



# Analyzing differences between psychotherapy groups and social support groups for breast cancer patients: Development of an assessment method using video recordings

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## ABSTRACT

**Objective:** When comparing the efficacy of different interventions for cancer patients, there should be certainty that these types are sufficiently different in the way they are actually presented. The aim of the present study is to develop a method for assessing differences between the content of social support groups and experiential–existential therapy groups.

**Methods:** Independent and blind raters assessed video fragments of both intervention types, using a self-developed checklist of five questions. This checklist was first evaluated by a group of experts for appropriateness, importance, and rateability.

**Results:** Three out of the five questions were selected on the basis of these experts' evaluation and on inter-rater reliability. The scores on these questions were used to evaluate five social support groups and six experiential–existential therapy groups for breast cancer patients. According to the independent and blind raters the content of the two intervention forms appeared to be significantly different.

**Conclusion:** The assessment method we developed appeared reliable and valid.

**Practice implications:** Our assessment method is feasible as a check to compare the content of psycho-oncological interventions and can be easily adjusted into a test for other intervention types.

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## 1. Introduction

The efficacy of psychological interventions for people with cancer has been demonstrated in many controlled and randomized studies [1–6], though recent reviews and meta-analyses conclude that the evidence is still unconvincing [7,8] or conclude that psycho-oncological interventions are not efficacious [9,10]. Although several studies did find an improvement with respect to anxiety, depression, worry, confusion, self-esteem, experienced control, quality of relationships and somatic symptoms, there is limited knowledge about which types of psycho-oncological interventions are most efficacious.

Various group interventions have been compared [11–17]. The types of group interventions distinguished in psycho-oncological studies are self-help groups, social support groups, psycho-education,

cognitive behavioral oriented 'stress management'/'coping skills training', psychodynamic therapy, experiential–existential centered therapy and mindfulness-based stress-reduction training. The contrast most often studied is between support groups and stress management groups [11–14]. Stress management appeared to be more efficacious than social support alone, though one study found similar effects of a coping intervention and supportive counseling [16]. Helgeson et al. compared group psycho-education, peer-discussion (support group) and no therapy. Psycho-education – either on its own or in combination with peer-discussion – generated greater benefits than supportive discussions alone [15].

We compared the effectiveness of social support groups and experiential–existential psychotherapy groups; a contrast which had not been evaluated before. When comparing different intervention types, there should be certainty that these forms are sufficiently different in the way they are presented during the study. Tests on treatment integrity are laborious and rarely applied [18], though such tests are of primary importance in clinical trials before any meaningful determinations of outcome can be made [19]. A test on treatment differentiation, as applied in the present study, may be considered a minimal, though essential component of treatment integrity.

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**Table 1**  
Similarities and differences between social support groups and experiential–existential psychotherapy groups.

	Social support group	Therapy group
1. Group leader has a professional back-ground in psychotherapy	Not necessary	Necessary
2. Mutual support group members	Yes	Yes
3. Exchange of disease and treatment related experiences and emotions	Yes	Yes
4. Discussion of practical solutions for disease and treatment related problems	Always	Regularly
5. Psycho-education	Always	Often
6. Utilizing group processes for learning	Rarely	Always
7. Attention for personal meaning of experiences and emotions	Rarely	Always
8. Systematically analyzing problems	Rarely	Always
9. Encouragement to express emotions	May occur	Always

The distinctive features of social support and experiential–existential therapy groups are rather subtle (see Table 1), which makes such a check all the more necessary. The experiential–existential therapy approach is based on the assumption of the client as the active change agent. The therapist's role is that of a facilitator, helping the client to develop his or her own awareness and understandings of current difficulties, resources and blocks. Although the therapeutic relationship is an essential foundation for productive use of therapy by the client, internal self-exploration is emphasized over transference, interpersonal understanding or support [20]. Mulder et al. describe the function of the therapists of an experiential–existential group intervention for HIV-positive men as follows: “The main function of the therapists was to help the men to become aware of incongruences between emotional, cognitive and behavioral schemata and to restore congruence. The therapists refrained from giving advice or making interpretations, and worked actively with the clients to help them develop insights and solutions to problems. Self-disclosure, sharing mutual fears and concerns, and addressing feelings about a shortened life perspective, illness, and death were facilitated by the group leaders” [21].

