Structure, process, and impact of a staff support group in an oncology setting in a developing country

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According to the latest statistics, the global burden of cancer is estimated to be 14.1 million new cancer cases and 8.2 million cancer deaths in 2012.[1-2] Emotional factors are faced not only by the cancer patients and their caregivers but by oncology health-care professionals as well.[3-5]

Oncology staff is prone to intensive stress related to suffering and repeated confrontation with death, experience of grief, with demands on emotional engagement, which may lead to stress and burnout.[6-12] About 44%-56% of American oncologists surveyed reported experiencing burnout in their professional practice.[13,14] The prevalence of psychiatric disorders in a study on cancer clinicians of United Kingdom was reported to be 28%.[15] Work-related stress was found to be a factor in a study on stress and burnout in medical and radiation oncologists and palliative care professionals.[16-18] Other health-care workers in oncology such as support and administrative staff also go through stress and need support to prevent burnout and improve motivation.[19-21]

Staff support groups are beneficial for medical and nursing staff.[12,22] Explorative studies have shown that staff who are well supported, have better understanding of their own and others’ emotional reactions in their care for patients,

Background: Health-care staff working in oncology setting experience excessive stress, which if unrelieved can lead to burnout. Staff support groups have been found beneficial.
Aims: This study aims to evaluate the structure, process, and impact of a staff support group conducted for field workers involved in cancer screening in an urban tertiary cancer center in a developing country. Settings and Design: Retrospective analysis of staff support group conducted in a tertiary care cancer center. Methodology: Prospectively maintained data with structured notes for documenting the process of the support group sessions for the field workers was analyzed. Impact was analyzed through a feedback questionnaire designed for the purpose completed by participants at 4 months, 1, and 2 years following session completion. Statistical Analysis: Descriptive statistics for reporting the overall structure and participants’ profile and content analysis for identifying the support group process and themes expressed by the participants were used. Results: Eleven participants attended the support group consisting of 8 structured sessions. The processes identified were planning, implementation, and supervision of the lead therapist conducting the group. Work overload, target completion, feeling demoralized, interpersonal conflicts, and importance of team support were the main issues identified. Cognitive behavioral approaches were learnt for stress management. Eight, nine, and all 11 participants found the support group moderately to very useful at 4 months, 1 year, and 2 years, respectively. Conclusions: The support group followed a planned structure, with good implementation, recording of content and supervision, with both short-term and sustained positive impact.

Keywords: Developing country, oncology, screening, staff support group

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Deodhar and Goswami: Staff support group in an oncology setting

possess confidence, and high motivation and perform better.\textsuperscript{[23,24]}

Majority of the studies on staff support have been done in palliative care setting, mainly with doctors and nurses, and in staff working with patients with human immunodeficiency virus/autoimmune deficiency state.\textsuperscript{[21,25]} There is, also, insufficient literature on interventional studies and support groups conducted for field workers. None of the studies were conducted in low- or middle-income countries.\textsuperscript{[21,26]}

Our tertiary care cancer hospital in the country manages approximately 60,000 newly registered cancer patients annually. The psycho-oncology service of the hospital, apart from patient care, provides psychological support for staff, either through the hospital staff clinic or self-referral.

In an affiliated department of the hospital, the team leader of staff involved in fieldwork for cancer screening requested emotional support from our service for issues perceived to be impacting on the mental health and work functioning of the field work staff. This staff support group was conducted as a service program to address this felt need.

In this paper, we report the conduct, evaluation, and impact of a mental health professional-led cognitive behavioral therapy (CBT)-based staff support group. The purpose of the study was to (a) evaluate the structure and process and (b) assess the impact of this staff support group in a tertiary care cancer centre in India.

**METHODOLOGY**

The study was conducted as a retrospective analysis after obtaining approval from Institutional Ethics Committee.

Prospectively maintained data for the support group for field workers of an urban outreach program for cancer screening was retrospectively analyzed. Attendance record and structured notes maintained for documenting the process of each session were perused. Documentation of verbal feedback taken immediately at the end of the final session in the session records was noted. A questionnaire designed to collect feedback was used for postintervention survey at 4 months, 1, and 2 years after completion of the support group. A second mental health professional of the same psycho-oncology team provided supervision for the therapist who conducted the support group. The same professional also conducted the postintervention feedback (verbal and questionnaire surveys).

The process of conduction of the support group was studied by examining the recorded notes of all the sessions.

