Stress management for breast cancer patients: service development

Maura Hindley, Sue Johnston

Abstract

There is broad consensus that following cancer diagnosis, patients' lives can be disrupted by diffuse, long-term psychosocial problems. There is also increasing evidence to suggest that group cognitive behavioural techniques, as used in stress management and relaxation may be an effective means of offering help. In the context of increasing interest in psychological interventions for patients suffering from cancer, this article discusses the rationale for a stress management programme, incorporating relaxation techniques, for women with breast cancer. The content and implementation of the programme are described and psychological approaches including stress management and relaxation techniques for the wellbeing of patients in cancer care are outlined.

Maura Hindley is Staff Nurse and **Sue Johnston** is Occupational Therapist, St Ann's Hospice, Manchester, UK

Women with breast cancer experience a threat to their lives, an assault on their femininity and physical desirability, and a profound disruption to their family and vocational functioning (Speigel, 1990). This article describes the development of an initiative which introduced a stress management course for women with breast cancer. It aimed to help women maintain their psychological wellbeing at a particularly vulnerable time in their lives. A demand for such a service was identified while working with women with breast cancer and breast care specialists within a local palliative care setting. The need to provide psychosocial support for patients with cancer has also been acknowledged in the literature.

The impact of cancer

The experience of having cancer creates unique stresses for patients and their families. Mehls (1983) stated that the patient with cancer 'is often overwhelmed by the global effects of the disease on himself and his family'. Shock, disbelief, denial, anger, sadness, depression and grief, describe some of the extensive psychological reactions which newly diagnosed cancer patients may face (Maguire, 1992; Massie and Holland, 1994; Fawzy, 1995).

The initial shock of diagnosis can be intensified by a variety of problems, e.g. decisions about conventional treatment, the need to continually absorb information, the process and unpleasant side-effects of specific treatment regimes, the fear of pain, the possibility of disfigurement and the prospect of living with a potentially life-threatening disease. Difficulties directly related to living with cancer may also present and include: financial insecurity; changes in relationships; feelings of isolation, loss of confidence and self-esteem; and a sense of loss of control. The person may re-evaluate his/her personal values.

Other problems such as having a dependent relative, changes in health, pressure of work, marital issues, or dealing with traumas from the past may already exist for cancer patients. Such issues can result in individuals experiencing high levels of distress and feelings of helplessness. Greer, (1994) reported that between 23% and 40% of cancer patients suffer from clinically significant anxiety or depression and a significant number of people require psychological support, or even psychiatric intervention. From the point of diagnosis, therefore, the individual may experience many forms of stress and distress.

Psychological approaches

As early as 1959, personal and clinical reports have suggested that psychosocial interventions are beneficial to cancer patients (Holland and Rowland, 1994).

Over the last 20 years, within mainstream medicine, a number of psychological approaches have been developed to help cancer patients. These include individual psychotherapy, support groups, group therapy, psychoeducational programmes, the use of bio-feedback, imagery and hypnosis. These initiatives have led to a growing acceptance that the maintenance of mental and emotional health in patients with cancer is an important aspect of care (Seago and Conn, 1996).

Some studies, for example, Spiegel (1993) and Fallowfield (1995), have shown that early psychosocial interventions are impor-

'The use of stress management is not a specific treatment, but a general approach aimed at helping people to learn new and adaptive ways of coping. Stress management generally incorporates relaxation and cognitive behavioural approaches.'

tant to patients. Positive benefits including: a reduction in mood disturbances; improvement in coping skills and the ability to express emotions; a reduction in the side-effects of chemotherapy; and a general improvement in quality of life have been reported. Teaching stress management and relaxation skills is supported in the literature (Mastrovito, 1994), and may provide an important source of support for women with breast cancer.

Research suggests that time is an important factor for many patients:

> **'Emotional distress in patients with cancer improves over time; to the extent that we can lessen the intensity of distress, we will achieve another measure of success in our efforts to enhance quality of life'**
>
> **(*Edgar et al, 1992*).**

This would suggest that introducing an intervention early in the disease process may be beneficial in helping patients to cope during times of maximum need. Although psychological approaches have not been found to extend life, and do not claim to cure, heal, or control the disease process, there are consistent reports which suggest that patients experience improved quality of life; fewer side-effects of treatment; fewer symptoms of disease; improved pain control; and a reduced need for medication (Lerner, 1994).