Sivesind and Baile mention four distinctive features of social support groups [22]. Though we do not agree with their opinions we still present them, because they are one of the few authors who explicitly describe the differences between social support groups (1) Sivesind and Baile argue that support groups offer concrete guidelines, such as directing patients as to when they should report troubling symptoms to their physician, whereas psychotherapy groups often refrain from offering such guidelines. In our view, the difference is more gradual. A therapy group for cancer patients will not avoid discussion of practical aspects, although explicit guidelines do indeed tend to be set more often in a support group. (2) According to Sivesind and Baile (1997), support groups often run for an indefinite period of time and change members frequently, whereas psychotherapy groups usually have an identified ending point and strive to maintain a stable group membership. Support groups are in our view indeed more often open-ended, whereas therapy groups are more often closed and time limited. However, these differences are far from absolute and not imperative. (3) Members of support groups are often identified by a common problem, whereas in group psychotherapy members are not, according to Sivesind and Baile. However this characteristic does not apply to psycho-oncological interventions, which are often tailored to a specific type of cancer; a specific phase of the disease, such as metastatic disease or palliative phase; a specific problem, such as fatigue, insomnia or pain; or a specific demographic group, such as spouses, children or adolescents. (4) According to Sivesind and Baile (1997), group psychotherapy generally focuses on making personal changes through obtaining insight with the aim to enhance interpersonal skills or relieve intrapsychic distress. Support groups, in contrast, specialize in helping patients cope with the trauma of an illness, such as cancer or another life crisis, decreasing the sense of isolation of group members and helping find a new meaning in life.

Siveskind and Baile are correct with respect to the focus of psychotherapy groups. However, the aims mentioned for support groups apply equally to therapy groups, in our view. In summary, the characteristics of social support groups described by Siveskind and Baile do not offer enough indications for developing a treatment differentiation test. Therefore, we tried to formulate ourselves the correspondences and differences between both intervention forms.

We believe mutual support among group members, and sharing experiences and emotions are common and important elements in both interventions. Social support groups are more practically oriented and tend to dedicate more attention to psycho-education, conceived as structured provision of information about the disease, its treatment and psychological adjustment, and discussion of this information. Psychotherapists will use the group interactions as learning experiences for participants. They also systematically analyze the psychological problems of participants and focus on the personal meaning of the experiences and emotions expressed by participants, more than leaders of social support groups do. Emotional expression is important in both psychotherapy and social support groups, because venting one's emotions can be salutary in itself. Its additional importance in psychotherapy groups is that it helps to discover what is essential to the individual. Emotional activation is often a clue to what is personally relevant. These differences are related to the professional background of group leaders, which is often a psychotherapist in therapy groups, whereas leaders of support groups are more often social workers, medical doctors or oncology nurses (without psychotherapeutic training).

The aim of the present study was to develop a method for analyzing the differences between the content of social support groups and experiential–existential psychotherapy groups in the way they are offered to patients. The method for testing treatment differentiation includes the development of a checklist. If this method proves to be feasible and valid, it can also be applied when comparing other types of interventions by replacing the topics of the checklist to those relevant for the type of interventions in question.

## 2. Methods

### 2.1. Design

This study is part of a larger intervention study to evaluate the efficacy of psychotherapy groups in comparison to social support groups. Breast cancer patients were randomly allocated to a psychotherapy, social support or a waiting list condition. Patients in the waiting list condition were later randomly allocated to one of the two types of intervention [23–26]. The sample included six therapy and five social support groups. Each intervention consisted of twelve weekly sessions and two follow-up sessions, which were scheduled one and two months after the last weekly session. Sessions lasted two-and-a-half hours and included a short break halfway through.

For the purpose of this study every second, sixth and eleventh session was recorded on video. Afterwards, five minutes fragments were selected from each session: one before and one after the break. Fragments had to satisfy the following two conditions to be included in the evaluation tape. Firstly, the fragment should not include a meditation or relaxation exercise and, secondly, it should show at least two people speaking, one of whom was a therapist/group leader. The first fragment that satisfied the two mentioned conditions after the first twenty minutes of the videotape was chosen. Video fragments were selected from the eleven groups, three sessions per group, and two fragments from each session, making a total of 66 fragments minus three unusable fragments, due to failed recording. The selected, remaining 63 fragments were placed in random order on a new tape and were rated by three raters, who were blinded to the conditions.

