their patients to direct them to the kind of group that best fits their particular stage of care. Within this broad range, many patients early in their illness trajectory will benefit from groups that provide support and psychoeducation about the

illness and promote self-efficacy and coping. Patients at later stages of their illness trajectory may require more in-depth therapy to address existential concerns and adaptation to mortal illness.

Problem-focused coping emphasizes provision of information, psychoeducation, learning about the meaning of medical symptoms, how to be an effective advocate, and how to enhance self-care. Such coping may involve a focus on exercise, diet, sleep, and the role of relaxation, mindfulness, or visualization in reducing stress. Coupled with these topics is information on the hazards of maladaptive coping strategies.

Emotion-focused coping aims to improve patient social support and social integration and encourages emotional ventilation and reduced suppression of affect. This focus may involve encouraging self-disclosure, talking and grieving, and reducing the tentativeness in communication that often compounds isolation for those with medical illness. Emotion-focused coping enhances patients' emotional literacy and expressiveness. It encourages acceptance and normalization of vulnerability that counters disavowal of emotion and denial of the need for support (30).

When emotion-focused and problem-focused coping prove insufficient, meaning-focused coping becomes key. The group therapy incorporates existential awareness of life's limits and confrontation with one's mortality, supports spirituality where possible, and helps patients reframe and reprioritize their use of time and energy in the face of evident limitations. An important element in meaning-focused coping is helping individuals live their lives in ways that reduce avoidable regrets and adds meaning to their personal experience.

There has also been a dramatic increase in the use of group visits for the integrated medical and psychological treatment of clients with a range of chronic medical illnesses (31). Often held in primary care practices, ideally co-led by a primary care practitioner and a mental health professional, these groups help support patients who experience significant psychosocial challenges in addition to their chronic medical illness (32). Group medical visits provide peer support, education, and coping skills in a cost-efficient way that improves both medical and psychological outcomes. Despite the assumption that patients prefer one-on-one care, these groups provide greater time in care and are highly valued by patients. Areas of outcome that have been studied have included health-related quality of life, depression, anxiety, traumatic stress symptoms, general levels of stress, and adherence to medical treatment (i.e., the capacity to complete the prescribed course of treatment and enhance self-care. Consistently positive findings have been reported.

A focus on self-efficacy is an economical way of understanding the key ingredient of all therapy groups for patients with medical illnesses. These groups promote members' capacity to engage adversity actively and constructively, marshaling external and internal resources to restore a sense of personal effectiveness. Additionally, group work promotes self-efficacy by helping patients make meaning when faced with the inexorable decline in function caused by severe illness and mortal threats. The group supports the individual's sense of self in the face of an illness that challenges one's sense of self, identity, and capacity to manage one's life.

Groups address the psychological distress many patients with medical illness experience. Depression, anxiety, and stress reactions are common and may amplify the impact of the medical illness, increasing the risk of progression of the illness or the risk of another episode, for example, post–heart attack (33). Psychological stress also tends to increase health-compromising behaviors, such as alcohol use and smoking, and interferes with adherence to recovery regimens of diet, exercise, medications, and other forms of healthy stress reduction (34).

Medical advances have introduced another layer of psychological need. This is evident on two fronts. First, many formerly fatal illnesses are now manageable as long-term chronic illnesses. These lifesaving outcomes, however, may generate worry about recurrence or the need to adapt to body- or life-altering treatments and surgeries (35). Advances in genetic screening have similarly created opportunities for earlier detection, although these are accompanied by the stress of knowing one's risk for developing serious illness, such as cancer or progressive neurological disorders (36). Individuals may require assistance in managing the impact of this genetic information, evaluating their risk, and determining which prophylactic treatments may be indicated. For example, a young woman with a genetic predisposition to breast cancer may face questions about prophylactic mastectomy, marriage, children, and sharing the information with family members who may prefer not to know it. Identification with one's mother or sister, who may have died from the illness, may emerge as a component of grief that complicates risk assessment. Individuals may overestimate their risk and suffer significant emotional distress as a result. Group therapy can modify one's sense of a foreshortened life and reduce psychological distress and anxiety (37).

Many illnesses also carry significant psychological stigma associated with feelings of shame that produce social withdrawal and avoidance. This response is particularly concerning because those with medical illness often benefit from greater social engagement. Social integration can preserve both health and longevity of life (11, 29, 38).

Severe medical illness also can generate social isolation through pressure for positive thinking, which in turn can generate tentativeness in communication as family and patient each seek to protect one another from directly acknowledging the impact of serious illness (39). Groups may help their members to become more open with their loved ones and to become better advocates with their health care providers. Collaborative, assertive communication is generally associated with greater well-being and better decision making. One group member's reminder to another—"Tell your doctor that you know she is busy, but if she can give you 5 more minutes of time right now to answer your questions, she may provide you with a month's peace of mind"—is a simple but powerful peer-to-peer intervention shown to be effective (40).