In addition, a meta-analysis by Devine and Westlake (1995) demonstrated the positive outcomes of psychological care, i.e. people experienced less anxiety and depression, and a reduction in physical symptoms such as vomiting, nausea and pain.

Based on the evidence from the literature and an identified patient need at local level, it was decided that patients with breast cancer could benefit from a local service set up to meet the expressed needs of this group of patients. The psychological approaches used within cancer care were reviewed before deciding on course content. Studies report positive results from relaxation training; Campbell et al (1984) found that progressive muscular relaxation training was helpful in promoting normal food consumption, was associated with weight gain in cancer patients and reduced insomnia, a common symptom in people with cancer (Cannici et al, 1983).

In another study, cancer patients in a support group received a care package which included counselling sessions, training in relaxation and information about diet, exercise and their illness (Cain et al, 1986). Subsequent comparisons with control subjects showed that those in the support group were less depressed and less anxious and had more knowledge of their illness, better relationships with their care givers, fewer sexual difficulties and participated more in leisure activities.

In support of such interventions Spiegel (1993) states that:

> **'There is now no doubt that psychosocial interventions are efficacious in helping patients and their families cope with cancer. The existing evidence suggests that they should be part of the standard medical treatment for cancer patients; it is not simply a case of mind over matter, rather it is now clear that mind indeed matters'.**

Stress management

The use of stress management is not a specific treatment, but a general approach aimed at helping people to learn new and adaptive ways of coping. Stress management generally incorporates relaxation and cognitive behavioural approaches.

Sarafino (1994) suggests that such coping methods do not necessarily lead to a solution of the particular problem, but can help the individual to:

- Alter his/her perception of a situation
- Tolerate or accept the harm/threat
- Escape or avoid the situation.

People normally acquire coping skills through past experiences; they may use methods they have already tried in the past, or develop new ones which they have seen others use. Coping skills include: taking direct action, i.e. doing something specifically to deal with the stressor; seeking information for self-help; turning to others for comfort; coming to terms with the situation; expressing anger, crying, or using jokes and gallows humour to help allay the strain; and denial or avoidance of the problem itself (Sarafino, 1994). However, the author points out that sometimes these skills can be inadequate, possibly because the stress is so intense, new, or prolonged.

Considering physical illness, Moos and Tsu (1977) claim that 'a situation which is so novel or so major that the usual habitual responses are inadequate constitutes a crisis, and leads to a state of disorganization often accompanied by anxiety, fear, guilt, or other unpleasant feelings which contribute further to the disorganization'.

'Relaxation has been used for centuries, as a positive and natural means of controlling both psychological and physical symptoms of stress. Relaxation is an active and conscious process, and can be influenced by both internal and external stimuli.'

When people cannot cope effectively, it is thought that they may need help to learn new and adaptive ways of managing stress. Stress management aims to help people understand that the stress they experience can be controlled and that it is a normal body reaction, which may be exacerbated by the disease process.

Becoming aware of the body's response to stress, can help people to understand why they perhaps feel so tired, emotional, and possibly unwell. The need to create an effective balance in life, in order to enable patients to cope more effectively is an important aspect of stress management programmes.

Methods of stress management may vary, however, each programme will have some common elements:

- Cognitive restructuring, e.g. tackling irrational/faulty thinking
- Relaxation techniques
- Social skills and assertiveness training
- Nurturing self-awareness (Payne, 1995).

Relaxation

Relaxation has been used for centuries, as a positive and natural means of controlling psychological and physical symptoms of stress. A useful definition of relaxation incorporates mental and physical dimensions of relaxation and refers to it as 'a positively perceived state or response, by an individual in attaining relative freedom from tension, toil, or strain' (Sweeney, 1978).

Relaxation is an active and conscious process, and can be influenced by both internal and external stimuli. It is manifested by psychological and physiological behavioural responses. Since 'being relaxed' refers to lax muscles or to peaceful thoughts, and since a general state of relaxation can be achieved by using physical and/or psychological methods, this suggests that an important link exists between the mind and the body. Relaxation techniques aim to encourage the mind and body to work together, breaking the cycle of disturbing thoughts and creating a more calm and relaxed state. The rationale for using relaxation includes:

- Protecting the body from unnecessary wear and tear
- Helping to relieve stress
- Calming the mind and allowing thinking to become more clear and effective.

Relaxation techniques work by using systems under conscious control to affect those under autonomic control. Progressive relaxation involves teaching muscles to relax which reduces the production of stress hormones; the physical symptoms of stress gradually subside and the body regains equilibrium and balance. The use of visualization/imagery involves presenting the mind with peaceful situations which have a positive effect on calming the mind.

