DESCRIPTION OF A GROUP COGNITIVE BEHAVIOUR THERAPY PROGRAMME WITH CANCER PATIENTS

SARAH EDELMAN* and ANTONY D. KIDMAN
Psycho-oncology Unit, University of Technology, Sydney, NSW 2065, Australia

SUMMARY
Cognitive Behaviour Therapy (CBT) has already been shown to be highly effective in the treatment of various psychological disorders within mental health populations; however, it has not been widely tested in the treatment of cancer patients. In the last decade there has been growing interest in the application of CBT interventions within psycho-oncology, and some studies have reported on its efficacy, both with individuals and in group-therapy contexts. To date there have been few descriptions of how a CBT programme for cancer patient groups can be structured and delivered. We present a description of a 12-session CBT programme that has been developed by our centre, for delivery to cancer patient groups. Copyright © 1999 John Wiley & Sons, Ltd.

INTRODUCTION
A diagnosis of cancer is a major and catastrophic life event for most individuals. Several studies have documented moderate to high levels of psychological morbidity amongst various patient groups (Lehmann et al., 1978; Derogatis et al., 1983; Greer et al., 1992; Zabora et al., 1997). In the last three decades, as medical advances have enabled cancer patients to live longer, or in some cases to be cured, increasing attention has focused on patients’ emotional state and quality of life. As a result, psychological interventions aimed at helping patients to better cope with the emotional aspects of the disease have been developed.

Studies have examined the effects of different types of psychological intervention on the mood and quality of life of patients, and have found varying outcome (Andersen, 1992; Trijsburg et al., 1992). There is some evidence that structured interventions which focus on the acquisition of specific skills achieve better results than unstructured ‘supportive’ interventions (Jacobs et al., 1983; Telch and Telch, 1986; Cunningham and Tocco, 1989); however, this is not clearly established, as few interventions that focus primarily on group support have been quantitatively assessed.

It has been noted that therapy delivered in a group format has become particularly popular in recent years (Krupnick et al., 1993). Groups have the advantage of being more cost-effective than individual therapy, and can also confer additional benefits in the form of peer support, diminished stigma and reduced social isolation. Groups also facilitate the sharing of information, and enable participants to learn adaptive attitudes and coping strategies from the better functioning members of the group (Spiegel, 1994).

COGNITIVE BEHAVIOUR THERAPY
A major development in Western countries over the last three decades has been the emergence of Cognitive Behaviour Therapy (CBT) as the dominant approach for treating a wide range of psychological disorders. CBT emanated from the work of Ellis (1962) and Beck (1976), and gained its status from the large body of empirical data which supported its efficacy in treating anxiety, depression and various other psychological conditions (Blackburn et al., 1986; Butler et al., 1987; Clark and Fairburn, 1997). Unlike the more traditional psychodynamic therapies, CBT is reasonably brief and directed primarily at current
problems, and aims to teach patients specific coping skills.

In spite of extensive research supporting its effectiveness with various mental health populations, few trials have used CBT interventions with cancer patients. While several studies with cancer patients have utilised behavioural interventions such as relaxation, problem solving and goal setting (Worden and Weisman, 1984; Cain et al., 1986; Telch and Telch, 1986; Cunningham and Tocco, 1989; Fawzy et al., 1990; Edgar et al., 1992), and some have also incorporated cognitive techniques (Telch and Telch, 1986; Fawzy et al., 1990; Edgar et al., 1992), very few studies have applied the complete CBT model as described by Ellis (1962) and Beck (1976).

In 1989, the first text describing a CBT intervention programme for cancer patients was published (Moorey and Greer, 1989). Although the programme was named Adjuvant Psychological Therapy (APT), it drew largely on the work of Beck (1976) while focusing on issues specifically relevant to cancer patients. The text describes the application of cognitive techniques for individual patients or couples, and explains how they can be taught to identify the negative automatic thoughts underlying their emotions and how these can be changed. It also describes various behavioural techniques that can be applied, including relaxation, distraction, activity scheduling and graded assignments.

