Relaxation Therapy for Those with Cancer: A Grounded Theory

By

Jane Anne Marilyn Emberly

A thesis submission to the Faculty of Graduate Studies of

The University of Manitoba

In partial fulfillment of requirements of the degree of

MASTERS OF SOCIAL WORK

Faculty of Social Work

University of Manitoba

Winnipeg

Copyright © 2008 of Jane Anne Marilyn Emberly

THE UNIVERSITY OF MANITOBA

FACULTY OF GRADUATE STUDIES

*****

COPYRIGHT PERMISSION

Relaxation Therapy for Those with Cancer: A Grounded Theory

BY

Jane Anne Marilyn Emberly

A Thesis/Practicum submitted to the Faculty of Graduate Studies of The University of Manitoba in partial fulfillment of the requirement of the degree

Of

MASTER OF SOCIAL WORK

Jane Anne Marilyn Emberly © 2008

Permission has been granted to the University of Manitoba Libraries to lend a copy of this thesis/practicum, to Library and Archives Canada (LAC) to lend a copy of this thesis/practicum, and to LAC's agent (UMI/ProQuest) to microfilm, sell copies and to publish an abstract of this thesis/practicum.

This reproduction or copy of this thesis has been made available by authority of the copyright owner solely for the purpose of private study and research, and may only be reproduced and copied as permitted by copyright laws or with express written authorization from the copyright owner.

Abstract

Mind-body approaches have been used to target stress and anxiety associated with a diagnosis of cancer. A specific on-going, open, relaxation mind-body group offered through Cancer Care Manitoba in Winnipeg MB experientially taught patients three mind-body approaches; (a) progressive muscle relaxation, (b) guided imagery and visualization and (c) suggestions and affirmations. Ten participants and four facilitators were interviewed. Interviews focused on three topics; (a) the role the group played in the participants' lives and their cancer experience, (b) what home practice looked like for participants, and (c) how participants were able to apply the approaches to spontaneous situations. The interviews were coded and analyzed according to grounded theory methodology. A theory developed which found that when three conditions were present, participants used the approaches the most frequently and regularly to cope with cancer related situations, as well as every day stressful events. The three conditions were (a) presence of stress and anxiety producing situations, (b) external motivation, and (c) personal motivation. However, participants continued to use modified versions of the approaches long after they finished cancer treatment and stopped attending the mind-body group. Those with minimal exposure to the approaches and as well as those who had not attended the group in up to 5 years continued to use the approaches in some fashion. Information from the facilitator interviews was not included in this coding, however did substantiate findings to some degree.

Acknowledgements

Of course, this thesis could never have been fulfilled if it had not been for the many people who assisted along the way. Most importantly, I thank all the participants for opening yourselves so freely to a stranger and sharing stories of one of the hardest times in your lives. Your word is out there and I hope I have done it justice.

Thank you to all the professionals for helping with recruitment of participants when there were so few attending, and for those whose suggestions and feedback helped me along the way.

Thank you to the endowment fund for providing financial assistance. Thank you Claudette Cormier for saving me an enormous amount of time by transcribing so quickly after each interview.

Thank you to Tuula for your patience and understanding as I grew and learned through this very long journey. Thank you to Jill Taylor-Brown and Ruth Dean for sitting on my committee and waiting patiently in between updates. To all three, your advice and suggestions along the way have guided me in many ways and I appreciate that.

To Heather, thank you for editing my paper, and for support through this. To all my friends and family-your encouragement and subtle inquiries on progress kept me on track.

Cole and Hayley, my life and my everything, thank you for all the hugs and kisses that got me through the hard parts. Mom is done her homework – my time is yours now.

Finally to Brad, you held down the fort without complaint or question, you pushed and encouraged when I wouldn't. You always knew that I could do it and now I have. I love you.

Table of Contents

Page

Chapter One: Introduction
General research problem 1
Relevance to social work practice 1
Group therapy 2
Relaxation mind-body approaches 3

Chapter Two: Literature Review 6
Medical and treatment considerations 6
Psychosocial issues 7
Definitions 8
Progressive muscle relaxation 9
Guided imagery/visualization 10
Suggestions and affirmations 10
Psycho-educational groups 11
Psychosocial interventions 12
Three relaxation approaches 13
Empirical gaps 14
Psychosocial interventions 14
Home practice and long term use 16

Chapter Three: Methodology
Research questions 18
Qualitative research 18
Relaxation mind-body group 21
Inclusion criteria and recruitment 23
Data collection instruments 24
The semi structured interview 25
Field notes 28
Research ethics 29
Confidentiality and consent 29
Risk of emotional distress 29
Compensation 29
Analysis 30

Chapter Four: Findings
Demographics 35
The theory 38
Conditions that impact need to use relaxation 41
Stress and anxiety producing situations 41
External motivation 43
Personal motivation 46

Use of relaxation outside group setting 47
Regular practice 47
Spontaneous use 49
When conditions were not present 52
When relaxation was not the answer 55
Specific participants 56
Facilitator findings 61

Chapter Five: Conclusions and Recommendations
Comparison of the theory with literature 64
Psychosocial interventions 64
Psycho-educational groups 68
Limitations of study 69
Recommendations for future research 70
Recommendations for social work practice 71

Appendices
A: Information Sheet 73
B: Sign up sheet 74
C: Interview Guideline 75
D: Facilitator Interview 78
E: Consent Form 79
F: Resource Information 81

References 82

Tables

Table One: Codes 33

Table Two: Demographics 37

Table Three: Participant Attendance History 57

Figures

Figure One: Visual Representation of the Theory 37

CHAPTER ONE: INTRODUCTION

General Research Problem

The purpose of this research was to examine the impact of attending a relaxation mind body group (RMBG) on individuals who had cancer. The RMBG was an on-going, open, drop-in style group that taught, through practice, three relaxation mind-body approaches: progressive muscle relaxation, visualization/guided imagery, and suggestions and affirmations. The main purpose of this group was to offer an opportunity to learn three relaxation approaches in order to provide participants with skills to manage the psychosocial impact of cancer, specifically managing anxiety and distress. My interest was to speak to participants on their experience with the group. There were three areas of focus in this research. The first was the role the RMBG played in the participants' lives (i.e., did they attend regularly, was the group part of their weekly routine, overall what impact did they feel that the group had on their life). The second area focused on how many of the participants practiced what they were taught. If they did practice, what was that like for them and to what extent did they make it a regular part of their lives. The final area addressed whether the participants were able to take the relaxation approaches that they learned in the group and use them in everyday situations. This research looked for descriptions of specific situations in which an approach was applied, and whether participants could generalize the approaches over various cancer- and non-cancer related situations.

Relevance to Social Work Practice

A diagnosis of cancer can disrupt the life of the individual and the family. It can be further exacerbated by the type of cancer, the prognosis, and the course of treatment.

The area of psychosocial care for those with cancer has begun to receive more focus and advocacy for increase in resources in medical settings (Bultz & Carlson, 2005). The role of the oncology social worker in a medical setting is to provide psychosocial care to people affected by cancer and their families and to educate the public on cancer survivorship (AOSW, 2008). Psychosocial concerns, specifically anxiety, have been found to be prevalent in those diagnosed with cancer. Although there have been varying rates of prevalence noted in research (Stark, et al., 2002), anxiety is a common psychosocial concern among those with cancer. For the oncology social worker who would help those with cancer manage anxiety and reactions to stressful situations, this research adds to the literature on the self reported benefits of psychosocial interventions, specifically a psycho-educational group focused on teaching relaxation approaches to manage stress and anxiety.

Group Therapy

Group therapy is an integral part of social work practice. Before social workers had ever been instructed in group work, it had been established as a means of support in social agencies (Northern & Kurland, 2001). Early group work emphasized the understanding and respect of the cultures of the participants, then slowly incorporated knowledge on behaviour and development and systems theory (Northern & Kurland, 2001). Group work can be found in any field of practice, including the health care field, although it took longer for it to take hold in this area than others (Northern & Kurland, 2001).

The participants interviewed in this research were part of a psycho-educational group offered to those that had cancer and their family members. This was an open, on-going, drop-in group offering relaxation therapy instruction for those affected by cancer. Open groups have advantages: (a) experienced members can role model for newer members, (b) flexibility of group attendance and (c) constant availability of support (Berger, 1984). With open membership, the group is constantly renewing itself but at the same time, new members have the task of fitting into an already existing group (Brown, 1998). Shifting membership can hinder a group from moving on to a more mature stage and the on-going nature may lead to loss of focus and purpose (Gitterman, 1982).

Psycho-educational groups are offered to help members learn new skills and information, with opportunity for discussion to help learning. Members are connected by a common interest in what will be learned and by common characteristics, such as being affected by cancer. Self disclosure is often low to moderate in these groups (Toseland & Rivas, 2001). Although one can speculate that many of the positive aspects of a support group might be found in educational groups, such as group cohesiveness, or being with others with similar issues (Gitterman, 1982), these were not the specific goals of the group in this research. This group had a strong experiential component, emphasizing skills training and teaching. Its purpose was to teach individuals the relaxation approaches through practice in a group setting. The skills taught included progressive muscle relaxation, suggestions and affirmations and guided imagery.