Teaching relaxation techniques to cancer patients is a holistic means of focusing on the whole person rather than concentrating merely on the physical area of disease. It aims to offer patients a method of self-help, at a time when they often feel dependent on others for their wellbeing.

Benefits of groups

Group therapy is often used as a means of offering support. There is evidence to favour group intervention not only on the basis of cost-effectiveness but also because of the therapeutic benefit associated with giving and receiving (Bottomley, 1996). Groups generally fall into two categories:

- Self-help, patient-led groups
- Professionally-led groups.

Historically, nurses have not been actively involved in running groups, although they may frequently encourage patients to attend (Freedhoff, 1993). Health professionals may doubt the value of groups; the fear of distress caused by the death of a group member is the primary cause of resistance (Holland and Rowland, 1994). However, Massie et al (1994) argue that patients report that facing their anxieties and mortality in a supportive environment is a positive experience. If the group is a self-referral one, joining may indicate intent to improve the present situation and a desire to access information and regain control. Three main factors influence group culture:

- Structure
- Characteristics of individual members
- The process a group develops in order to operate (Vernelle, 1994).

Setting up a group

The way in which individuals in a group interact determines the process. Each group is unique in its own development. The behaviour of individuals within a group is neither constant nor predictable and the group can influence these factors. The size of the group should be appropriate to the nature of group. It is more difficult to achieve equal participation in larger groups and therefore the maximum recommended number of people is 10. Ideally, members should face each other in

'The main aims of the stress management group initiative were to reach women in the early stage of breast cancer, to encourage self-referral and to meet as a group which would work through a framework of seven weekly sessions.'

a circle to facilitate verbal and non-verbal communication, maintain attention and the opportunity to contribute to group discussion (Freedhoff, 1993).

It is important to allow sufficient time per session to cover the agenda. Group participants may have commitments at certain times of the day, e.g. mothers with dependent children or working mothers, and this should be taken into consideration when planning the time of group sessions. The venue/setting for the group and issues such as maintaining privacy and a lack of interruption are also important.

Each group is responsible for setting its own ground rules which are fundamental to the cohesion of the group and should be agreed at the first session. All group members need to understand the aims and goals of the group. The characteristics of individual members including: status outside the group; individual behavioural reactions and responses to group pressure; and previous group experiences will influence the dynamics of each group. In the context of a support group, the common link is a diagnosis of a potentially life-threatening disease and a desire to improve the quality of life.

Establishing the service

A formal needs-based assessment was not undertaken before setting up the stress management programme. However, women with breast cancer who attended a local day care facility spoke of their need for improved support, information and guidance at a time when they felt that they were physically and emotionally overwhelmed by the disease process. This unmet need highlighted a gap in service provision for these women.

The authors (a part-time staff nurse and occupation therapist) work within a multidisciplinary team based at a hospice and liaise with a nurse specialist in breast care at the local NHS trust hospital. She confirmed that psychosocial support obtained in breast clinics is likely to be inadequate for many women because of the limited time available. There is little supplementary support in terms of stress management or relaxation on offer for women with breast cancer in this locality. Therefore, the authors decided to set up a support group in line with the hospice philosophy of care, which focuses on maintaining and, where possible, improving the quality of patients' lives.

Experience has shown that patients need support at different times (Houston, 1994). Identifying a need and seeking help is often the first step in the therapeutic process. It is important to offer a service which meets the needs of each individual; needs may be identified at the time of diagnosis or months or even years afterwards.

The main aims of the stress management group initiative were to reach women in the early stage of breast cancer, to encourage self-referral and to meet as a group which would work through a framework of seven weekly sessions. These included:

- Developing an understanding of the nature of stress
- Becoming aware of the importance of balance in life
- Becoming aware of the individual's particular responses to stress
- Increasing confidence to practice selected coping strategies and relaxation techniques on a regular basis
- Increasing self-confidence, self-esteem, self-worth and control
- Receiving professional support, friendship and information
- Gaining a better understanding of illness and how to maximize energy and quality of life.

The content of the course was carefully structured (*Table 1*), aiming to meet the needs of the group in a holistic way. Each 2-hour session included theoretical and experiential elements of stress management, incorporating physical, cognitive and behavioural means of self-help. Maintaining group confidentiality is necessary to promote effective group interaction and cohesion, and to provide a 'safe' environment in which to share and receive support. Ground rules were established at the first meeting, i.e. punctuality, confidentiality and a no smoking policy. Group facilitators need to adopt a flexible and adaptable approach in order to deal with issues or concerns as they arise.