This therapy was utilised in a randomised trial with patients who showed psychological morbidity on a screening questionnaire (Greer et al., 1992). Therapy was administered individually, and outcome data was compared with that of the non-therapy control group. Assessments in the subsequent 2 and 4 month periods revealed significantly less distress (based on a number of measures) amongst patients who had received therapy. Further, a 12 month follow-up assessment (Moorey et al., 1994) revealed a significantly lower incidence of psychological distress amongst therapy recipients relative to control patients on the Psychosocial Adjustment to Illness Scale (Derogatis, 1983). It also found a significantly lower proportion of therapy patients in the clinical range for anxiety, as defined by the Hospital Anxiety and Depression Scale (Zigmond and Snaith, 1983). This was an important finding as few previous psychological intervention trials with cancer patients had found an effect of therapy beyond the short-term.

While the therapy described by Moorey and Greer (1989) was designed for use with individual patients, it was adapted to a group therapy format in two pilot studies. The first (Bottomley et al., 1996) evaluated the effects of the programme with newly diagnosed cancer patients (various sites) who had been screened for high levels of distress. Nine participants were randomised to attend eight sessions of CBT, while eight were randomised to attend a standard support group. A further 14 patients who refused to participate in therapy served as a standard care control. The study found that in the period immediately after therapy patients who participated in the CBT intervention showed significant reductions in anxiety and increased ‘Fighting Spirit’, while the support group and the non-therapy participants showed no significant improvements. These differences were no longer apparent in the 3 month follow-up.

The second pilot (Watson et al., 1996) was not randomised and involved the provision of six sessions of group CBT to 14 early stage breast cancer patients. The study found no significant changes in mood outcome of therapy participants, as measured on the Hospital Anxiety and Depression inventory (Zigmond and Snaith, 1983). The authors suggest that this may have been due to the low level of pre-treatment psychological morbidity, as most patients entered the study below threshold for clinical caseness and were, therefore, less likely to show statistically significant improvements than a more distressed population.

In our work at the University of Technology, Sydney, we have developed a group CBT programme for cancer patients, and have trialled the programme in a randomised study with 60 primary breast cancer patients (under review). Patients were randomly allocated to receive 12 sessions of CBT or 12 sessions of supportive discussion (based largely on expression of feelings and discussion of issues of concern). Outcome data in the post-therapy period revealed significant improvements on quality of life and self-esteem amongst participants in the CBT group relative to those in the supportive discussion group (see Table 1).

Given the recent interest in the use of CBT with cancer patients and the growing popularity of groups for the delivery of therapy, it appears timely to provide a description of a specific group CBT programme. The following is an outline of the structure and content of the group CBT programme which has been developed at our centre.
AIMS OF THE PROGRAMME

1. Cognitive restructuring. Participants will:
   - identify their patterns of maladaptive thinking and core irrational beliefs;
   - learn to challenge and modify their maladaptive perceptions.

2. Behavioural strategies. Participants will learn a variety of behavioural coping strategies including:
   - effective communication/ assertiveness techniques;
   - coping strategies;
   - goal setting;
   - utilisation of social contacts;
   - deep-relaxation/meditation.

3. Self-expression. Participants will express their issues of concern and associated feelings within the group, and be more willing to communicate openly with their family members and close friends.

METHOD

The programme comprises 12 group sessions, each of approximately 2 h duration. There are seven to nine participants per group, led by two therapists. Each session consists of a review of the week’s homework, a small theoretical/information component, followed by group discussion exercises. The homework review is totally ‘open’, with participants reflecting on issues of concern that arose during the week. Discussion focuses on applying the various cognitive and behavioural techniques in order to ‘take charge’ over potentially upsetting situations. While the information component of each session is pre-determined, it is followed by discussion aimed at encouraging participants to reflect on the subject’s relevance to their own experience.