The raters were three paid psychology students, who had completed a short observation training course. During this training course they practiced the rating system, developed in this study, using recordings from group sessions made during a pilot study. The raters were intentionally not provided with descriptions of a psychotherapy group and social support group. They were expected to use their own expertise as clinical psychology students in evaluating the fragments. Students were chosen, because in our view one can only reliably conclude to actual differences between the two intervention types if these differences were clearly visible, that is even to clinical psychology students.

## 2.2. Development of the checklist

A checklist was developed to be used by independent raters to score recorded video fragments of both intervention types. It consisted of the five questions presented in Table 2. The questions in the checklist were based on the differences between a social support group and an experiential–existential therapy group, described in Table 1.

We used two methods for the selection of suitable items for this checklist. First, the rateability, appropriateness and relevance of the checklist was evaluated by a group of experts. Second, the checklist was applied by independent raters who scored the video fragments and their scores were used to determine inter-rater reliability. On the basis of the experts' opinions and the inter-rater reliability scores, questions were selected that appeared to be ratable, appropriate, relevant and reliable for analyzing the

differences between support groups and experiential–existential psychotherapy groups.

The descriptions of the two intervention types were intentionally labeled with the neutral description of an A and B type of intervention, and not as descriptions of a therapy group and a social support group, to prevent any possible prejudices by the raters. The first four questions included a short description of a 'Type A' and a 'Type B' intervention. The formulations were chosen such that the experiential–existential therapy was represented in questions 1, 2 and 4 by the B-type and in question 3 by the A-type. The raters were asked to score whether a fragment was 'more Type A', 'more Type B', 'somewhat of both Type A and Type B', or 'neither similar to Type A nor Type B'. Resembling more Type A was later coded as  $-1$ ; more Type B was coded as  $+1$ ; and somewhat of both Type A and Type B or neither Type A nor Type B was coded as 0 for the questions 1, 2 and 4. For question 3 the coding was the opposite. The fifth question asked directly whether the rater found the fragment mainly representing 'a psychotherapy group', 'a social support group', 'somewhat of both', or 'neither' (later coded as 1,  $-1$ , 0 and 0, respectively). Thus, a positive score means that the rater considered the fragment to represent an experiential–existential therapy group, whereas a negative score means that the rater considered the fragment to represent a social support group.

## 2.3. Evaluation of the checklist

We asked twelve experts in the field of psycho-oncology to evaluate the relevance, ratability, appropriateness and relevance of the first four items in the checklist; there was no doubt about the appropriateness and relevance of the fifth item. Eight psychotherapists and four support group leaders were asked to indicate on a checklist (1) which of the two descriptions for each question they would classify as describing a social support group, (2) whether they thought the descriptions were appropriate, (3) whether the descriptions expressed an important difference between the two types of intervention, and (4) whether they thought the question could be rated reliably.

## 2.4. Statistical analysis

Squared weighted Kappa coefficients were used to determine inter-rater reliability. A Kappa larger than 0.40 is considered reasonable [27].

**Table 2**

The checklist for scoring social support groups and experiential–existential therapy groups.

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The answering categories for questions 1–4 were: 'The fragment you just saw shows agreement with the description of intervention A/intervention B/somewhat of both interventions/no agreement with either type'

### Question 1

Type A: The group supervisors have a guiding role, though attention is also given to themes introduced by the participants. Participants are provided with a lot of information about the disease and its treatment, psychological reactions, and practical adjustments.

Type B: The group supervisors stimulate and guard the group process: Does everyone receive sufficient attention, are individual differences honored, and is sufficient attention paid to the personal meaning of experiences?

### Question 2

Type A: Emotional aspects are discussed, but the emphasis is on practical solutions to the problems discussed.

Type B: Practical solutions are discussed, but the emphasis is on emotional aspects and personal meaning of problems and solutions.

### Question 3

Type A: If participants have found solutions to their problems themselves, they are invited to share them. That people are themselves often capable of finding their own solutions is emphasized. Attention is also paid to what people are good at, in addition to those problems they are struggling with.

Type B: If participants have found solutions to their problems themselves, they are invited to share them, because these solutions may be helpful to others.