The Relaxation Mind-body Approaches

The connection between the mind and body can be traced back centuries. Thousands of years before modern medicine, bodily suffering was often attributed to the

state of mind of the person and treated through physical and mental interventions (Lewis & Lewis, 1972). In the second half of the 19th century, the germ theory of disease took precedence in the medical field, placing more emphasis on the discovery of microorganisms that cause disease (Lewis & Lewis, 1972). The emotional aspect of physical ailments took a back seat to the physiological discoveries that were being made in that era. Compartmentalization of the mind and body into many systems allowed for study of the body in minute detail but, at the same time, the individual personality was ignored and thought to be of little influence or consequence in treatment (Loscalzo & Zabora, 1996).

In recent years, there has been a move to mend this split of the mind and body and view the person in totality, attending to all psychological, social, spiritual, and physical consequences of a diagnosis (Loscalzo & Zabora, 1996). There is relevant literature relating to the effectiveness of widely used psychosocial interventions for those with cancer. Overall, individuals with cancer have shown improvements in distress and anxiety levels due to psychosocial interventions (Andrykowski & Manne, 2006).

There is a growing body of literature focusing on Mindfulness Based Stress Reduction, a program based on intensive, daily teaching and practice of body scan meditation, sitting meditation and mindful hatha yoga, discussions of stress and coping and a home practice component (Kabit-Zinn, 1985; Kabit-Zinn, Massion, Hebert, & Rosenbaum, 1998). Introducing this program to individuals with cancer has shown positive and long term effects on managing stress (Carlson et al., 2001; Carlson, Speca, Faris, Patel, 2007; Speca et al, 2000; Matchmin & Armer, 2007).

Relaxation approaches have been defined as a set of techniques that can result in a reduction of anxiety, stress, and tension involving psychological or physiological origins (Snyder, 2002; Wren & Norred, 2003; Zahourek, 1988). Relaxation approaches, often introduced in conjuction with medical care to promote optimal functioning and rehabilitation of the person with cancer and his or her family, allow individuals to learn specific skills which increase their sense of control (Loscalzo & Zabora, 1996). Three relaxation approaches introduced in the RMBG discussed in this research are progressive muscle relaxation, guided imagery/visualization, and suggestions and affirmations. These approaches were taught in a group setting with the intent to offer skills to help individuals manage stress and anxiety associated with a cancer diagnosis. The literature spanning these three approaches suggests positive results concerning their effectiveness on a variety of concerns, including reducing anxiety, relieving pain, and reducing nausea and vomiting, among others (Davis, 1994; Post-White & Fitzgerald, 2002; Scott, Donahue, Mastrovito, & Hakes, 1986; Sloman, 1995; Syrjala, Cummings, & Donaldson, 1992; Wallace, 1997) They have been applied alone or in combination to observe effects on anxiety (Bridge, Benson, Peitroni, & Priest, 1988). This study explored the impact of introducing all three of these approaches to individuals, within a psycho-educational group, with the intent of helping participants combat stress and anxiety encountered after a diagnosis of cancer. The research study here will add to this body of literature by looking at relaxation approaches taught to individuals with the intent to offer skill to reduce stress and anxiety, and by discussing long term use of these approaches.

CHAPTER TWO: LITERATURE REVIEW

It has been estimated there would be 166 400 new cases of cancer in Canada in 2008, and 73 800 deaths due to cancer (Canadian Cancer Society, 2008). Many people today have had to learn to live and cope with the emotional, physical, and psychosocial issues surrounding a cancer diagnosis and treatment. These issues can range in severity depending on the type of cancer and the supports available. Medical considerations will first be discussed then psychosocial issues of those with cancer will be outlined. Literature will be used to define the three relaxation approaches taught in the RMBG. Psychosocial interventions will be discussed and the gaps in the literature will be described.

Medical and Treatment Considerations

The severity of cancer can range from minimal to life threatening, depending on several issues; type of cancer, location, size of initial tumor, stage at diagnosis, and whether the disease has spread to other areas of the body (Veach, Nicholas, & Barton, 2002). There are four main clinical courses that cancer can follow: (a) long term survival and cure, (b) no primary treatment possible therefore death results, (c) primary treatment with no response where death occurs, or (d) primary treatment resulting in remission with cancer recurrence and death. Whatever the course, there are always decisions to be made, including medical, personal, and quality of life considerations. Main treatment options include surgery, radiation, and chemotherapy (Veach et al., 2002). Each of these treatments has unique physiological side effects. Surgery is often used when a tumor is confined to a specific area and can be safely removed. Depending on the extent of the surgical procedure, great physical deformation can result. Radiation is used to kill cancer

cells by destroying their ability to divide (Veach et al., 2002). The most common side effects of radiation are fatigue and localized skin irritation. Side effects can also be specific to the type of cancer. For example, if receiving radiation for neck or throat cancer, irritation of the throat may occur (Veach et al., 2002). Chemotherapy uses chemical agents to treat cancer but is a generalized method that can affect other organs or body parts. The goals of chemotherapy are to eradicate all malignant cells or to control the disease (Veach et al., 2002). Generally, chemotherapy side effects are caused by the impact on healthy body cells, resulting in hair loss, nausea, vomiting, diarrhea, constipation, and fatigue (Veach et al., 2002).

Psychosocial Issues

A diagnosis of cancer is a threat to a person's health and life. Individuals with cancer often face many common psychosocial issues (Helgeson & Cohen, 1999). Cancer instills fear and a sense of dread in those affected by it, creating a sense of uncontrollability and vulnerability (Loscalzo & Zabora, 1996). Feelings of low control over life events can result in anxiety and depression (Siegel, 1990). Some level of anxiety would be expected when faced with cancer and thus efforts by professionals to help individuals cope with this anxiety should begin at time of diagnosis. Anxiety in those with cancer can occur as an acute episode or develop into a chronic anxiety disorder (Noyes, Holt, & Massie, 1998; Stark et al, 2002). Research on the prevalence of anxiety among those with cancer is varied, (Jacobsen & Jim, 2008; Stark & House, 2000) but research shows that anxiety is one of the most common psychosocial issues those diagnosed are face with. In Fawzy, Fawzy, Arndt, and Pasnau's 1995 review, it was found that those with cancer are often distressed, anxious, and cannot use their normal

coping skills effectively. They also posited that psychosocial interventions and behavioural training should be offered early on for newly diagnosed individuals, and ongoing group support should be offered for those with advanced stage cancer. Psychosocial issues such as anxiety and distress can be present throughout the disease course, arising in different intensities for different reasons (Veach et al., 2002). The time of diagnosis, regardless of the prognosis, is a time of crisis for the individual and family and often includes disruption of normal life functioning. During treatment, there is extreme disruption of normal life routine and side effects can enhance the feelings of loss of control over the body and over health. Even those who have survived cancer have feelings of vulnerability and anxiety surrounding fears of recurrence (Arnold, 1999; Siegel, 1990). Although this may diminish over time, Siegel's (1990) review suggests that it may never completely go away, compromising a long term sense of well being.

Despite the diagnosis or prognosis, psychosocial and emotional issues for a person with cancer must be taken into account. The support available to the individual can influence their coping strategies and the experience of cancer. Psychosocial interventions are a focus for the oncology social worker, who can offer support to those battling cancer (AOSW, 2008). Relaxation approaches can be on set of psychosocial interventions that can help individuals cope with a diagnosis of cancer.

Definitions

Relaxation approaches have been discussed as a set of techniques that can result in a reduction of anxiety, stress, and tension involving psychological or physiological origins (Snyder, 2002; Wren & Norred, 2003; Zahourek, 1988). These techniques have been shown to result in a relaxation response, consisting of several changes in

physiological activity that work to calm the autonomic nervous system and return the body to a stable state of homeostasis (Benson, 1976). The physiological changes that are thought to occur include reduced oxygen consumption, reduced respiratory rate, reduced heart rate, reduced muscle tension, and return to normal blood pressure (Benson, 1976). Further research has found that two components are necessary to elicit the relaxation response. One is use of a mental device such as focused breathing or mental imagery and a second is the use of a passive attitude to keep out invasive thoughts and distractions (Benson, 1984).

The RMBG in question for this research focused on three relaxation approaches: (a) progressive muscle relaxation, (b) guided imagery/visualization, and (c) suggestions and affirmations. The definitions of these three as presented in the literature are important to discuss. There seems to be a consensus on what each of these techniques entails and how they are generally understood in the health care field, although there may be variation in therapists' personal style of facilitation or employment of techniques.

Progressive Muscle Relaxation

Progressive muscle relaxation (PMR) was described by Jacobson (1938) as the "voluntary continued reduction of contraction of muscle groups…and of motor or associated portions of the nervous system" (p. 33). The individual is taught to recognize the sensation of muscle tension, then shown how to relax this group of muscles. This is done, in progression, with most of the muscle groups of the body (quite an extensive list as outlined by Jacobson) while the individual is comfortably lying on his or her back, arms at the sides, with the legs uncrossed. This method appears to have an effect on the musculoskeletal system, decreasing muscle tension and spasms, which can in turn reduce

anxiety (Snyder, 2002). This proven method of inducing a relaxed state continues to be used, often in modified form. It has been administered in the absence of other relaxation techniques, to improve psychological parameters as measured by the Profile of Mood States questionnaire for those undergoing radiation treatment (Decker, Cline-Elsen, & Gallagher, 1992). Individuals who have been taught this method have been able to use it successfully in busy, noisy environments. This is an important concept when focusing on the use of relaxation mind-body techniques at home or in the hospital setting (Benson, 1984).