During the first session participants receive a manual which provides information on the principles of CBT and on each of the topics dealt with in the programme. Additional discussion sheets and homework exercises are also supplied during group sessions.

COMPONENTS OF EACH SESSION

Discussion of homework exercises

To facilitate the acquisition of specific skills, participants are asked to complete written (and sometimes behavioural) homework exercises each week. Homework always comprises a thought-monitoring exercise (see examples in Table 2a,b), and on occasions some additional exercises which reflect on the topic of the day (see example in Table 3). Each session begins with a group discussion of the homework exercises which were set in the previous week. This process takes at least 1 h, and may take up to 1 ½ h when participants have significant issues to raise. The discussion of homework provides an opportunity for group members to reflect on and explore issues of concern. It also encourages participants to apply the cognitive and behavioural strategies presented in the

<table>
<thead>
<tr>
<th>Psychological domain</th>
<th>Group difference of change at post-therapy</th>
<th>(p_1) value (post-therapy)</th>
<th>Group difference of change at 4 months</th>
<th>(p_2) value (4 months)</th>
<th>(p_3) value (overall difference between groups)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-esteem</td>
<td>−2.27</td>
<td>0.024*</td>
<td>−4.83</td>
<td>0.437</td>
<td>0.033*</td>
</tr>
<tr>
<td>Quality of Life</td>
<td>−12.07</td>
<td>0.027*</td>
<td>13.60</td>
<td>0.145</td>
<td>0.038*</td>
</tr>
<tr>
<td>Anxiety</td>
<td>2.81</td>
<td>0.179</td>
<td>−1.39</td>
<td>0.520</td>
<td>0.367</td>
</tr>
<tr>
<td>Depression</td>
<td>3.61</td>
<td>0.170</td>
<td>−0.14</td>
<td>0.965</td>
<td>0.369</td>
</tr>
<tr>
<td>Anger</td>
<td>2.65</td>
<td>0.344</td>
<td>0.42</td>
<td>0.886</td>
<td>0.680</td>
</tr>
<tr>
<td>Vigour</td>
<td>−2.33</td>
<td>0.383</td>
<td>−2.46</td>
<td>0.719</td>
<td>0.605</td>
</tr>
<tr>
<td>Social support</td>
<td>−1.09</td>
<td>0.249</td>
<td>−0.17</td>
<td>0.895</td>
<td>0.518</td>
</tr>
</tbody>
</table>

Group difference of changes at post-therapy and 4 months follow-up, using repeated ANOVA. \(p_1\): \(p\) value for group difference of change at post-therapy (post-baseline), using univariate F-test. 
\(p_2\): \(p\) value for the group difference of change at 4 month follow-up [4 months—(post-baseline)/2], using univariate F-test. 
\(p_3\): \(p\) value for the overall group difference of the within subject effect, using multivariate Hotellings \(T^2\) test.
Table 2. Thought-monitoring exercises

(a) Thought monitoring homework exercise, for sessions 1–2

<table>
<thead>
<tr>
<th>Situation</th>
<th>Feelings</th>
<th>Thoughts</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(b) Example of completed thought monitoring homework exercise (used after session 3)

Challenging maladaptive beliefs

<table>
<thead>
<tr>
<th>Situation</th>
<th>Feelings</th>
<th>Thoughts &amp; beliefs</th>
<th>Dispute</th>
<th>Positive actions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Having to keep asking Anne (my friend) to do things for me, that I used to be able to do myself.</td>
<td>Guilt, despair.</td>
<td>I should be totally self-sufficient I should never ask people to do things for me. By asking for help, I a being a burden to my friend.</td>
<td>I prefer to be self-sufficient, and I usually am, but I don’t have to always be completely self-sufficient. It’s OK to ask for help when I need it. I have no reason to believe that Anne feels burdened by my request for help. She appears always happy to help. People often enjoy feeling that they can help others. I would not mind if someone asked me for help; I have no reason to presume that Anne doesn’t feel the same way.</td>
<td>I will tell Anne that I feel bad about asking her for help, and ask her how she feels. I’ll reassure her that if it’s not convenient for her to help out, I completely understand.</td>
</tr>
</tbody>
</table>

programme to their daily experiences, and to discover other applications from the experiences of other group members.