Once the aims and objectives of the group had been established a meeting was arranged with colleagues at senior management level. The initial meeting was encouraging and helped to identify areas that needed to be considered before the course could begin, e.g. where to hold the course? How much would it cost the organization? Would the involvement of the community dietitian incur a fee? How would patients be made aware of the new service? Although it was agreed that the service should be free to patients, salaries had to be costed and agreement for secretarial support obtained.

A meeting with the breast nurse specialist was arranged to discuss the course pro-

'Nine women attended the first course, all were self-referrals. All had cancer; the length of time since diagnosis varied from 6 months to 3 years. Evaluation of the pilot course was positive and the authors were encouraged to run more courses.'

posals. She had founded a breast support group 12 months earlier which met on a monthly basis, and considered that the proposed service would be compatible with the development in her area. It was agreed that the authors would attend the monthly meetings to inform members of the new service and offer ongoing support.

Leaflets were printed and designed for circulation in outpatient departments and local general practices. All hospice services are accessed through referral from health professionals, but it was considered crucial that patients could self-refer to this service. The emotional demands that the programme could place on the facilitators were acknowledged and it was agreed that they would receive support and time for supervision funded by the hospice.

The main aims of supervision in this context were to:

- Support and challenge the facilitators in relation to current practice
- Recognize the personal and developmental needs of the facilitators.

The timing of the meetings was important, considering the work commitments of the patients and facilitators, and the availability of a room. Evenings appeared to be the most suitable time as some patients were working or had family responsibilities during the day. The first course ran for 6 weeks and a follow-up session took place 1 month later.

Nine women attended the first course, all were self-referrals. All had cancer and the length of time since diagnosis varied from 6 months to 3 years. Evaluation of the pilot course was positive and the authors were encouraged to run more courses.

Evaluation

The first course was evaluated by a palliative care counsellor working in the community, which proved to be a valuable independent link and her input on subsequent courses continues. Questionnaires are distributed to each group member in the last session of the course. Honesty is encouraged and the value of feedback for future developments is stressed. The purpose of evaluation is to:

Table 1. Topics covered in the first stress management course

Topics	
Recognizing stress	The nature of stress — increasing self-awareness (I, PC)
Fight or flight principle	Increase awareness — the body's response to stress (I, PC, PS)
Muscles/muscle fatigue	How muscles work — link tension to stress response, tension headaches, backache etc. (I, PC, PS)
Breathing	Basic physiology and mechanism — link release of muscle tension with breathing out, diaphragmatic breathing (I, PC)
Hyperventilation	Link to faulty breathing use of 'STOP' technique (I, PS, PC)
Fatigue	Identify personal vulnerability to fatigue (I, PS, PC)
Coping strategies	Distinguish between maladaptive and adaptive methods (I, P, PS, R)
Sleep	Link stress response with insomnia Relaxation as an effective coping strategy (I, PC,PS, R)
Balanced diet	Importance of balanced diet — boosting energy levels (I, PC, PS)
Raising difficult issues	Improving effective communication — breaking bad news (PS, P)
Increasing self-esteem	Making small lifestyle changes, valuing oneself becoming more assertive (PS, P, I)
Self-massage	Link to muscle tension — head, neck, shoulders (I, PC, R)
Easing movements	Hands, arms, shoulders, head and neck (PC, I, R)
Loss and change	Link loss with change and associated stress symptoms (PS, I)
Positive thinking and talking	Link to individuals' perception of stress (PS, I)
Information	Awareness of services, resources available — encourage self-help (I, PS)

KEY: Sessions contain elements of: PS = problem solving; P = peer support; I = information; R = relaxation; PC = physical care

'In using the hospice as a venue for the course, the authors had anticipated a number of difficulties; most important was dealing with the fears and anxieties associated with the concept of a hospice being a place where people go to die...'

- Assess how well the sessions had met the needs of group members
- Ascertain whether group members had made any lifestyle changes
- Provide quality awareness
- Identify areas for future course development including content, style and delivery.

Feedback from the first group was very positive and all members found the sessions helpful and supportive. Common perceived benefits of the course included learning relaxation and stress reducing techniques (*Table 2*), and the social aspects of the group. All members reported making positive lifestyle changes to cope with stress as a result of the course.