Guided Imagery

Guided imagery (GI) is another relaxation mind-body approach. It has been extensively defined in the literature as a technique that invokes and uses all the senses (Achterberg, 1985; Korn & Johnson, 1983). It uses direct suggestion of comfort associated with a specific image through the formation of mental representations of an object, place, event, or situation perceived through all the senses (Post-White & Fitzgerald, 2002). The aim is to alter physiological and mental processes in order to stimulate relaxation, provide mental distraction or promote creative thinking (Zahourek, 1988).

Suggestions and Affirmations

The third technique, suggestions and affirmations, includes statements, positive or negative, in which a strong feeling is expressed and believed by a person (Davis, 1994). In order to be believable, suggestions should be meaningful to the individual at that time and relate to the stressful situation (Strauss, 1990). Suggestions and affirmations have been used as a psychosocial intervention for a variety of health concerns (Hammond,

1990). The aim of this is to encourage individuals to be responsible for what they think and do, however difficult it may be to remove learned patterns of negative thinking and behaving (Davis, 1994). The key to changing these negative patterns is finding positive and powerful affirmations for the individual. A few important guidelines to remember when utilizing affirmations are to; (a) make them positive, (b) state them in the present tense, (c) keep the affirmation simple and to personalize it (Davis, 1994). For example, a suggestion for a person with end stage cancer may revolve around ideas of being free from discomfort, tension, stress and strain, repeating words such as relax, ease, and rest (Crasilneck & Hall, 1990).

Psycho-Educational Groups

The purpose of the RMBG described in this research was to experientially teach three relaxation approaches to people who had been diagnosed with cancer. In this psycho-educational group, participants were encouraged to use these approaches outside the group setting. The objective was that participants would learn these techniques in order to better manage stress and anxiety and gain some control over these reactions. There is evidence showing that psycho educational groups can be more beneficial than groups that offer only support. For example, Helgeson, Cohen, Schulz & Yasko (1999) found that women with breast cancer benefited from attending an educational group which provided information on breast cancer, managing treatment effects, and enhancing overall recovery. They found positive effects on adjustment for those in the education group, immediately and six months after the intervention but no evidence of such benefit from the peer discussion group. Further analysis of this study found that women who had the most difficulties (lack of partner support, information, or personal resources) were

most likely to benefit from the educational group (Helgeson, Cohen, Schulz, & Yasko, 2000). One review article found that educational groups that focus on how to live with cancer, relaxation techniques, and coping with stress and anxiety were particularly beneficial for those with early cancer diagnoses and good prognosis (Fawzy, et al., 1995)

Psychosocial Interventions

Research shows that there is an accepted importance to offer psychosocial interventions for cancer related anxiety and stress (Jacobsen & Jim, 2008). As stated earlier, stress and anxiety can arise in individuals through out the course of the illness, and beyond. Evidence has shown that anxiety can be managed with psychosocial intervention. In research on Mindfulness Based Stress Reduction (MBSR), positive outcomes have occurred. Individuals involved in a seven week MBSR program which introduced guided imagery, breath work, yoga and teaching on mind body connections and application at home, were found to have overall reductions in total stress symptoms(30.7%) compared to a control group (Speca et al, 2000). This study also included home practice components, homework assignments and monitoring of home practice. Individuals who attended all sessions and reported completion of homework assignments had better outcomes. Individuals in Speca et al's study were also required to develop a plan for continued use. This speaks to the topic of long term use of psychosocial interventions. Recent literature on MBSR emphasizes the home practice piece and incorporates it not just as a suggestion for good practice, but as a necessary component of the intervention, should the individual fully commit. A follow up to the Speca et al. study indicated that these reductions were maintained six months after the original intervention. Other studies have shown similar results, indicating a reduction in

stress symptoms, with specific notes on reductions on an anxiety/fear scale (Carlson & Garland, 2005; Garland, 2007).

Three Relaxation Approaches

Discussed previously, there is evidence in the literature that psychosocial interventions are an effective means of reducing anxiety in those with cancer. There were three psychosocial interventions offered in the RMBG discussed in this research – PMR, GI and Suggestion and Affirmations. These three approaches have specifically been tested and discussed in the literature, and this evidence will be outlined next.

PMR and GI have also been used to counter stress, anxiety, promote positive perceptions and a strong sense of well being (Zahourek, 1988). A decrease in stress, and an increase in coping mechanisms and mental awareness have also been cited as benefits of relaxation (Wren & Norred, 2003). A study that compared PMR training and PMR plus GI training found that both interventions resulted in improvement as measured on a Profile of Mood States scale (Bridge et al, 1988). The most significant results were shown in the PMR plus GI group's results. Stress reduction by relaxation and imagery was studied in outpatients undergoing radiation treatment (Decker et al., 1992). Results showed statistically significant decreases in tension and anger in the treatment group, a trend toward less depression and a significant increase in fatigue for the control group. A study utilizing six sessions of PMR showed a decreased rating of psychological distress by those who completed follow up measures, however, lack of a control group impedes a definite conclusion (Baider, Uziely, & Kaplan De-Nour, 1994). Overall, positive outcomes have resulted for those using relaxation mind-body techniques to cope more effectively with a diagnosis of cancer.

The literature in the area of suggestions and affirmations is much less extensive and seems to focus on case studies, reducing the generalizability of the results but nonetheless showing positive outcomes for the individual (Brice, 1987; Davis, 1994; Sullivan, 1988). Mental and physical symptoms such as anxiety, depression, and bodily aches and pains have been decreased with the use of hypnosis and suggestions (Sullivan, 1988). As well, use of suggestions has reduced panic and anxiety preceding a surgical procedure (Brice, 1987). Imagery is often combined with suggestions and affirmations, as visually sensing and perceiving the new pattern of thinking is often helpful for restructuring thought (Davis, 1994; Hammond, 1990). For example, suggestions for those with cancer can be individualized and presented in such a manner that they visualize the shrinking and dissolving of a tumor in the lung. Words such as dissolve, shrink, destroy, and fight along with physiological phrases such as immune system and white blood cells can give the individual a mental picture of their cancer actually disappearing through the suggestive words of the therapist (Auerbach, 1990). This combination of suggestions and visualization has also been found to lead to positive results in cases of negative thought programming due to victimization and loss of relationship (Davis, 1994).

Empirical Gaps

Psychosocial Interventions

A recent review of psychosocial interventions for stress and anxiety in those with cancer states several areas that could be further developed (Jacobsen & Jim, 2008). Specific discussions focusing on men and racial minorities is lacking as is evaluation of the entire process through which psychosocial interventions should be received, especially for those with advanced disease or who have completed treatment. Also,

psychosocial interventions need to be studied in combination with other interventions, such as medication for anxiety.

The gaps in the literature on groups for specific relaxation mind-body approaches are apparent. Often, sample sizes are small in experimental studies, ranging from 16 to 40 participants in a review of relaxation and imagery studies for cancer pain (Wallace, 1997). In other studies, case studies are often the research design of choice (Brice, 1987; Davis, 1994; Sullivan, 1988). This type of study is useful in looking at individual experiences with a technique but is hard to generalize to the whole population or to other similar cases. As well, the range in the cancer population is so broad, that each person may experience different symptoms or side effects of cancer and its treatment. Grouping all cancers together in a study may not be effective because the subjects are not comparable on a number of levels, which could compromise the results of the study (Decker et al., 1992). Homogeneity among participants in terms of stage, prognosis and treatment of the disease is ideal to compare the effectiveness of the intervention (Bridge et al., 1988).

Research on relaxation mind-body approaches has been both qualitative and quantitative in nature. The qualitative studies are often in the form of case studies, exploring one individual and his or her experience with cancer and the impact of a certain relaxation technique. Quantitative studies focus on pre- and post-test measures focusing on a range of issues from pain sensation, mood or affect, to level or intensity of nausea or vomiting. As was outlined earlier in the research, there are experimental studies that use control groups to compare results of measures with the treatment group. There have also been a variety of treatment groups to compare effects of various interventions, and there

have been studies with no treatment groups, using pre and post measures to compare before and after effects of the intervention. This research can fill a gap in the qualitative studies, using semi-structured interviews to gain the individuals' account of the impact of a RMBG on the cancer experience. A clearer view of how different techniques influence each person and how the individual has transferred the skills to situations outside the group were sought.

Home Practice and Long Term Retention

It has been recommended that relaxation training must be taught for six to eight weeks before clinically significant benefits are achieved (Wren & Norred, 2003). Most studies have met this requirement (Bridge et al., 1988; Decker et al., 1992), but some studies have varied in their length of training (Scott et al., 1986; Syrjala, Cummings, & Donaldson, 1992). Whatever the length of training offered to group participants, there often seems to be a home practice component required of the participants. Home practice is often recommended for 20 to 30 minutes daily (Wren & Norred, 2003). One study that looked at the role of home practice of PMR to alleviate tension headaches did not find statistically significant results (possibly due to small sample size) but found a trend towards more improvement in the home practice group than the "no home practice" group (Blanchard et al., 1991). Many other studies have incorporated home practice as a component of the intervention (Bridge et al., 1988; Sloman, 1995; Decker et al., 1992; Scott et al., 1986; Syrjala et al., 1992). Literature on autogenic training, a self-hypnotic procedure with the specific purpose of strengthening independence from the therapist and giving control back to the individual (Linden 2007), incorporates intense training and home practice into its program, defining the ultimate goal as the ability to self induce a

relaxed state free of external guidance. Mindfulness based stress reduction (Carlson, et al., 2001; Speca, et al., 2000) also incorporates practice and practical application into its learning programs and puts much more emphasis on practical use and developing continued use plans. The training sessions for MBSR are intended as a catapult for prolonged ability to incorporate the principles of MBSR into daily life.