Participants are encouraged to hand in their homework exercises at the end of each session. While this is optional, our experience has been that most group members are willing to do so. Reviewing participants’ homework gives us more specific feedback regarding participants’ understanding of the theoretical concepts of CBT, and their ability to apply them to their own daily situations. It also gives us the opportunity to respond to issues raised by individuals who did not speak-up during the group session. At times we may suggest further actions and/or disputing statements that they could use, and on some occasions, with the participant’s consent, we may raise their issue for group discussion.

Theory/information component

Each session includes a short theory component, where participants are given specific information regarding a particular topic (see contents in Table 4). This is usually in the form of a short talk (5–10 min) given by one of the therapists, with reference to further reading in the participants’ manual.

Group discussion

All topics presented in the theoretical section are followed up with discussion. This may involve the entire group or, alternatively, small groups comprising two to three participants. Small group discussion is particularly useful for engaging the less outspoken members of the group, and is usually followed by debriefing within the larger group.

Table 3. Example of homework exercise ‘Reflections on Relationships’

<table>
<thead>
<tr>
<th>Relationships</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. How satisfying are your current relationships/level of social support? Do you have all the support you need? Are you happy with the ‘quality’ and quantity of your relationships?</td>
</tr>
<tr>
<td>2. If you were to have ideal relationships/friendships what would be different?</td>
</tr>
<tr>
<td>3. If you were to work towards having ideal relationships, what sort of things would you need to do?</td>
</tr>
<tr>
<td>4. What would you need to believe in order to be motivated to take these actions?</td>
</tr>
</tbody>
</table>
Table 4. Agenda for theoretical component of each session

<table>
<thead>
<tr>
<th>Content</th>
<th>Homework</th>
</tr>
</thead>
</table>
| 1 | Introduction to the programme and to CBT  
Introduction to thought monitoring common irrational beliefs | Thought monitoring |
| 2 | Identifying underlying beliefs  
'Taking Charge'—self-efficacy and locus of control  
Problem solving | Thought monitoring  
Identifying underlying beliefs |
| 3 | Introduction to disputing  
'Beating the Blues'—managing sadness/depression | Thought monitoring/disputing  
'Mastery' and 'Pleasure' |
| 4 | Effective communication techniques  
Creating 'whole' statements  
Disputing practice (continued) | Thought monitoring/disputing  
Communication exercises  
'Mastery' and 'Pleasure' |
| 5 | Managing anxiety  
Relaxation, breathing, visualisation, meditation  
Disputing beliefs that create anxiety | Thought monitoring/disputing  
Communication exercise  
'Mastery' and 'Pleasure' |
| 6 | Managing anxiety, continued  
Coping statements, problem solving, social support  
Review of problem-solving strategies  
Overview of programme to date | Thought monitoring/disputing  
'Mastery' and 'Pleasure' |
| 7 | Managing anger  
Causes, effects of symptoms of anger  
Disputing beliefs that generate anger  
Behavioural strategies for resolving anger | Thought monitoring/disputing  
Anger exercise  
'Mastery' and 'Pleasure' |
| 8 | Self-esteem  
Perceptions that influence self-esteem  
Body image, sexuality, libido  
Challenging diminishing cognitions  
Behavioural strategies for enhancing self-esteem | Thought monitoring/disputing  
Reflections on self-esteem  
'Mastery' and 'Pleasure' |
| 9 | Interpersonal relationships  
Strategies for enhancing quality of social support  
Communication strategies | Thought monitoring/disputing  
Reflections on relationships  
Communication exercise |
| 10 | Balanced lifestyle: work, play, mind, health, relationships  
Strategies for improving quality of life | Thought monitoring/disputing  
'Mastery' and 'Pleasure' |
| 11 | Goal setting,  
Clarifying future directions | Thought monitoring/disputing  
Goal setting exercise  
'Mastery' and 'Pleasure' |
| 12 | Overview  
Benefits of setting goals, and reinforcement strategies  
Overview of programme |  |