### Question 4

Type A: Discussing certain topics may touch participants emotionally. Room for expressing emotions is allowed for, but this is not the focal point. Finding a practical solution is attempted.

Type B: Discussing certain topics may touch participants emotionally. Time to express emotions is allowed for and what these emotions mean to the individual is discussed.

### Question 5

Does the fragment represent mainly a therapy group, a social support group, both or neither?

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**Table 3**

Evaluation of the checklist by the twelve experts. Mean values of appropriateness, importance and rateability of the questions are presented. Scores range from 0 ('not at all') to 4 ('very').

	Question 1	Question 2	Question 3	Question 4
Appropriate	2.6	2.8	1.8	2.3
Important	2.8	2.8	2.1	3
Rateable	2.9	3.0	1.5	2.6

To determine whether the raters were able to differentiate between the two interventions on the basis of the video fragments, only those questions were used that were rated as acceptable by the experts and showed sufficient inter-rater reliability. The mean of the scores of the three raters was determined for each of the six video fragments recorded in each of the eleven intervention groups. A General Linear Model Repeated Measures Model was used with a between-subjects factor of two levels: the therapeutic intervention and the social group condition. The 'subjects' in this model are the eleven intervention groups (six psychotherapy groups and five social support groups). Each intervention group had six repeated measures: the scores for three sessions, determined before and after the interval. The repeated measurements in this study are interrelated at two levels: the three sessions of each group are interrelated and the two fragments of each session are interrelated, nested within the first series of data. A significance level of  $p = .05$  was used in all tests.

### 3. Results

#### 3.1. Evaluation of the checklist

The experts rated questions 1, 2 and 4 as appropriate, important and rateable (see Table 3). Their mean scores to these three questions were between 2 ('reasonably') and 3 ('good') on a four-points scale. When asked which description (A or B) referred to a social support group or psychotherapy group, one of the twelve experts systematically scored in a direction opposite to what we considered correct on theoretical grounds. All other experts agreed on questions 2, 3 and 4. However, only 8 of the 12 experts scored question 1 in the correct direction. We concluded that only questions 2 and 4 appeared to be valid and relevant on the basis of the expert ratings.

#### 3.2. Inter-rater reliability

The squared weighted Kappa coefficients of the five questions are presented in Table 4. Questions 1 and 3 appeared unreliable,

**Table 5**

Mean raters' scores per session and intervention type.

	Therapy groups (n=5)			Social support groups (n=6)		
	Session 2	Session 6	Session 11	Session 2	Session 6	Session 11
Question 2	0.49	0.31	0.11	-0.26	-0.63	-0.07
Question 4	0.33	0.33	0.00	-0.33	-0.50	-0.33
Question 5	0.39	0.33	0.06	-0.52	-0.67	-0.67

Positive score = more like a psychotherapy group; negative score = more like a social support group.

**Table 6**

Mean raters' scores for fragments before and after the interval per intervention type.

	Therapy groups (n=5)		Social support groups (n=6)	
	Before interval	After interval	Before interval	After interval
Question 2	0.17	0.43	-0.38	-0.29
Question 4	0.15	0.29	-0.60	-0.19
Question 5	0.19	0.33	-0.79	-0.45

Positive score = more like a psychotherapy group; negative score = more like a social support group.

**Table 4**

Reliability of the questions.<sup>a</sup>

	Squared weighted Kappa coefficient
Question 1	0.15
Question 2	0.38
Question 3	0.17
Question 4	0.44
Question 5	0.47

<sup>a</sup> A Kappa coefficient of 0.40 or larger is seen as indicating sufficient interrater agreement [27].

because the inter-rater reliability is too low. Inter-rater reliability was acceptable for questions 4 and 5 and the Kappa coefficient of question 2 (0.38) approached the criterion of Landis and Koch (0.40).

A check was made to determine whether one of the raters systematically deviated in his judgment from the other two raters, which appeared not to be the case. A check was also made to determine whether reliability was different for fragments before or after the interval, or differed per session. This was generally not the case, with some rare exceptions (for items 2 and 4 the reliability was sometimes lower for session 2, than for later sessions).