The research presented here looks at a relaxation mind-body group that offered experiential teaching of three approaches, with the intent of providing skill to help individuals manage stress and anxiety due to a diagnosis of cancer. Specifically what was looked at was the role the group played in the individuals' lives, how individuals used the approaches at home and how individuals applied the approaches spontaneously to anxiety producing situations.

CHAPTER THREE: METHODOLOGY

Research Questions

There were three questions that were the focus of this qualitative research. The first question was "what role did the RMBG play in the participants' lives" (i.e., did they attend regularly, was the group part of their weekly routine, overall what impact did they feel that the group had on their life)? The second question was "how many of the participants interviewed practiced what they were taught"? If they did practice, what was that like for them and to what extent did they make it a regular part of their lives. The final question addressed whether the participants were able to take the relaxation approaches that they learned in the group and use them in everyday situations. This research was looking for descriptions of specific situations in which an approach was applied, and whether participants could generalize the approaches over various cancer- and non-cancer related situations.

Qualitative Research

To understand the experiences of those with cancer who had attended a relaxation therapy group, the most appropriate method was to interview those who had attended the group. The research questions dealt with the personal experiences of attending the group, the participants' home practice routine and use of the approaches in every day situations. Therefore, it was important to understand these experiences in the participants' own words. Qualitative research allowed for analysis of the participants' words in a purposeful and systematic manner, as well as discovery of connections between incidents and events surrounding the use of the relaxation mind-body approaches.

Creswell (1998) presents five approaches to qualitative research: 1) biography, 2) phenomenology, 3) grounded theory, 4) ethnography, and 5) case study. The nature of grounded theory, the framework of choice for this research, is to develop a theory from the data collected (Glaser & Strauss, 1967). This research looked at participants' experiences with a particular group and how they used what was taught outside of the group. This group was very unique in that it was an ongoing opportunity for individuals to learn and practice relaxation techniques. Using grounded theory allowed me to derive a theory specific to the population studied and the relaxation/mind-body techniques in question. This seemed the most comprehensive way of looking at the experiences of participants involved in such a group. Other methodologies may have worked. A case study, for example, would have given a very in depth analysis of the impact of attending this group on one individual with cancer, but would not have allowed for an overall understanding of the impact of a group of individuals learning the techniques. Phenomenology could have developed some very important themes and patterns on participants experiences with the approaches taught in the group, however would not have developed a theory specific to this sample.

Grounded theory was introduced by sociologists Glaser and Strauss in order to further the area of social research (1967). They proposed that bridging the gap between theory and research should not be done by only testing existing theories and hypothesis but by following guidelines for discovery of theory from systematically obtained data (Glaser & Strauss, 1967). The intent of grounded theory is to generate a theory that relates to a particular situation "in which individuals interact, take action, or engage in a process in response to a phenomenon" (Glaser & Strauss, 1967, p. 56). The ultimate goal

of applying grounded theory methodology is to develop a theory from the data collected and then illustrate the theory by "characteristic examples of data" (Glaser & Strauss, 1967, p. 5). The constant comparative method sets the stage for researchers conducting grounded theory (Glaser & Strauss, 1967). As the data is coded, codes are compared to each other and are grouped together into categories. As more data is collected, categories are built upon and new ones are formed. As the researcher codes and categorizes, thoughts on emerging patterns and themes should be written down in a memo (Glaser & Strauss, 1967). As coding and data collection continue, categories are compared with other categories. As major themes emerge out of growing data, and a preliminary theory may be forming, the researcher can begin to focus on this and devote more time to comparing codes and categories that fit into this emerging theory. This focus can drive data collection, recruiting and collecting data from participants who would further verify the theory. This is defined as theoretical sampling, the "process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what data to collect next and where to find them, in order to develop his theory as it emerges" (Glaser & Strauss, 1967, p. 45). In other words, the data defines the sample. Determining what data to collect and which and how many interviews to conduct is based on the theory that is emerging and how it will be developed (Morse & Field, 1995).

Theoretical saturation determines when to stop collecting data (Glaser & Strauss, 1967). If subsequent interviews no longer provide new theoretical insight nor reveal new properties of categories, then one can be confident in the findings and collection of data in that area is no longer necessary (Charmaz, 2006).

Grounded theory allows for the development of categories of information, interrelated to produce a theory based on the findings (Creswell, 1998). Although influenced by different theorists, both Glaser and Strauss (1967) had the goal to produce research that would develop a solid theory of reality (Morse & Field, 1995). Although grounded theory is generally explained in a systematic, seeming straightforward way, when it comes to actually applying grounded theory, it can be very complicated, time consuming and tedious. However, several more recent sources of literature on grounded theory provided practical explanations on how to physically code and analyze data in my research (Charmaz, 2006; Coleman and Unrau, 1996; Morse & Field, 1995).

Relaxation Mind-body Group

Using qualitative methodology, the purpose of this research was to study the impact that attending a RMBG had on those who participated. The sample of participants came from a relaxation mind-body group (RMBG) offered through a major cancer facility in Winnipeg, Manitoba. The group was offered to those with cancer and their families. The criteria to join the group was inclusive: the individual had been diagnosed with cancer at some point in his or her life. The group was held for one hour, once per week, on a drop-in basis. There was no record of attendance, sign up protocol, or fee to register, although the number in attendance was recorded each week. Facilitators were social workers and a psychologist from the psychosocial department of a cancer facility.

The main purpose of this group was to offer an opportunity to learn three relaxation approaches in order to provide participants with skills to manage the psychosocial impact of cancer, specifically managing anxiety and distress. The approaches offered were organized on a monthly rotation. Week one of each month

focused on PMR; week two on GI; week three on suggestions and affirmations. Week four focused on other mind-body techniques, for example meditation, yoga or story telling, facilitated by a practitioner from the community.

Each session was set up in the same format. The group was held in a large, sunny parlor room. Chairs were placed in a circle with soft music often playing in the background. The group would begin with very brief introductions around the room. The facilitator would then address issues that might arise during the exercise. Individuals were reassured that any feelings that come up are normal and should be dealt with in a comfortable way for that person. It was also explained that strong feelings might arise and that it was not uncommon for people to cry. Participants were encouraged to just let themselves cry, or if the feelings were too overwhelming to open their eyes to get back in touch with space and time. Individuals were then invited to get as comfortable as possible. This might mean moving to the floor, putting on slippers, or elevating one's feet. The position often recommended was to sit on a chair, to uncross the legs, place both feet flat on the floor and rest the palms of the hands on one's thighs.

The next 40 minutes (approximately) were devoted to the relaxation approach of the week. The facilitator would verbally take the group through the approach. Following this, there was an opportunity for participants to debrief with the group about what they had experienced during that session. Then, any announcements for the week were acknowledged. In a final exercise, some facilitators would suggest everyone to form a small circle by joining hands. The facilitator would then make a few comments referring to the technique of the week or anything that may have come up during the session.

Inclusion Criteria and Recruitment.

At the time of planning a recruitment strategy for this study, the number of participants in the group had decreased dramatically from previous years. There was some concern that recruiting enough participants to reach saturation would be difficult. As the criteria to join the group was very broad, inclusion criteria for participation in the study was also kept very broad.

Initially, inclusion criteria were to be as follows:

1. those who had a diagnosis of cancer (not family members, in order to keep the scope of issues experienced narrow);
2. those who were attending the group at the time of the study's interview;
3. participants who had attended 6 to 8 sessions within the past 6 to 8 months (Wren & Norred, 2003) to ensure that regular exposure to the approaches had occurred; and
4. those who were not hospitalized at time of interview

Before beginning recruitment, a pilot interview was conducted with two facilitators of the relaxation group. They expressed concern that the inclusion criteria, although fairly broad, would still be too narrow considering the low number of individuals attending the group at the time. Criteria number two was modified to include individuals who had participated in the group at any time in the past. Criteria three was dropped to allow those participants who had much experience as well as those who had little experience with the group.

The research was first introduced to the group by the group facilitator, not by anyone involved in the research. Information sheets (Appendix A) and a sign up sheet

(Appendix B) for those interested in participating were given to the facilitators to take to each session. Participants were asked to leave their name and phone number on the sign up sheet if they were interested in participating and were informed that the researcher would contact them to set up an interview. Over the phone, the purpose of this research was reviewed. It was also determined whether the participant was currently attending the group or not. An interview date and time were set up.

Although sign up was slow, it was steady. Facilitators were also asked to approach any potential participants they were still in contact with who had previously attended the relaxation group. At one point participant recruitment to the study became quite slow. Facilitators hypothesized that many past members of the relaxation group had gone on to join other groups associated cancer and healing. For this reason, facilitators of other groups ran through the cancer facility were approached. They were given the information sheet to pass out at gatherings, and also verbally announced the research at the art therapy group. All participants but one who had signed up followed through with participation in the research. This participant had agreed to an interview, however it was cancelled due to researcher's illness. A subsequent interview was attempted to be scheduled, however the participant did not return phone calls to reschedule.

Data Collection Instruments

Grounded theory methodology requires the researcher to begin analysis of the data while collecting it. However, for the purpose of this paper, the methods of data collection will be discussed first, followed by the analysis of the research.