**Setting of homework**

The last 5 min of the session is spent on distributing and explaining homework exercises for the following week. A friendly and informal atmosphere is maintained through the use of humour and discussion that focuses on personal experiences. To illustrate theoretical concepts, personal examples are elicited from participants, or are occasionally provided by therapists. There is also allowance for some informal ‘chatting’ during the sessions and after each session through ‘coffee time’.

Copyright © 1999 John Wiley & Sons, Ltd.  
CONTENTS OF GROUP THERAPY SESSIONS

The first three sessions of the programme aim to introduce participants to the principals of CBT, as well as to establish a friendly and supportive group environment.

The first session begins with an outline of the programme and a description of what will be required of participants. This is followed by an ‘icebreaker’ exercise, where participants are asked to introduce themselves and to describe a thought that they had on the way to the session. This exercise opens discussion on the concept of thought-monitoring, which it is pointed out, will be a major theme of the programme. Following a simple exercise to learn participants’ names, group members are asked to describe previous experiences where they felt ‘hassled or upset’ and to identify thoughts that accompanied those situations. Through this exercise the link between thoughts and feelings is introduced. Finally, a modified version of ‘Common Irrational Beliefs’ defined by Ellis (1994) (see Table 5) is presented, and participants are asked to state which of these they relate to and to describe the consequences of each belief.

At the end of each session, participants are given some homework thought-monitoring forms (Table 2a) on which they are asked to record any stressful situations that occur during the week, and the thoughts and feelings that accompanied each situation. This is to be discussed in the following week. After the third session, the thought-monitoring forms also include provision for recording underlying beliefs, ‘disputing’ statements (that challenge their negative thoughts and beliefs), and positive actions that can be taken. Table 2b illustrates the modified format and demonstrates an example of a completed ‘thought-monitoring’ homework exercise.

In the ‘theory section’ of the second session, the issue of problem-solving is introduced and a basic problem-solving approach is demonstrated from issues of concern that had been raised by group members. A distinction is made between cognitive and behavioural strategies and it is pointed out that problematic situations can be resolved either by taking some sort of constructive action (behavioural), changing one’s perceptions (cognitive), or by doing both. The issue of ‘control’ is also discussed, and group members’ perception of their own degree of control over their life experiences is explored. This usually opens discussion on the issue of cancer, and the feelings of helplessness that accompany the diagnosis. Group members are asked to examine areas of their life where they can take greater control. The practice of deep-relaxation/meditation is raised as a means of gaining greater control over distressing thoughts and feelings, and participants are encouraged to practice on a regular basis. A relaxation tape is provided to facilitate this.

In session 3, the issue of disputing maladaptive cognitions is introduced and examples from the homework exercises are used to illustrate how negative thoughts and beliefs can be disputed (see example in Table 2b). In the ‘theory section’ the topic of depression is formally introduced (although this may have already arisen in previous group discussions). Following a short talk on depression, participants are invited to describe their own experiences with sadness or depression, and to identify the thoughts that accompany this state. Initially the therapists suggest some disputing statements that could be used to challenge the thoughts identified by group members. This task is then assigned to the participants, who are asked to devise several disputing statements for each negative thought. For homework, participants are asked to perform (and record) at least three tasks each day that give them a sense of ‘Mastery’ and