#### 3.3. The difference between the two intervention types

For this analysis only questions 2, 4 and 5 were used, because only these questions appeared to be valid and relevant. The raters' scores did not change over time. There was no significant effect for session (early, middle or late session) or interval (before or after interval). Interaction effects were tested for group  $\times$  session, group  $\times$  interval, session  $\times$  interval and group  $\times$  session  $\times$  interval. Only once was an interaction effect noted: for question 2 the interaction between session, interval and intervention type was significant ( $p = .03$ ).

The main effect for intervention type was significant for the three questions (question 2,  $F = 11.4$ ,  $p = .008$ ; question 4,  $F = 13.9$ ,  $p = .005$ ; question 5,  $F = 23.6$ ,  $p = .001$ ). After a Bonferroni correction for multiple testing (critical  $p$ -value =  $.05/3 = .017$ ) all differences remained significant. The strongest effect was found for the direct question "Does this fragment represent mainly a 'psychotherapy group', a 'social support group', both or neither of both" (question 5).

Tables 5 and 6 show the mean scores for psychotherapy and social support groups, for the different types of fragments: early,

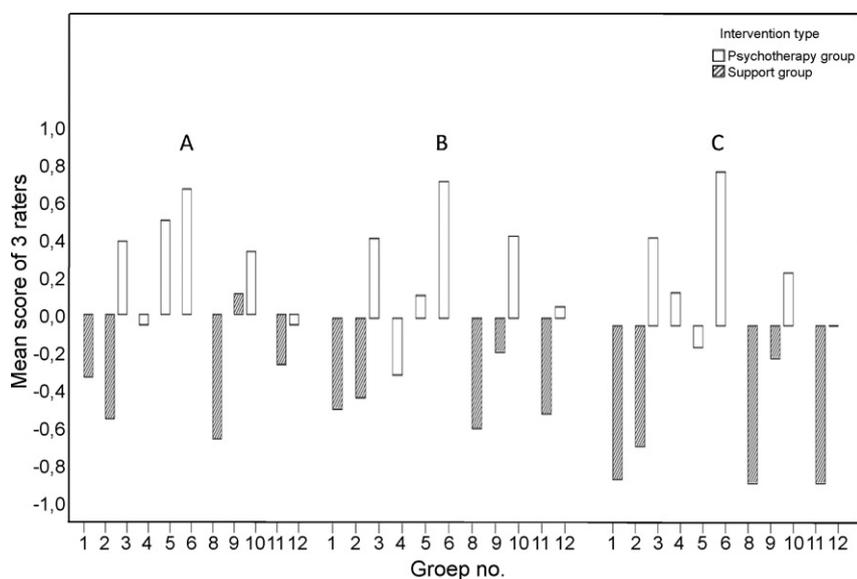


Fig. 1. Mean scores of the three raters for each of the eleven groups to question 2 (A), question 4 (B) and question 5 (C).

middle or late session (Table 5) and before or after the interval (Table 6).

As expected, psychotherapy group fragments were rated as psychotherapeutic (scores > 0) and social support group fragments were rated as social supportive (scores < 0).

The scores for the psychotherapy groups were near zero at the last session, which means that they were judged as being in between a psychotherapy and social support type of intervention. Intervention types differed the most in week six (the middle session) and fragments after the interval are more psychotherapy alike than before the interval.

Though it was demonstrated that psychotherapy groups were rated by independent and blind raters as being different from social support groups, some psychotherapy groups appears to have been more like a social support group and vice versa. Fig. 1 shows the mean scores (average of the six scores for each fragment) for the eleven groups with respect to the three most important questions.

The figure shows that there is quite some difference in how the individual groups were rated. Using the scores to question 5 – the question that yielded the largest difference between both intervention types – only six of the eleven groups sufficiently represented the expected intervention type (groups 1–3, 6, 8 and 11).

## 4. Discussion and conclusion

### 4.1. General discussion

The aim of the present study was to develop a procedure to check whether social support groups and experiential–existential therapy groups differ in the way they are presented to the clients. Such a test on treatment differentiation is essential in testing differences in the efficacy of psychological interventions. By preference, the test should be performable by raters who have an interest in but are not specialized in this specific field of psycho-oncological interventions, to be not dependant on the limited availability of therapists. The two intervention types differ only gradually, which makes a test for actual dissimilarities even more important, but also difficult. Another problem is the absence of generally accepted guidelines in the literature about what constitutes a support group and a psychotherapy group.