The outcome measures were (1) structure of the group (number, duration, and format of sessions), (2) process of the group—defined by planning, implementation, content analysis, and supervision, and (3) impact of the group as assessed by verbal feedback comments and results of the questionnaire surveys.

**Analysis**

Frequency and percentages are used to report the participants profile, attendance record, and some elements of the questionnaire survey. The important elements of the support group and themes expressed by the participants during the sessions are identified and described in narrative.

**RESULTS**

**Participant profile**

There were 11 participants in the support group. Their sociodemographic characteristics are depicted in Table 1. All were community field workers with no medical or nursing background. Their job entailed motivating people from the allotted area for undergoing cancer screening program and helping those who screened positive to help in their cancer therapy plan in the tertiary care cancer center throughout their treatment and follow-up period. The project workers did not have any advanced or professional training in counseling before their fieldwork placement and had only undergone a basic orientation program run by their department.

**Structure**

A total of 8 sessions were conducted as planned, with each session lasting 90 min and being divided into introductory phase and structured group work, ending with recapitulation of learning and setting homework assignments.

**Process**

We identified four components in conducting this support group as follows:

**Planning**

The team leader had identified the felt need for conducting the group recognizing the perceived difficulties the staff

| Table 1: Participant characteristics |
|-------------------------------------|
| Sociodemographic variables | No. |
|--------------------------------|-----|
| Age (range) | 25-50 years |
| Gender | | |
| Women | 11 |
| Married | 8 |
| Single | 3 |
faced which impacted on emotions and coping. The group was planned considering these problems. Eight weekly sessions were agreed on, of 90 min duration each, and at a fixed venue and fixed time, facilitated by a single group therapist. It was a homogeneous and closed group, with maintenance of attendance records and emphasizing confidentiality. Advance planning of supervision sessions for the therapist was done, scheduled for within a day or two after each session.

**Implementation**

The support group was implemented as follows:

All eight sessions were conducted at the preplanned time and venue on a weekly basis. There were no postponements or cancellations by the therapist.

Attendance record revealed that out of 11 participants, 8 attended all, 1 attended 7, and 2 attended 6 sessions.

The initial two sessions focused on rapport building, psycho-education about group process, and cognitive behavioral approaches, and identifying links between mood and thoughts [Table 2].

The next 4 sessions were focused on identifying emotions, dysfunctional beliefs and cognitive distortions, challenging negative automatic thoughts, and homework exercises. The penultimate session reinforced self-talk and cognitive restructuring and preparation for the final session. The final session focused on the group learning and sharing of experiences before and after starting the support group.

**Content analysis**

The content analysis of the support group revealed 4 major themes emerging from the sessions.

**Identification of issues and feelings**

The initial two sessions were exploratory in which participants expressed some common problems. These were (1) stress related to work pressure, (2) target completion within given deadlines, (3) lack of co-operation from community members in undergoing cancer screening, and (4) inadequate support from team members. Emotions identified were “tension,” sadness, helplessness, frustration, demoralization, and grief following death of cancer patients in their case workload [Table 3].

All participants felt death of a patient as a personal loss, which affected their work and family life. One participant very honestly expressed that “I go back home but I just can’t forget if something is seriously wrong with my patients. Many times I cry and often am not able to enjoy anything that time”. Another participant said, “My personal life is badly affected but I can’t leave my job there is no option.”

Participants also expressed issues about interpersonal conflict among staff and need for more support from colleagues, seniors, and higher authorities. Participants learnt to identify antecedent incidents, behavior, and consequences.

**Information provision**

Participants realized the crucial role of clarity in their job responsibilities. Some issues were felt to be due to communication difficulties and interpersonal conflicts with patients and their caregivers. A kind of “reality check” was done to differentiate between practical problems in any job situation and self-perceptions about competence.

**Cognitive errors**

Participants identified their own cognitive distortions through session work and homework exercises from the third session onward. The main cognitive errors were maximization (“I completed work with only 2 families today, so that was the worst performance of any team member”), minimization (“Anybody could have done that job, it was nothing great.”), generalization (“I couldn’t complete the field work yesterday, I won’t be able to do any of my work”), selective abstraction (“My boss didn’t acknowledge me during the team meeting, hence...