Semi Structured Interviews

The data was collected by conducting semi structured interviews with those voluntary participants who had been a part of a relaxation mind/body group. Open ended interview questions were developed based on my exposure to the relaxation group, consultation with the thesis committee and with group facilitators, and literature reviewed on relaxation approaches and home practice. The interview was divided into three sections- demographic characteristics, the impact of the group on the experience of cancer for the individual, and the use of techniques outside of the group. A guideline of questions (Appendix C) was formed to keep the discussion focused but there was flexibility in what was discussed with individuals. The nature of open ended questions allowed an individual's experience to influence the answers and the subjective nature of the situation to be explored.

The demographic section of the interview guide focused on personal information about the participants, specifics of the cancer diagnosis, and the amount of experience with RMBGs or techniques. The purpose of this section was to establish the participants' backgrounds and their experience with the RMBG. These questions were often asked first as it was important to understand the individual's cancer history as it may be related to research questions. For example, knowing that a person is receiving chemotherapy will influence what side effects they experience and may affect their purpose in attending this relaxation group. Understanding the individual's history with the group allowed for comparison of experiences between those experienced with the group and those new to the group. The open ended nature of the demographic questions created a more natural and comfortable way of talking during the interview, and allowed a rapport to develop

with the individual. This helped to ease the conversation slowly towards more sensitive topics. Often times however the demographic information was melded into the discussions which made for a very cumbersome task of picking out the demographic information during analysis of the interview transcript. In hindsight, it may have been more effective to have the participants fill out a demographics sheet prior to the verbal interview.

The second part of the interview guide looked at what each person felt was the role of the RMBG in her cancer experience. Individuals were asked what issues they had faced since their diagnosis, how these issues had influenced joining the group, and if any of the approaches had targeted these issues. They were also asked specifics on what they learned in the group, what approaches they preferred, what impact they felt the facilitators had on their experience each week, and any other aspect of the group that they felt was important to them.

The final section of the questionnaire looked at the role of home practice and the use of these approaches outside of the group. Details on home practice patterns were explored, for example, did the individual set time aside and actually practice the approaches taught in the group, and if so, how often? When? Where? And what encouraged them to continue with this practice. As well, the individuals were asked to discuss situations in which they spontaneously used the approaches taught in the weekly group.

The same basic interview guideline was used for every interview, however some changes were made along the way with wording and order of questions. During the first and second interviews, many questions were too long and cumbersome and required

explanation during the interview. These were modified to be more clear and concise for subsequent interviews. Some participants were not attending the relaxation group at the time of their interview, and thus modifications were made to these interview guides to better reflect their past experiences. Also, the topic of cessation of the relaxation group came up in the first few interviews. As these first participants had ideas themselves as to why there were very few people attending the group, a question was added at the end of the interview to discuss this topic.

Ten interviews were conducted over a five month period. All but one interview occurred in the participant's home. The home was most convenient and comfortable place for all participants. One interview was conducted in a room of a psychosocial oncology department of a cancer facility, as this was most convenient for the participant.

The research was designed so that participants of the group would be interviewed first, and initial coding completed, then to conduct facilitator interviews. Four facilitators were interviewed. I had felt that the facilitators of the group could elaborate on such topics as the intended purpose of the group and on how the participants' accounts of their experience with the group compared to the facilitators' hopes of what participants got out of the groups. The interviews for the facilitators followed the same outline as for the participants (Appendix D). Basically, the facilitators were asked to discuss the purpose of the group from a their perspective, and what they had experienced through their profession in terms of relaxation and those with cancer. It was hoped that by discussing the purpose of the group as seen by the facilitators, further insight could be given to what impact the group may have on participants.

Field Notes

Each interview was tape recorded and field notes were written on the interview guide as well as in a separate journal after each interview. The field notes included major topics discussed, nonverbal cues, as well as general notations of responses to questions. They also included major descriptions of the person and the setting as well as any insight into the interview itself and any themes or patterns that were noted or a particular topic that was focused on by the participant. Also, personal feelings towards the interview and suggestions for subsequent interviews were noted (Morse & Field, 1995). During coding, notes were kept in a journal on comparisons between codes and categories as well as possible themes and patterns that were emerging due to this comparison. Continually recording while collecting the data allowed me to begin the analysis process before all interviews were conducted and began the development of themes that eventually lead to the theory.

The importance of using two methods to record interviews was soon discovered. The third interview was mistakenly recorded over with the fourth interview. After review of the field notes and discussion with the thesis advisor, it was decided that the data collected in the notes was sufficient to keep and re-interviewing the participant was not necessary. A second technical mishap with the audio recorder resulted in a portion of interview six being deleted. However, substantial notes were taken during the interview and most of the interview was able to be transcribed. Therefore this data was also still considered sound information to include in the analysis.

Research Ethics

Confidentiality and Consent

Before each interview began, the participant was reminded of confidentiality. It was reviewed that names would not be used in the interview transcriptions, that all information would be stored in a locked file cabinet accessible only by the researcher, and that the participant could withdraw from the study or refuse to answer a question. A consent form was signed by the participant (Appendix E). This ensured the participant had read the information sheet and understood the purpose of the research and the role she would play in the study.

Risk of Emotional Distress

Risk of distress due to the recollection and retelling of potentially painful stories related to the cancer experience was noted. Individuals were given the contact information for social workers in an oncology department if the individual felt it necessary to speak to someone further after the interview (Appendix F). The participant was also informed that notes would be taken during the interview.

Compensation

A token amount of money was given to each individual at the end of the interview to compensate for costs of attending the interview (transportation, parking and childcare) This was explained, however, many participants were surprised and slightly reluctant to accept the compensation. Because of this, I felt uncomfortable as well. It seemed that a monetary offering was somehow perceived as cold after engaging in personal conversation. For future consideration, a gift certificate or some relaxation products may have been more appropriate.

Analysis

The methods of analysis used in this study are common in grounded theory data analysis. Methods are often presented in a sequential manner in the literature, however, the analysis is not conducted this way (Morse & Field, 1995). Grounded theory demands that there be movement back and forth between data collection and data analysis as each is influenced as patterns and theory emerges. As a pattern began to form, interviews were modified to further explore this pattern. Patterns were verified and tested through further data collection and culminated into the theory presented here. The major identifying feature of grounded theory methodology is its emphasis on theory development (Strauss & Corbin, 1990).

As per grounded theory methodology, as interviews were conducted, analysis began. The interviews were audio taped then immediately transcribed by a third party. Although personally transcribing each interview would have allowed for a more intimate connection with the data, utilizing a third party to transcribe saved time. For each interview, I received a hard copy of the transcription and a computer copy via email. On first receipt of the transcription, it was proof read and compared to the audio recording to ensure accuracy. Corrections were made to the transcription and any identifying information was eliminated. Any nonverbal recordings that were noted during the interview were added to the transcription, such as extended pauses and crying.

Once this initial review of the interview transcript was complete, first level, or line by line coding, began. This first level coding broke down the data and conceptualized it, giving each incident, idea, or event a label (Morse & Field, 1995). Labels were written in the margins of the paper copy beside each line or paragraph. Except for a few

occasions where time constraints made it impossible, line by line coding of the interview was completed before the next interview was conducted. As this routine of coding and interviewing continued, notes were continually made of what was being discovered from the interviews, for example, themes or patterns that were emerging and thoughts of the direction analysis may take. Also, if a common pattern was becoming apparent, and this warranted more attention in subsequent interviews, it was noted, and the interview guideline was modified.

During initial stages of coding, each sentence was given a label. As this coding process became more comfortable, a few phrases or a paragraph would then be given a label. Written codes were then entered electronically and interview notes were incorporated from the electronic transcription into the relevant code.

Following the analysis of the ten interview transcripts, 91 codes in individual word documents were created. After review of these 91 codes, some were collapsed together, sub-codes were created, which resulted in a final tally of 74 codes.

Once all ten participant interviews transcripts coded were, four facilitator interviews were completed. These interviews were conducted back-to-back, in one day. There was little time between interviews, so quick notes were made by on my initial reactions to the interviews. Following the four facilitator interviews, more complete field notes were made and the transcripts were coded. These codes however were not used in the development of categories and theory but were used to substantiate findings.

The data analysis next involved reviewing the 74 codes from participant interviews. Charmaz (2006) describes the process of focused coding as picking out the most significant or most frequent codes to help sort through all the data. This was

followed by referring to the research questions and then grouping the relevant codes together under categories. In the end, 39 codes were used and grouped into five categories. These are illustrated in Table One below.

Table One: Codes

Category	Code/Subcodes
Turmoil after diagnosis	Being strong Blaming self Controlling diet/healthy lifestyle Coping Denial Disconnection from self Fear Isolation Overwhelmed Loss of control/routine
Group description	Discovering group Referral to group Expectations of group Feeling comfortable in group Differentiating approaches Declining attendance Ending group participation Interfering circumstances to attendance
Continued group attendance	Attending impacts transfer Attending motivates practice Connecting with others Doing it for me Escaping Finding strength/support in group of like others Integrating group into life Normalizing Peer support
Benefits of relaxation	Balancing Doing it for me Escaping Sense of well being Soothing/cleansing Tuning into body Tuning into mental/emotional state
Personalizing relaxation	Describing at home practice Favoring an approach Improving relaxation through practice Integrating approaches into daily life Unable to implement an approach

For the next step, second level coding, excerpts were taken from the transcripts that fell under each code and compared with the other excerpts under that code, and under that category (Coleman & Unrau, 1996). The context and meaning of excerpts were looked at and compared with other excerpts that were similar. By analyzing the codes under each category, categories can be compared and contrasted, and further, more abstract patterns and themes emerge. Throughout the literature, grounded theory speaks to "pulling the data apart" and "putting it back together". The meaning of this became quite clear at this point in the analysis. By taking excerpts from the interview and labeling them then grouping similar codes together, the real meaning behind each excerpt can be lost when it is "pulled away" from the interview. The importance of initial line by line coding was clear and modifications were made to the first level coding to ensure the meaning of the interview data was not lost.