A checklist with five questions was developed and was used by three independent raters for the assessment of video fragments of

psychotherapy and social support groups. The checklist was evaluated by a group of experts for appropriateness, importance and rateability. Two questions were rejected on the basis of insufficient inter-rater reliability and a negative evaluation of the experts.

The three remaining questions were used to determine whether the two intervention forms differed, according to the independent raters, in the direction that was theoretically assumed. The tests showed a significant difference for each of the three questions despite its low power, based on only six repeated measurements for six intervention groups versus five social support groups. Apparently, the raters found the content of the two intervention types clearly distinguishable.

The items of the checklist were chosen on the basis of expertise of psychotherapists and our own view as therapy researchers, because generally accepted guidelines for social support groups and psychotherapy groups and formulations about their differences, did not exist.

Recent reviews on psycho-oncological intervention do not give rise to optimism. The conclusion about their efficacy is considered to be inconclusive [7,8] or negative [9,10]. These reviews urge the necessity to make methodological improvements in therapy research, but tests on treatment integrity are under exposed. Treatment integrity refers to the extent to which a therapeutic intervention is implemented as intended and its ability to be differentiated from other approaches [19]. The test on treatment differentiation, described in the present study, meets its objective and is probably the most simple and effective test on treatment integrity.

When all social support groups were compared to all psychotherapy groups, there appeared to be a significant difference in the raters' scores, which supports the validity of the assessment method. However, when inspecting the figure it appears that this overall difference has to be qualified. Though the scores for most intervention groups were in the expected direction, one may conclude that the scores were sufficiently high for only six of the eleven groups included in our study; only these six intervention groups sufficiently represented the expected intervention type. So, in a test on the efficacy of psychotherapy groups versus social support groups in – for instance – lowering distress levels, it would be better to use only these six intervention groups, instead of all eleven groups.

#### 4.1.1. Relevance and application of the video-scoring method in health communication research

If findings of therapy evaluation studies are communicated to the scientific world, there should be no doubt about what is offered to patients participating in the psychological interventions. As described in the introduction, there is no certainty about the definition of a social support group. A first requirement for the understanding of readers is a substantial description of the intervention components. It is, however, not certain that interventionists offer these components as described in a therapy manual. Moreover, many types of therapy, besides behavioral therapy, allow the interventionists a great degree of freedom. A check on treatment integrity should, therefore, be a necessary element of an intervention study. An additional advantage of applying a treatment integrity procedure is that it forces researchers to explicit what the essential elements are of the psychological interventions that are studied. This clarification is not only useful for research purposes but also for the communication in the scientific world. It elucidates what is meant by offering patients, for instance, a social support group or an existential-experiential therapy.

Most treatment integrity procedures are, however, laborious and time-consuming and are rarely applied. This also holds for the few treatment integrity studies that used video recordings [28,29]. These studies applied detailed coding to analyze therapy processes or to check treatment fidelity to one psychotherapy approach, instead of a check on treatment differentiation. The test on treatment differentiation that is described in the present study is relatively simple. It focuses on global, though essential components of the interventions studied. Procedures described in the literature imply the scoring on many details, which will convey to the reader of therapy publications the impression of its distinguished scientific level but does not present a clarifying picture of the characteristics of psychological interventions.

#### 4.2. Conclusion

We selected for our assessment method on treatment differentiation questions that could be scored with sufficient interrater reliability and were considered by a group of experts as adequately representing an experiential-existential group and a social support group, respectively. Using this method in a practice test, the scores of independent raters showed a significant difference between the two intervention types.

#### 4.3. Practice implications

The procedure described and tested in the present study can be easily applied in future psychotherapy and health communication intervention studies. The formulation of characteristics of psychoeducational groups, cognitive behavioral oriented stress management/coping skills training groups or psychodynamic groups will be no more difficult than we have done for experiential-existential groups. An advantage of our method is that it is simple and that it allows for the restriction of data-analysis to intervention groups that represent the theoretical model.

I confirm all patient/personal identifiers have been removed or disguised so the patient/person(s) described are not identifiable and cannot be identified through the details of the story.

#### Conflict of interest

There was not any influence of the funding agency –the Dutch Cancer Society – on the conduct of our research or the preparation of this article.

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