The following comments express group members' feelings: 'it made me aware of tension, stress and body reactions. I am now able to relax quite easily'; increased ability to cope with panic attacks, decreased tiredness and improved sleep, 'I am now sleeping without the help of tranquillizers'; and feelings of isolation and helplessness decreased 'meeting other women who have had the same illness and treatment so you don't feel so alone', 'meeting people who have similar experiences with breast cancer, realizing I'm not alone'.

None of the women dropped out of the course and group members always telephoned with apologies if they could not attend indicating a high level of commitment to the group. Attendance figures for the first course are shown in *Table 3*. In general, the women on the first course were satisfied with the content of the sessions; suggestions for improvement included requests for more information on complementary therapies, massage and the effect of breast cancer on relationships. Half of the women had informed their GPs about the course and commented that the GPs were supportive.

In the future, it may be possible to develop a more systematic evaluation of patients' anxiety levels and coping abilities at planned stages throughout the course.

Conclusion

Introducing and managing change effectively is a time-consuming process (Tappen, 1995). As part-time staff, finding time to plan and initiate developments was difficult and therefore being organized was crucially important. Management and other colleagues were both supportive and flexible which was essential in order to create time to fulfil goals and deadlines within an already busy schedule.

In using the hospice as a venue for the course, the authors had anticipated a number of difficulties; most important was dealing with the fears and anxieties associated

Table 2. Relaxation techniques used on the stress management course

Relaxation techniques	Mechanism	Intended outcomes
Simple sitting relaxation Based on the Benson/Alexander technique	Introduction to relaxation	'Permission to stop' – time to feel still and more calm
Progressive relaxation Based on the Jacobson relaxation technique	Focus on releasing unnecessary muscle tension	Deeper form of relaxation – increases self-awareness and ability to relax
Relaxation Based on Laura Mitchell technique (Relaxation for Living Trust)	Emphasis on awareness of joint and skin sensations, stretching out unnecessary muscle tension	Simple and quick method – increases awareness of position of ease in muscles
Relaxation Based on Madders (1979)	A form of mental imagery –overtones of suggestion	Increased sensory awareness Deeper relaxation
Countdown technique of relaxation by recall Based on Payne (1995)	Based on memory of routines of progressive relaxation	Quick, unobtrusive relaxation
Mind disciplines Based on Payne (1995)	A form of imagery — used as a continuation of relaxation	Calm and 'still' the mind
Visualization/Imagery relaxation techniques Based on Payne (1995)	Utilizes the power of creative thinking	Induces a feeling of calm Enhances relaxation – a distraction from stressful thoughts

Table 3. Number of women who attended the first course

Week	Number
Week 1	9
Week 2	8
Week 3	7
Week 4	7
Week 5	6
Week 6	8
Week 7	8

with the concept of a hospice being a place where people go to die (Sharpe, 1992). Personal reassurance, explanation of the hospice services and regular attendance at the monthly support group meetings helped to dispel such fears.

Six courses have now been completed and these have been evaluated. Patients are encouraged to share what they have found both useful and not so useful, and programmes have since been adapted and developed accordingly. Based on their comments and course evaluation, the course has been extended from 7 to 9 weeks. The hospice pharmacist is now included in the programme, addressing queries on various medications. It is hoped that increased knowledge and understanding will help to decrease the women's anxiety levels (Fallowfield, 1995).

Many of the patients are at risk of developing lymphoedema and this issue is addressed by providing information on care such as basic skin care. Referral to the lymphoedema specialist is suggested for anyone needing further advice. A self-assessment questionnaire (completed at the beginning and end of the course) has been developed and is now used to help patients identify their personal vulnerability to stress.

The service has developed since it began and three stress management groups are now run annually, with an average of seven women attending each group. Overall, patients have found the stress management course helpful and evaluation has enabled further developments in the service to be undertaken. It is hoped that this article will provide a focus for discussion among health professionals who work with this vulnerable group of patients.

We wish to thank Miss Wendy Burford, former Director of Nursing, St Ann's Hospice, for her support in developing this service, and Dr Katie Booth, Director Macmillan Practice Development Unit, University of Manchester, for her comments and suggestions concerning this article.