The next step was to take the categories that had emerged and begin to find a pattern in the data that would lead to a theory. The main purpose of this research was again reviewed to discover the impact learning relaxation approaches had on the participant and what home practice and use of the approaches outside the group looked like for the participants. Constant comparison of categories, reading through interviews and coding, and recording ideas and patterns that emerged in the comparisons, eventually led to the surfacing of a theory on what conditions seemed to be necessary to encourage participants to continue to use the relaxation approaches outside of the group, and how this changed once the group was no longer available.

CHAPTER FOUR: FINDINGS

Demographics

Ten participants of the RMBG were interviewed between October 2004 and March 2005. All participants interviewed were women. There have been studies that conclude that women and those from higher educational backgrounds are more likely to engage in complementary therapies (Astin, 1998; Sparber, et al. 2000). However, in this study information on education level was not included. Although there is no data to support that participants in this study were from higher education levels, observations from home and neighbourhood surroundings during interviews would suggest that most participants lived in middle class areas of the city of Winnipeg. Most had employment histories and a few were employed in areas which would typically require post secondary education. However, these are only based on assumptions and cannot be included as facts.

All participants were between the ages of 45 and 63, the average age being 55.3. Seven of the women were married, two were single, and one was widowed. All but two had children.

Seven of the participants had breast cancer, one had lymphoma, one had suspicion of cancer in her kidney, and another had cancer in the gastrointestinal area. Participants had been diagnosed anywhere from within a year before the interview to eight years before the interview. Only one participant was actively involved with treatment at the time of the interview.

All participants began attending the RMBG within one year of being diagnosed. When recruitment for this research began, attendance rate was very low and the group in

fact ended just after interviews began. Two interviews were conducted before the group stopped running; both of these participants were still attending the group when interviewed. Eight participant interviews were conducted after the discontinuation of the relaxation/mind body group. A critical question then arose: why did participants stop attending? One had stopped because the group ended. Seven stopped for other reasons: three because they returned to work, two reported they were too fatigued in the morning to continue to attend, and two reported that they had begun attending other groups. The period of time in which participants attended the group varied greatly. One participant began attending the group in 1997, soon after it began running, and attended for three years. Another participant started the group in 2004, just six weeks before it was going to end. This portrayed varying degrees of involvement with group, and allowed for comparison of those who had intense, long lasting experience with the group, to those who were just beginning.

Eight of the participants learned about the group from professionals they met through their diagnosis and treatment. Two participants found out by searching for resources on their own. Three participants had experience with relaxation before attending this group, four reported having no experience with any type of relaxation, and three reported having moderate experience. Previous experience included either through yoga or theoretical knowledge.

It is somewhat difficult to determine how representative the participants of the research were to the population that attended the group. There was no record kept of those who participated in the group and therefore no way to compare those who were interviewed and those who attended over the nine year duration of the group.

Table two shows demographic information as was at the time of the interview.

Table Two: Demographics

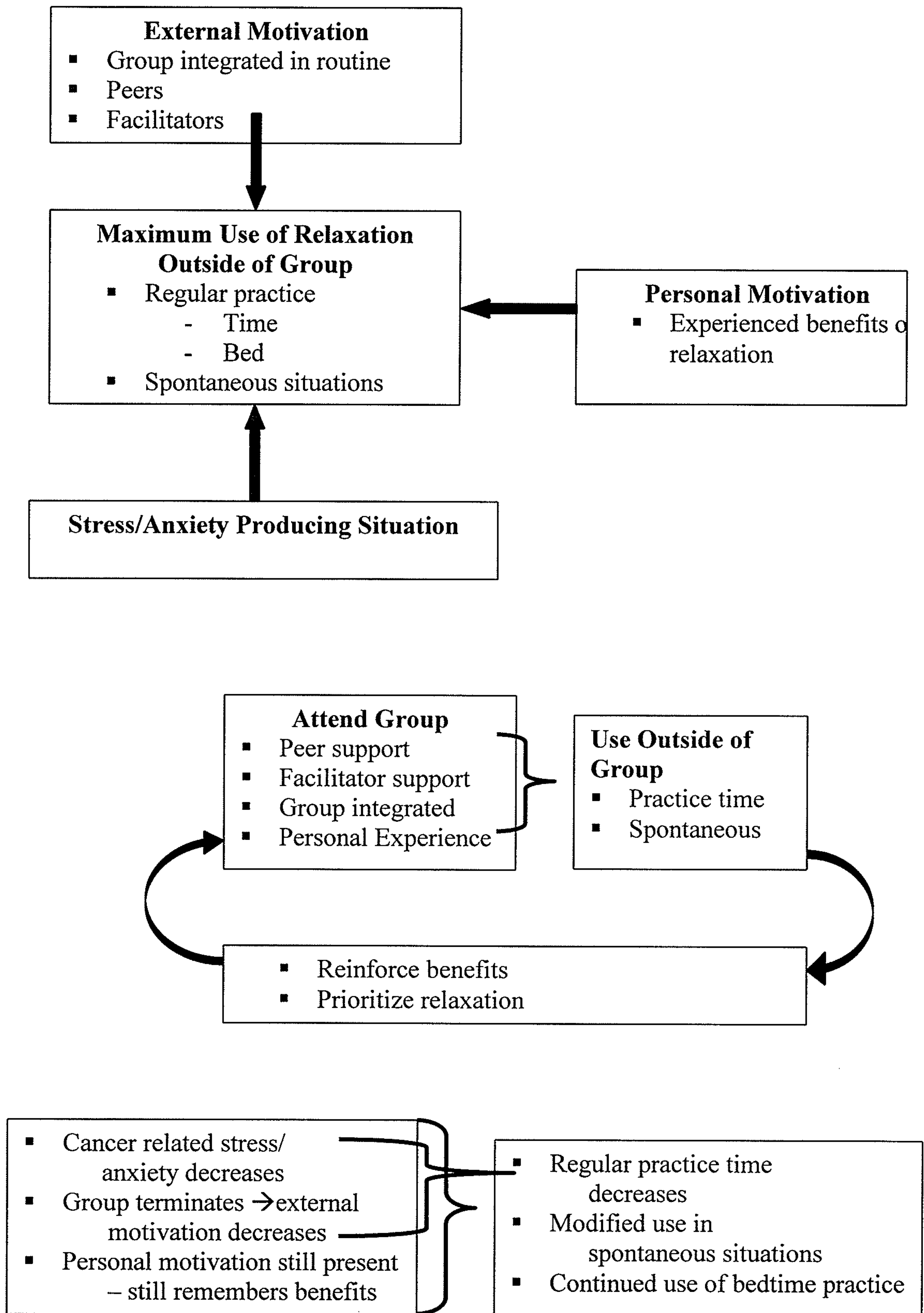
Gender	Male 0 Female 10	**Type of cancer**	Breast 7 Lymphoma 1 Kidney 1 Gastro-intestinal 1
Age	<50 1 50-60 8 >60 1	**Discovery of group**	Through professionals 8 Self discovered 2
Marital status	Married 7 Single 2 Widowed 1	**Experience with relaxation before group**	None 4 Moderate 3 Extensive 3
Family	Children 8 No children 2	**Reason to stop attending group**	Back to work 3 Group ended 1 Time of day 2 Other groups 2 Still attending 2

The Theory

The purpose of this research initially focused on the three research questions: impact of attending the group on the cancer experience, home practice, and use of approaches in everyday situations. As interviews were conducted and analysis began, the second and third research questions gained most of the attention and eventually guided the evolution of the findings and the ultimate theory. This theory looked at the continued use of relaxation approaches. Those with cancer (not the family members) were the participants of this study. Through the interviews with the participants, many common patterns were discovered. The data was coded, then categorized into five main categories that developed into a theory explaining what is necessary for participants to continue to use relaxation approaches outside a structured learning environment.

The theory is presented in a pictorial representation; see Figure One below.

Figure One: Visual Representation of the Theory



This theory was derived by constant comparison of the data as codes, categories, patterns and themes were formed, by rereading interviews and coding, and by following the paradigm model (Strauss & Corbin, 1990). The paradigm model brings density and precision to the theory through thinking of the data. The basics of the paradigm model include the following six features: causal conditions, phenomenon, context, intervening conditions, action/interaction strategies and consequences. The theory presented here falls into this model:

(a) causal conditions: external motivation, personal motivation, and stress and anxiety producing situations.

(b) Phenomenon: the long term use of relaxation approaches outside of the group setting

(c) Context: relaxation approaches are used on a regular practice routine or for spontaneous situations

(d) Intervening conditions: medical situations in which there are many interruptions or movement is constricted; when they were not in tune with themselves and their emotions became too overwhelming to calm; the absence of external motivation (group was not present and peer or facilitator encouragement no longer present)

(e) Action interaction: participants attend the group on a regular basis and experience the benefits of relaxation. They receive encouragement from peers and facilitators. They begin to prioritize relaxation and use it outside of the group.