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**Table 2: Implementation of the sessions**

| Session number | Tasks |
|----------------|-------|
| 1 and 2        | Rapport building, Psycho-education about group process and cognitive behavioral approaches, Exploration of problems |
| 3, 4, 5 and 6  | Identifying links between mood and thoughts, Identifying emotions, dysfunctional beliefs, and cognitive distortions, Challenging negative automatic thoughts, Homework exercises |
| 7              | Cognitive reframing exercises, Preparation for final session |
| 8              | Group sharing and learning, Individual tasks for future |

**Table 3: Types of problems and emotions identified by participants**

| Problems                                      | Emotions  |
|-----------------------------------------------|-----------|
| Stress related to work pressure               | Tension   |
| Target completion within given deadlines      | Sadness   |
| Lack of support from community members in undergoing cancer screening | Helplessness |
| Inadequate support from team members          | Frustration, Demoralization, Grief |

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I will not be continued in my job”), and personalization (“It was my fault that the patient’s disease progressed”). Once these were identified, participants learnt to challenge these negative automatic thoughts, in experiences shared in the group and in individual homework assignments. Cognitive reframing was taught to the participants who practiced in the group setting.

Participants used behavioral techniques such as relaxation methods, meditation, and yoga.

**Mutual support**

In the initial sessions, there was a perception of lack of support from other team members. Concerns were expressed about lack of coordination and planning, interpersonal conflict, and difficulty in getting cooperation from other hospital staff to help the patient. The participants had expressed that sometimes they were blamed and criticized for their incompetence, which they found very stressful and difficult. Through the third to the final session, this perception changed through sharing of individual experiences and feeling validated by the group. Mutual support was acknowledged and appreciated through the exercises.

**Supervision**

As planned, a second team member of the psycho-oncology team provided supervision for the group therapist. Sittings were conducted within a day or two of the staff support group sessions. Recorded notes of each session were discussed; difficulties, if any, were talked through and structure of the following session was planned. Any deviation from the structured format was assessed and explained.

**Impact**

Immediate brief verbal feedback collected at the end of the last session was extremely positive.

Participants were asked to enumerate reasons for attending the group, which were mainly stress management, improving coping, and addressing depression in routine work. Their main expectations from the group were decreasing tension, improving self-confidence, and learning stress management strategies [Table 4].

Eight out of 11 participants found the support group moderately to very useful at 4 months. Nine and all the 11 participants rated the group moderately useful to very useful at 1 year and 2 years, respectively, on a scale of 1–5 (not useful to very useful).

The specific areas in which the staff found the support group useful are enlisted in Table 5. Table 6 records the components of the support group that participants found helpful in order of priority, at different points of assessment.

**DISCUSSION**

An earlier study has addressed the needs of support and administrative staff in oncology.[28] Our group was different, comprising of nonmedical staff, working in the community and hospital, untrained in patient care yet working with cancer patients. Our study is the first to report on a structured staff support group for this set of individuals in an Indian oncology institute setting.

Group psychotherapeutic approaches are applicable and beneficial in various clinical situations.[27–29] With respect to structure and process of the staff support group, studies have advocated application of rigorous method to the establishment of such groups, which we followed.[30] The number of participants in the group was as per group therapy standard practice. A planned structure adds to better conduct of the group, which we adhered to in our study.[31,32]

Our support group model was based on cognitive behavioral techniques, following similar structure used in other models but used for cancer patients.[33] Our program also focused on experiential aspects, developing mutual support between participants, active behavioral problem solving, and relaxation techniques. This model has been outlined in another paper.[34]

The content of the sessions revealed participants’ feelings of sadness, worry, tension, frustration, and demoralization. This range of emotions is akin to compassion fatigue in palliative care workers and hospice nurses, who face this turmoil despite their training.[35–38] Furthermore, stress affects highly trained staff like hospice workers.[39] Since our participant group consisted of field workers who

| Reasons to attend group                  | Expectations from group                              |
|-----------------------------------------|------------------------------------------------------|
| Tension                                 | Decrease in tension and stress                        |
| Work stress                             | Increase confidence, self-esteem, self-image          |
| Stress management                       | Stress relief                                         |
| Improving coping and                    | Learning stress management techniques                 |
| communication                           | Improvement in coping and communication skills         |
| Problem-solving and dealing with        | Increased competency and dealing with difficult issues|
| difficult issues                        | Work–life balance                                     |
| Personal satisfaction                   |                                                      |
| Feeling sad                             |                                                      |
did not have training to work with patients who needed emotional support, they understandably felt stressed in their work.

Literature is available on teaching coping strategies to health-care professionals. In our support group, we did this through employing cognitive behavioral approaches. Negative self-thoughts have been noted in studies on stress in oncology staff. Cognitive reframing helped to improve coping skills, decrease negative feelings such as sadness, guilt and helplessness and improve self-confidence, competence and positive outlook in work. This has been seen in other reports. Kojima et al. have conducted a clinical controlled trial using CBT in workers, using E-mails. In contrast, we used face-to-face sessions with our participants.