KEY WORDS

- Breast cancer
- Stress management
- Support group
- Relaxation
- Psychosocial interventions
- Quality of life

Bottomley A (1996) Group cognitive behavioural therapy: an intervention for cancer patients. *Int J Palliat Nurs* **2**(3): 131–7

Cain EN, Kohorn EI, Quinlan DM, Latimer K, Schwartz PE (1986) Psychosocial benefits of a cancer support group. *Cancer* **57**(1): 183–9

Campbell DF, Dixon JK, Sanderford LD, Denicola MA (1984) Relaxation: its effect on the nutritional status and performance status of clients with cancer. *J Am Dietetic Assoc* **84**(2): 201–4

Cannici J, Malcolm R, Peek LA (1983) Treatment of insomnia in cancer patients using muscle relaxation. *J Behav Ther Exp Psychiatry* **14**(3): 251–6

Devine EC, Westlake SK (1995) The effects of psychoeducational care provided to adults with cancer: meta-analysis of 116 studies. *Oncol Nurs Forum* **22**(9): 1369–81

Edgar L, Rosberger Z, Nowlis D (1992) Coping with cancer during the first year after diagnosis. *Cancer* **69**(3): 817–28

Fallowfield L (1995) Psychosocial interventions in cancer. *Br Med J* **311:** 1316–7

Fawzy NW (1995) A psychoeducational nursing intervention to enhance coping and affective state in newly diagnosed malignant melanoma patients. *Cancer Nurs* **18**(6): 427–38

Freedhoff S (1993) Structured cancer support groups: a valuable piece of cancer care mosaic. *Can Oncol Nurs Forum* **3**(1): 6–10

Greer S (1994) Psycho-oncology: its aims, achievements and future tasks. *Psycho-oncology* **3**(2): 87–101

Houston L (1994) Macmillan team work. *Partners Palliat Care* **1**(2): 3–4

Holland JC, Rowland JH, eds (1994) *Handbook of Psycho-oncology: Psychological Care of the Patient with Cancer.* Oxford University Press, New York

Lerner M (1994) *Choices in Healing*. MIT Press, Cambridge, Massachusetts

Madders J (1979) *Stress and Relaxation; Self-Help Techniques for Everyone.* 3rd edn. Optima, London

Maguire P (1992) Improving the recognition and treatment of affective disorders in cancer patients. In: Granville Grossman KL, ed. *Recent Advances in Clinical Psychiatry.* Churchill Livingstone, Edinburgh: 15–30

Mastrovito R (1994) Behavioural techniques: progressive relaxation and self-regulatory therapies. In: Holland JC, Rowland JH, eds. *Handbook of Psycho-oncology: Psychological Care of the Patient with Cancer.* Oxford University Press, New York: 492–501

Massie MJ, Holland JC (1994) Overview of normal reactions, and prevalence of psychiatric disorders. In: Holland JC, Rowland JH, eds. *Handbook of Psycho-oncology: Psychological Care of the Patient with Cancer.* Oxford University Press, New York: 273–82

Massie MJ, Holland JC, Straker N (1994) Psychotherapeutic interventions. In: Holland JC, Rowland JH, eds. *Handbook of Psycho-oncology: Psychological Care of the Patient with Cancer.* Oxford University Press, New York: 455–69

Mehls JD (1983) Occupational therapy as a component of cancer rehabilitation. In: *Progress of Cancer Control III: A Regional Approach.* Alan Liss Inc. New York: 231–40

Moos RH, Tsu VD (1977) The crisis of the physical illness: an overview. In: Moos R, ed. *Coping with a Physical Illness.* Plenum, New York: 3–21

Payne RA (1995) *Relaxation Techniques: A Practical Handbook for the Healthcare Professional.* Churchill Livingstone, Edinburgh: 54–55

Sarafino EP (1994) *Health Psychology: Biopsychosocial Interactions.* 2nd edn. J Wiley & Sons, Chichester

Seago M, Conn C (1996) Mind-body partnering for clinical practice. *J Psychosoc Oncol* **14**(4): 47–63

Sharpe E (1992) A traveller's tale. *Br Med J* **309**(6952)

Speigel D (1990) Facilitating emotional coping during treatment. *Cancer* **66**(6): 1422–6

Speigel D (1993) Psychosocial intervention in cancer. *J Nat Cancer Institute* **85**(15): 1198–205

Sweeney SS (1978) Relaxation. In: Carlson C, Blackwell B, eds. *Behavioural Concepts and Nursing Interventions.* 2nd edn. JB Lippincott, Philadelphia: 240–52

Tappen R (1995) *Nursing Leadership and Management. Concept and Practice*. 3rd edn. FA Davis Co, Philadelphia

Vernelle B (1994) *Using and Understanding Groups.* Whiting and Birch Ltd, London