(f) Consequences: individuals are better able to manage their stress, anxiety and reactions to situations, whether related to the cancer experience or applied to everyday situations

Conditions That Impact Need To Use Relaxation Approaches

It was found that when three conditions were present then the situation was ideal for consistent, continued use of the approaches outside of the group setting. These three conditions were; (a) stress and anxiety producing situations, (b) external motivation, and (c) personal motivation.

Stress and anxiety producing situations. Participants of the group interviewed for this research began attending within one year of being diagnosed with cancer and were all experiencing much stress and anxiety associated with this. Participants described many issues they faced after being diagnosed with cancer. Two major issues mentioned by all participants were fear and loss of control. Fear stemmed from not knowing what was going to happen (fear of the unknown) and the inability to control what was going to happen to them. Fears ranged from fear of death to fear of telling others of their illness. Participants talked of family and friends who had suffered from or died from cancer, illustrating a fear of their own mortality. Participant two described such a situation, "there was a lot of fear associated with the chemotherapy, cause my sister's chemo was horrifically bad…and so I had all those feelings of resentment and fear from what she went through as excess baggage coming in for my own treatment." Preconceived ideas based on what they have seen happen to others with cancer were common in many participants and often led them to be determined not to go through similar experiences. But even through this determination, fear was still very clear, as participants had to face

the possibility of death. "It was very, very frightening and scary. The first thing you think about really is death. Absolutely. When you hear cancer, you really do think of that, and your life is ending. That's what you think." (Participant three).

All participants discussed situations in which they felt they had lost control of aspects of their life due to a cancer diagnosis. Many examples were illustrated in which participants felt that they did not have control over medical decisions, over what their bodies were doing, and at times feeling like they had no control over their emotions. "You know, I think intellectually that I'm prepared in my head, but somehow, hearing you've got cancer, it was like, oh my God. So because I'm a bit of a control freak as well, I thought oh my God, I thought I'm totally out of control of my body." (participant two).

Control over and predictability of life was completely shattered with a diagnosis. Suddenly, everyone else was telling them where they should be, what they should do and what was going to happen to their bodies. Participants described feeling very disconnected from themselves, from their bodies, as though the body was a foreign enemy fighting against them. Participant five described that she felt as thought the cancer was a "thing, growing and spreading". This disconnection seemed to be a way to cope with all the procedures and unnatural events their bodies had to endure. Participant two described that after her diagnosis, but before finding the relaxation group, she was doing everything by rote and wasn't getting any joy out of doing things. Participant nine described this feeling very well:

> "as far as relaxation goes just being in touch with your body in the first place, like, then, when I had cancer, my body suddenly became my enemy and so, I was

a little reluctant at first in the group to be in touch with things in there because who knows what else scary, I mean when you're feeling totally out of control, it is a very scary prospect to go inside and look at things."

Fear and loss of control were the two primary issues that were common to all participants. Other issues that fed into their turmoil after a cancer diagnosis included being completely overwhelmed, trying to find cause of the diagnosis in themselves or some other factor, how to cope day to day and the isolation and helplessness felt when faced with a seemingly hopeless situation. Participant six described this as a time when "you just kind of float through, I wouldn't say float through, you crawl through those years with the cancer, and you exist for however you can through it. Living with uncertainty, living in fear, that you don't really have a routine."

Participants described these issues as reasons for initially joining the relaxation group. The stress and anxiety they felt from the constant fear and the major adjustments they had to make to their lives, created a need to be able to get back some control. They felt that they "needed something" to keep them balanced, to help themselves cope with the challenges they were facing and going to face. Relaxation became that "something". When participants joined the group and found that using relaxation helped them to manage the stress and anxiety they experienced, they used the approaches more often. As long as the situations presented the need, the approaches were used on a regular basis.

External motivation. The second factor that promoted continued use of relaxation approaches outside of the group environment was external motivation. External motivation came in three forms; establishment of a regular routine of using relaxation approaches, facilitator encouragement and peer encouragement. Through interviews with

the facilitators, it was discovered that the primary purpose of the RMBG "was to expose people to four different kinds of relaxation." Most participants were exposed to the three relaxation approaches taught in the group; visualization, progressive muscle relaxation, and suggestions and affirmations, as well as approaches taught by a community practitioner once per month. When the group was running on a weekly basis, participants often found that the simple act of getting to the group each week had an impact on how frequently they practiced outside of the group. Attending the group one hour per week helped participants gain some control back in their lives. So much of what happens while battling cancer uproots any stability and predictability that one once had. Participants talked of how attending a one hour group, once per week, brought some of that routine back. One participant described how she and her husband integrated the group into their lives. "We made it a part of our life, kind of just a part of our routine, because after being sick for so long, you try to have some kind of routine to your life and that was a part of it." It was an enjoyable activity that they were involved in voluntarily, and it occurred on a regular basis, making them feel as though they had some control over their daily routine.

The more frequently participants attended the group, the more likely they were to integrate the approaches into their daily life.

> "And not only do I do it over there, but I do it just about every day now, and I don't know, I sort of feel that if I didn't have that Tuesday group, that I'd skip a day once in a while. You know how it is. First thing you know, it's oh my god, I haven't done any relaxation in a whole week. Should go back, should, should, should. This keeps you on track." (participant one).

Attending the group kept relaxation on the participants' minds, and encouraged them to use the approaches at home, in whatever way they were comfortable with. For some participants, it took some time to begin using approaches at home, but most described trying to replicate the group exercise at home almost immediately after they began attending the group sessions.

As participants continued to attend the group, they were encouraged by facilitators to practice the approaches outside of the weekly group. Participants discussed how they felt that this encouragement by facilitators was influential in them trying it at home. They wanted to be able to go back to the group the following week and say they had in fact tried what they had learned. All four facilitators reported that they encouraged participants to use the approaches at home.

It was very apparent that the camaraderie and support received from others in the group was also a primary motivator in continuing with the group. "And going, at least, you know, the once a week and talking to people who had been in similar circumstances and just having their support and being able to take some time just for myself and relax, it was, it was absolutely wonderful" (participant two). There was a cyclic feeling to the way a large portion of the participants engaged themselves in the group, and it kept the group running with high numbers for a very long period of time. Participant four put it this way, "Oh it was better if you keep going. It was better. In what way was it better? It just, I guess it becomes, it can become a part of your being, a part of your living that when you're attending the sessions, it's within you." As participants kept attending, they continued receiving encouragement from the facilitators. As they kept attending, they continued to hear stories of other participants' relaxation experiences, and they

encouraged each other to continue with the group and continue practicing outside the group. They also formed a social network, and got together outside of the relaxation group. There was a cohesiveness between group members, held together by similar experiences with cancer and shared experiences with relaxation.

Personal motivation. Through weekly attendance at the relaxation group, participants were able to identify many benefits to learning and practicing the approaches in the group. Many participants compared their time once a week at the group to a "vacation", time just for themselves, away from the business of life and the chaos of medical appointments and feeling ill. "Just for me" was a recurring phrase through five of the interviews. Participants felt that for one hour a week, they could just forget about all that causes them stress and anxiety, and just relax for a while. This provided an opportunity for participants to rejuvenate and get in touch with their mind and body, even if for a brief period of time. The relaxation was necessary to help them relax for one hour, and the effect was immediate.

Participants claimed to be able to feel the benefits of relaxation after the first few sessions, so they wanted to begin practicing at home right away. They described how relaxed they felt after attending the group, that it was nice to "get away" for one hour and have time to concentrate on themselves. They physically and mentally felt relaxed after attending the group, and wanted to feel like that more often. The need for personal peace of mind and body, as was experienced in the group, was a huge factor in encouraging participants to do so on their own time.

Use of Relaxation Outside of Group Setting

When participants experienced frequent and recurring situations that produced stress and anxiety, when they had settled into a routine of weekly exposure to the approaches, were encouraged by the facilitators and their peers, and when they had experienced the benefits of relaxation approaches, conditions were then ideal for use of the approaches outside of the group setting. Participants discussed two patterns of use of the approaches: regular practice and spontaneous use.

Regular practice. In the group, participants were exposed to three relaxation approaches: visualization and guided imagery, progressive muscle relaxation and suggestions and affirmations. Many participants practiced these approaches on a regular basis outside of the group, in between weekly sessions. I had defined practice to the participants as time set aside on a regular basis to go through an approach as it was taught in session. Most participants closely followed the methods they had learned in the group, and often were able to identify a "favorite" approach that they used most often. Participant two described "going through, mentally through my whole body and telling my muscles to let go and relax and feel warm and heavy and then I'll think of, there's a mental image I have of a healing pool and I'll go for a swim in my healing pool." Participants' practice routines closely replicated what was taught in the group. All participants described that they often "started with the breath". They concentrated on breathing, focused on their breath going in and out of their bodies until they felt their bodies physically relax and their minds go blank, then they fell into their relaxation approach of choice.

Participants discussed their practice routines and there seemed to be two ways participants practiced what they learned in the group. Eight of the participants described how they set aside a certain amount of time during the day, to sit and practice what they had learned in the session. They would either go through a routine they had learned in the group, or would play a tape and follow along with the approach on the tape.

Three participants described practicing the approaches at night, in order to help them sleep, as a way of distracting themselves from overwhelming thoughts that plagued them at night, preventing them from falling asleep. Practicing the relaxation approaches would give them something else to concentrate on. Two of these three participants described night as the time they usually practiced, but it was also a means of helping them get to sleep. One participant did not practice in the same way each time, and would sometimes set time aside during the day and other times would use th approaches to go to sleep.