Table 5. Common irrational beliefs that create negative feelings*

<table>
<thead>
<tr>
<th>Belief</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>I must be loved or approved of by every significant person.</td>
<td>I must be competent, adequate and achieving in all respects.</td>
</tr>
<tr>
<td>I must be competent, adequate and achieving in all respects.</td>
<td>When people act unfairly or badly, they are horrible people and deserve to suffer for their sins.</td>
</tr>
<tr>
<td>My life should progress easily and smoothly. Things should not go wrong in my life.</td>
<td>My life experiences determine how I feel. It is impossible for me to feel good when things don’t go as they should.</td>
</tr>
<tr>
<td>If there is a chance that something bad might happen, I must keep dwelling on it.</td>
<td>If there is a chance that something bad might happen, I must keep dwelling on it.</td>
</tr>
<tr>
<td>It is better not to take risks, because when you stick your neck out, you can easily get hurt.</td>
<td>It is better not to take risks, because when you stick your neck out, you can easily get hurt.</td>
</tr>
<tr>
<td>I should always be in control over events in my life.</td>
<td>I should always be in control over events in my life.</td>
</tr>
<tr>
<td>People should be sensitive to my needs, and always do what I believe is right.</td>
<td>People should be sensitive to my needs, and always do what I believe is right.</td>
</tr>
<tr>
<td>The world should be a fair place. Things should always be fair, and I should always be treated fairly.</td>
<td>The world should be a fair place. Things should always be fair, and I should always be treated fairly.</td>
</tr>
</tbody>
</table>

*Adapted from *Reason and Emotion in Psychotherapy*, Dr Albert Ellis, 1994.

Copyright © 1999 John Wiley & Sons, Ltd.
‘Pleasure’. ‘Mastery’ tasks may include attending a medical appointment, cooking a meal or writing a letter. ‘Pleasure’ tasks might include watching a favourite TV show, having a bath or talking on the phone with a friend. This behavioural exercise helps participants to experience a sense of achievement and encourages them to partake in some pleasurable activities each day. Participants are encouraged to maintain this practice throughout the programme, with special encouragement given to group members who are currently experiencing depression.

The next three sessions (4–6) aim to consolidate the skills and practices introduced in the earlier part of the programme and, in particular, to ensure that participants are competent in identifying and disputing their maladaptive thoughts and beliefs. In addition to weekly thought-monitoring homework exercises, further disputing and ‘reflection’ exercises are provided to increase participants’ awareness of their own responses and to reinforce their skills.

In the ‘theory section’ of the fourth session, the principles of effective communication are described. Appropriate responses to various potentially confronting interpersonal situations are demonstrated and then practised in pairs. Participants are asked to describe their own past and current interpersonal issues which need to be resolved, and are invited to role-play appropriate responses. Typically participants describe needing to confront a family member, friend, work colleague, or medical practitioner. Further written communication exercises are provided for homework, and participants are encouraged to also practise these techniques in their daily interpersonal encounters.

In the fifth session, the issue of anxiety is examined. Participants are encouraged to explore various fears, including fears about disease progression, the possibility of suffering and death. At times some participants may feel threatened or uncomfortable in confronting these topics; however, they are usually reassured by the empathy of other group members and the realisation that they are not alone in their fears. Open and frank discussion is, therefore, strongly encouraged. A number of statements are suggested to help participants deal with anxiety provoking thoughts about their illness (e.g. ‘No matter what happens, I always cope’, ‘just relax!’), ‘I live fully today, and each day of my life’, ‘we all die eventually, but I prefer to focus on living!’). Participants are also reminded of the value of deep-relaxation/meditation for managing anxiety, and are asked to reflect on their relaxation practice and to describe any obstacles to regular practice.

The sixth session is used to explore further behavioural strategies for managing anxiety (phone calls, exercise, distraction, physical contact) and to consolidate the techniques presented so far. Various scenarios that typically arise for cancer patients are presented on handouts, and in small groups participants are asked to suggest appropriate strategies for dealing with each situation.