THERAPEUTIC FACTORS IN GROUPS FOR PATIENTS WITH MEDICAL ILLNESS

Overall, although the hallmarks of traditional group psychotherapy with regard to interpersonal learning and self-understanding are much less prominent among group therapies for patients with medical illness, other factors of group therapy continue to be important. The concept of universality diminishes participants' sense of isolation and stigma. Group cohesiveness directly provides a sense of belonging and social support. As is often the case in groups for people with medical illness, and unlike traditional psychotherapy groups, social and practical support can extend outside of the group itself. The experience of self-disclosure of previously unexpressed and unstated fears and concerns can generate relief and connection with group members. Accessing reliable, evidence-based information can reduce anxiety and promote a sense of knowledge-supported competence in an overwhelming environment. Group members can often learn coping skills more effectively from their peers rather than from experts (41). Modeling and constructive identification among group members are prominent. Hope, which is flexible and takes different forms at the various stages of illness (17), can be instilled through the experience of seeing how others manage with the illness. Initially, one may hope for cure; then for the courage to confront and engage the illness; then for dignity in the face of illness; then for comfort in the face of progression; and then for care, companionship, and peace of mind in the face of decline. Hope is also augmented by the group therapeutic factor of altruism as group members see the value they can bring to other members. They gain a sense of heartening usefulness through their support of one another. The focus on existential factors is also prominent as members are supported in confronting the fundamental anxieties of facing death, as well as personal responsibility, meaning, and isolation (42). Medical illness confronts us all with our fundamental vulnerability and the existential challenges of living life knowing that we are mortal. One's sense of invulnerability has been pierced by the diagnosis and treatment of an illness. Groups can provide the requisite support needed to confront this challenge.

SUPPORTIVE-EXPRESSIVE GROUP THERAPY

Many of these elements of group psychotherapy are integrated into a model known as supportive-expressive group therapy (SEGT). First developed by David Spiegel (43) and Irvin Yalom to treat individuals with metastatic breast cancer, SEGT has been manualized and widely used across the range of illness and clinical focus that cancer generates. It is a prototype of the integrative group therapy models noted earlier. SEGT has been used by individuals with metastatic breast cancer, primary breast cancer, genetic and familial predisposition to breast cancer, and other illnesses. In forming groups, the therapist should take care to respect the impact of diagnostic heterogeneity within these clinical populations to improve outcomes; introducing a woman with advanced disease into a group of women with primary breast cancer can generate exclusion of the woman with more severe illness, who may represent the other members' deepest fears (17).

The SEGT model has eight main foci, or goals (42). The first focus is to address the medical status and treatment issues (provision of information about the illness and its treatment, management of side effects, and understanding of treatment options). The second focus concerns illness-related coping skills (encouraging active coping to confront illness-related stress and to maximize one's sense of control with regard to the illness and its treatment). The expression of negative feelings and articulation of realistic expectations and hopes are important components of these skills. The third focus is on family and social network communication (reducing tentativeness in communication and enhancing the patient's capacity to speak openly with family and other members of the social network to reduce isolation and possibly reduce a sense of stigma). Members of the group evolve to become care receivers who guide their families with wisdom, rather than with physical action that may be harder to generate. Addressing feelings of guilt and burden caused by one's illness and reduced capacity are important components of this focus. The fourth focus is on the collaborative provider-patient relationship (supporting open communication with one's health care providers, reducing fear and confusion, and asking for realistic support and guidance).

The fifth goal is a reprioritization of life values (existential confrontation with limits in life and how to make meaning in the face of this confrontation with mortality). The objective of this reprioritizing is to help individuals live life in the present and to reduce feelings of regret about things left unsaid or undone before one's death. Those facing more serious and life-threatening illness often use this opportunity to reflect deeply on their life choices and address any unfinished business. The sixth goal concerns self-image (addressing self-image and body image and the related impact on self-worth that emerges from the illness and its treatment). Visualization and body image work may be incorporated (14). The seventh goal of the group therapy is to address death and fears about death and dying. This element is often the most difficult component of the group work but also may be its most important, as members reduce the denial of their mortality. Members may learn to manage anxiety about death through constructive and supportive confrontation with life's limits. The eighth focus relates to group issues (as noted, these groups do not work in the here and now and do not focus principally on interpersonal interactions, yet they are indeed groups). It is important for the therapist to create strong groups and to develop a sense of group cohesiveness and genuine member engagement. This work ensures that all members of the group participate, and that the group environment is made safe, welcoming, and as inclusive as possible. Therapist understanding and use of group process skills is invaluable, even in these structured groups (44). The capacity to reflect on when, why, and how the proceedings of group therapy unfold is an essential group process skill. The

therapist must also address issues around culture, diversity, and inclusion so that no member feels marginalized (45).

EFFECTIVENESS OF GROUPS FOR WOMEN WITH BREAST CANCER

Outcomes research across the past 30 years has consistently demonstrated the effectiveness of SEGT for women at risk of breast cancer, with primary breast cancer, and with metastatic disease. Our medical colleagues' initial apprehension that existential foci in group discussions would make women feel worse or cause them to withdraw from treatment has been thoroughly refuted (46).

A recent Cochrane review (47) summarized studies with 1,378 women with metastatic breast cancer, showing significant positive psychological effects of group cognitive-behavioral therapy and SEGT (4, 23). The first controlled study of group therapy for women with metastatic breast cancer reported longer survival, but other studies have consistently failed to replicate those first findings. Initial impact on survival may have been the result of the group enhancing social support, reducing isolation for those with limited relationships, promoting health equity, and helping vulnerable individuals to access and maintain adherence to difficult treatment regimens.

Setting aside the controversial question of whether group therapy prolongs life, studies consistently have shown significant positive psychological results: reduced experience of pain, less psychological distress, better quality of life, and even the capacity to grow personally as one faces the trauma of mortal illness. There is little doubt that group therapy for women with breast cancer and other medically ill patients can improve the quality of life for group members (48–50).

CONCLUSIONS

The application of group interventions for patients with medical illnesses has expanded significantly during the past 30 years. This expansion reflects a deepening appreciation for the integration of psychological and medical care across the trajectory of illnesses and a humanizing of care. The science supporting this work is encouraging, and further research will help refine the ability to tailor group interventions to the evolving needs of patients who seek care.

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