Work overload is a major factor creating stress in health-care workers. Lack of support from team members and authorities is also a well-established stressor. Participants in our staff support group expressed this as well, which led to negative emotions. Better colleague support and connection with coworkers have been noted to be helpful. Higher stress has been associated with less control, and this may be the reason why collaborative support can be found helpful.

The crucial role of supervision in both health- and nonhealth-care professionals has been noted in studies. In our study, the details of supervision were planned in advance, clearly designating the supervisor and scheduling the time for supervision.

There is evidence that staff well-being translates to better quality patient care. Although preemptive measures for staff support have been studied, the conduct of such groups and their impact has been addressed in very few studies. We have attempted to measure the effect of our staff support group through verbal feedback and a postsession questionnaire survey. A previous study by Le Blanc on a burnout prevention program had employed a similar evaluation method.

As in the study by Cashavelly et al. on nonlicensed staff in oncology, themes noted by our participants were difficulties with patients and professional work issues. Stress management, attitudinal change, and interpersonal issues were found important by most of the respondents at all 3 assessment points. However, the earlier study did not address the impact. The positive feedback and sustained impact even after 2 years are important findings, in an area, which is quite underresearched. In addition, in our study, feedback was taken by the second mental health professional who provided supervision and not by the group therapist, in an attempt to reduce participant bias.

Participants found different components of the support group useful at different points of assessment. Identification and ventilation of emotions were important at 4 months, which is understandable as participants learned to make the link between antecedent events and emotions, as

**Table 5: Areas found useful (total number of respondents=11)**

| Areas                              | After 4 months | After 1 year | After 2 years |
|------------------------------------|----------------|--------------|---------------|
| Stress management/relaxation       | 9              | 9            | 8             |
| Attitudinal change/coping          | 8              | 9            | 8             |
| Personal/family                    | 8              | 7            |               |
| Interpersonal and relationship     |                |              |               |
| Work                              | 5              | 7            | 5             |
| Professional communication         | 4              | 5            |               |
| Difficult situations               | 2              | 4            |               |

**Table 6: Components of staff support group found useful**

| 4 months | 1 year | 2 years |
|----------|--------|---------|
| 1. Ventilation     | 1. All or none thinking | 1. Problem-solving |
| 2. Coping skills   | 2. Ventilation of emotion | 2. Relaxation techniques |
| 3. Mutual support  | 3. Belonging in a group | 3. Ventilation and understanding of own emotions |
| 4. Dealing with patients | 4. Positive thinking | 4. Dealing with difficult situation |
| 5. Change in negative thinking | 5. Change in attitude | 5. Attitudinal change |
Deodhar and Goswami: Staff support group in an oncology setting

erienced in the group. At 1 year, the main component was working on disputing cognitive errors in thinking like “all or none thinking,” and at 2 years, this translated to problem-solving approaches, using CBT skills. This is in accordance with group CBT formats.[9] Attitudinal change, relaxation exercises, and self-help were found beneficial even after 2 years. These methods helped to improve their self-care and increase their self-reliance, as has been observed in a study by Grafton.[90]

The clinical implication of this study is that establishing protocols for support groups for oncology staff should be part of routine practice [Box 1]. Further research could address other models adopted for staff support groups.

Our study had a few limitations. Formal qualitative research methodology was not used for content analysis for themes and components of the process of staff support group, as we conducted this as an audit exercise. Furthermore, no standard questionnaire was used for collecting postintervention feedback. We did not use standardized measures for burnout, and our focus was only on improving coping and reducing stress.

CONCLUSIONS

Our study on staff support group for a unique homogenous group of field workers involved in cancer screening is the first such report in an Indian oncology setting, in our knowledge. The support group followed a planned structure, with good implementation, recording of content, and provision for supervision. Both the short-term and sustained impact was positive, with participants learning to use cognitive-behavioral approaches to improve coping with work difficulties and self-care.

Based on our experience, we would like to suggest that staff support groups, incorporating elements of sharing and peer support, stress management, working with grief and loss, and work–life balance, should be routine practice in oncology units, both adult and pediatric.[93] Support groups for pediatric oncology staff would benefit from specific elements such as narratives and “remembrance tree,” which provide a forum for staff discussing on relationships with the pediatric and their parents and opportunity to express grief in a protected milieu.[93]

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Conflicts of interest
There are no conflicts of interest.

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