Session 7 deals with management of anger, and after a short talk participants are invited to describe their personal experiences with anger. Discussion frequently focuses on issues related to the diagnosis, such as insensitive treatment by medical staff, lack of support from friends or family members, or the very fact of their diagnosis. The point is then made that injustices will invariably occur, and that people will act badly at times. However, it is emphasised that our experience of anger comes from a belief that these things should not happen—that people should be fair and sensitive to our needs, and injustices should never occur. Reference is then made to the ‘serenity prayer’, which emphasises the need to accept things that we cannot change and change those things that we can. Participants are asked to identify problem areas within their own lives that they might be able to modify, and to distinguish these from the situations that they cannot change. The importance of learning to accept unchangeable situations is underscored, and various ‘disputing’ statements which focus on ‘acceptance’ are suggested (see example in Table 6).
In session 8, the issue of Self-esteem is explored. Following a short talk on the factors which influence our self-image, participants are invited to identify their own beliefs and perceptions regarding their sense of self-worth. The effect of the cancer diagnosis on participants’ self-image is explored, and this often includes discussion on body-image, sexuality and libido. Participants are asked to reflect on their own diminishing beliefs (e.g. ‘People feel sorry for me because of my cancer’) and to suggest appropriate disputing statements (‘Most people don’t think about my cancer very much at all. If I don’t focus on it all the time, then neither will they’). These sentiments are reinforced through further group discussion.

The ninth session focuses on the issue of relationships, and participants are invited to reflect on their various relationships, and the degree of satisfaction which they provide. Discussion also focuses on the changes that participants have observed within their key relationships since their diagnosis, and what specific actions they could take to improve their social support. Where obstacles exist, participants consider how these might be overcome. Limiting beliefs, such as ‘they will feel burdened by me now that I have cancer’ are explored and challenged. Appropriate communication strategies for responding to various interpersonal situations are also reviewed.

The tenth session deals with the issue of lifestyle. A short talk is presented on the components of a balanced lifestyle (work, play, mind, health, relationships) and this is followed by a discussion on the changes that group members have experienced in this area since their cancer diagnosis. Participants are given an exercise to assess the degree of balance within their current lifestyle, and this is followed by discussion on areas which participants would like to improve on.

The eleventh session deals with the issue of goal-setting. Participants are encouraged to identify specific areas that they would like to change or modify, and are asked to reflect on the obstacles that they will need to overcome. Typically, the goals most commonly selected focus on developing a more healthy lifestyle (such as ‘improve my diet’, ‘do regular exercise’), followed by goals on improving relationships, developing interests or new skills, and learning to relax. From the examples raised by group members, participants are shown how to break down their goals into small, achievable steps, and how to work through each of these. Further reinforcement techniques are discussed, including visualisation, reinforcement symbols, and recruitment of supporters. For homework, participants are asked to fill in a ‘Contract’, identifying a specific goal and defining a plan of action.

The final session presents an overview of the programme, and is an opportunity to ‘tie up loose ends’. Participants are asked to describe what they got out of the programme and what, in particular, they hope to take away with them. They are also asked to define some of the obstacles that may prevent them from following through with their goals, and how these can be overcome. Finally, a number of resources are distributed, including a reference list of further reading material, various quotes and motivational statements, and a list of contact numbers for different helpful agencies. The last session is followed by a farewell lunch or dinner. Although we do not arrange to have further contact with participants, our experience has been that in most groups participants arrange to keep in touch with each other through social ‘get-togethers’.

CONCLUSION

In recent years that has been growing interest in the use of CBT intervention with cancer patients. To date, few intervention studies have applied the complete CBT model, as defined by its originators (Ellis, 1962; Beck, 1976), and only two small pilot studies have trialled CBT in a group context with cancer patients. However, several studies have applied aspects of the CBT model within their interventions, and outcome data for these has frequently been positive. We have outlined the structure and content of a CBT intervention programme that has been developed at the University of Technology, Sydney, for application with cancer patients in a group setting. The structure of the programme and agenda for each session has been described.

REFERENCES