Whether they practiced during the day or at night to help them fall asleep, they would develop a routine that felt the most comfortable for them. Many would practice for the same amount of time each day, approximately half an hour, in the same room, and sometimes at the same time each day. Participants' frequency of practice varied from daily, to a couple times per week, while some practiced as needed. Participant one said she liked to practice every day, at the same time as the group would run. Some described lying down on a couch with a blanket, dimming the lights and playing quiet music. Participant seven described sitting in a chair as she did in the group. Some liked to replicate the atmosphere of the group sessions. In group, there was always soft music

playing, lights were dimmed and it was a very calm and quiet setting. Replicating this at home helped participants with their practice time. Participant ten described:

> "I found at night it was the best time to practice on it because it would be very quiet. I like doing relaxation in the dark. I don't like doing it in the light. They always dimmed the lights there, and often the curtains were drawn too so it was a darker atmosphere, so I like the dark that way. I find it very relaxing, so night time."

Whatever the routine, practicing on a regular basis during the day or at bedtime, proved to be an effective means of improving skill as well as helping with overall well-being.

Spontaneous use. As well as practicing on a regular basis, participants were also able to use the approaches in spontaneous situations that acutely produced stress and anxiety. Participants all had numerous examples to share, and loved to tell stories of how beneficial relaxation was for them. The situations could be grouped together into a few categories. Medical situations (cancer-related and not) and non-cancer related daily situations were most commonly described. Some participants also discussed situations in which they felt completely overwhelmed by fatigue, thoughts, emotions and would use relaxation to help calm themselves. All ten participants described medical and everyday situations in which they applied the approaches. They did not limit their uses to only dealing with stress and anxiety due to a diagnosis of cancer.

Medical procedures are unavoidable and necessary for those with cancer, and can have positive or negative outcomes. Procedures can be uncomfortable, embarrassing or even painful. After procedures, individuals experienced a stressful time of waiting for the results, thus adding to their anxiety. Participants described how being able to use

relaxation helped them get through these difficult procedures. Some participants talked about focusing on breathing while waiting for a medical appointment, or through an MRI or scan, during which they had to lay still for an extended period of time. Focusing on the breath allowed them to keep their mind on something and helped them to control their anxiety during the procedure. Participant two was afraid of needles, and her anxiety would increase when she knew she had an appointment involving a needle. So before the appointment, while waiting, she would breathe deeply and focus on her breath, and would be able to get her anxiety to a manageable level. Participant four talked of her experience using relaxation during a bone scan. " And through the techniques that they taught me to go into deep breathing, to go into relaxation, even going to my next bone scan, I went through the machine. I didn't even know it was finished because I went into deep relaxation. I went to sleep..." Participants had discussed fears associated with recurrence and a somewhat unsettling feeling of never completely knowing if the cancer would return. This anxiety can be increased with medical appointments, as participant eight described. "Probably a good example of that would be going for your follow-up mammogram. That's always a very tense time, and yeah, those would be the techniques that I would use, you know, to relax myself and that, and talk to myself."

Aside from medical procedures, participants described everyday situations in which they were able to use a relaxation approach to help calm themselves. For example, a few participants described using deep breathing while experiencing a long wait for a train. Instead of getting frustrated with the delay, one participant would use self talk "this isn't something that deserves any of my energy. I need to use that energy in a positive

way, not a negative way." Participants also described using relaxation during breaks at work, if they were having a stressful day or had a particularly stressful job.

Participants described many situations in which they felt completely overwhelmed for a variety of reasons. Participants described fatigue they experienced to be absolutely draining. Using relaxation gave them a boost to help them get through it. Participant three described feeling "brain dead" from exhaustion. Engaging in a relaxation approach would allow her body to relax and rejuvenate itself, without actually having to go to sleep. Participant four described it this way;

> "...some days I was, maybe feel fatigued throughout the day or early evening you know, I was just wiped and I would...put some music on, relaxation kind of music, I would put that on and I would just, because, I guess because I just wanted to let myself just be and just relax."

Other participants described being overwhelmed with emotions or thoughts, and would spontaneously begin a relaxation approach to help calm down. Participant three described that one afternoon, she suddenly became overwhelmed with emotion and began to cry uncontrollably. She began breathing deeply and focusing on her breath going in and out and was able to calm herself and control her crying.

It seemed that most participants, when applying relaxation spontaneously, would use the deep breathing. This is something that's relatively quick to get into, and seemed to have the quickest impact on the person's reaction to a situation. If the participants had more time, if they were at home or lying in bed at night, then a more in depth relaxation was implemented, for example visualization or progressive muscle relaxation.

Of particular interest was that the most commonly described situations in which relaxation was applied were very different from each other. Participants used relaxation during medical procedures just as often as they did if they were frustrated with an everyday incident. This supports the idea that relaxation approaches are generalizable across many situations and can help in specific illness situations as well as with overall well-being. Many participants described a change in perspective on life issues and an overall sense of calmness after learning and using relaxation approaches. It appears that being able to overcome adversity and learn a way to regain some control can be very empowering experience, so much so that the benefits of this ability appear in other areas of life.

When Conditions Were Not Present.

Only two interviews were conducted when the group was running therefore only two participants could potentially have been experiencing all three conditions outlined in the theory. The influence of external motivation centered on the availability of the relaxation group. It allowed participants a guided opportunity to use the relaxation and to receive encouragement and reminders to use the relaxation outside of the group. When this external influence was removed, participants practice behaviours slowly changed. Thus is so with these participants' use of relaxation. Participants did not use their practice routine as frequently when they were not attending the group. Participants described how their practice and use of relaxation diminished. "I think it's like anything, if you're doing it, if you're involved in it, you automatically think about it more. It's on your, it's in your mind." (participant eight). Another described how the absence of the group had impacted her skill level.

"I'm not doing it as frequently. I'm finding that I'm losing the skill of the technique because I'm not doing it on a regular basis. I'm the kind of person where I need the routine. I think most of us are like that. And I prefer to do things in groups." (participant ten),

Participant four felt that

> "not attending the sessions so much, you would have a tendency to forget about it. Not focus on it as readily as if you were attending, you know, because then everything would just be so fresh. So you want to, I guess you could forget about it and not do it as regularly and then before you know it, you're kind of in a stressful state. You figure, 'phew, how did I let this happen? Oh my heavens, I haven't gone into relaxation for a long time' you know".

Participant ten described how she found it very difficult to do a relaxation routine on her own, so when she was feeling tense she went to acupuncture. "And so consequently, I'm using other people now when I could probably do it on my own, but I'm not self-disciplined enough to do it on my own. It's easier to go out and get the fix and then you don't have to worry about it."

Others described how much they felt that the group had benefited them and how they would like a refresher every once in a while. "I wouldn't mind having like a little check up, you know…it would be great to have a couple more sessions just to see if I am, even get it spiffed up" (participant six). Ideally attending the group on a weekly basis encourages optimal follow through outside the group, but participants felt that if that is not possible, then brief reintroductions to help keep them on track would be

beneficial. In fact, many speculated as to why, if they had such fond memories of the group and the approaches, they were not still attending the group.

Despite the lack of external motivation, most participants have continued to use the relaxation approaches in some fashion, even years after regular attendance in the group. An interesting note is that whether speaking to a participant who attended the group for six weeks, six months, or three years, the impact of learning and using the approaches was evident. No matter what the skill level, there was awareness by each participant of the influence of being able to control your own mind and body. In the group, participants felt as though they were able to "get away", even if just for an hour. This opportunity to escape was motivation enough for most to begin using the approaches outside the group after the first few sessions. Nine of the participants continued long term despite not having the group to keep them on track. The frequency became less and they felt "not as good at it", however, most continued to try to use some of what they had learned on an ongoing basis. Participant four described relaxation as "almost like if you could put it in your little bag and take it with you because it's your own, that it was something you had." Thus personal motivation was key to continued use of the approaches outside of the group, and after the group was terminated. They knew that relaxation made them feel better, and in the absence of the group, that was the only thing left to encourage them. There may have been some peer support, or support from other professionals, but there was no external opportunity for participants to regularly use the approaches in a guided environment. It was found that when personal motivation was the primary push to use a relaxation approach, the approaches were most often used

spontaneously in anxiety producing situations, and not so much for the regular practice routine.

At the time of the interview, one participant was actively receiving treatment and one participant had completed treatment but was waiting for results. The other eight were not actively involved in treatment (i.e., the medical aspect of treating cancer was complete, so the anxiety from medical tests and procedures was no longer as intrusive or frequent). However, anxiety on a daily basis or work related anxiety was not specifically discussed. The theory posits that when anxiety producing situations are less frequent, then participants were not practicing the approaches as regularly. This was based on the fact that most participants were not actively involved in treatment. Living was not dictated by doctors and hospitals as frequently as it once was. However, what was not measured was what else could be causing anxiety in the participants and if this had an impact on their use of relaxation approaches over the long term.

When Relaxation Was Not the Answer

The theory presented is based on experiences in which relaxation methods actually worked in the situations in which they were attempted. Conversely, all participants were also able to describe instances in which they found it impossible to apply a relaxation approach. There were two main reasons mentioned; (a) overwhelming emotions and (b) when there were too many interruptions. Some examples of being emotionally overwhelmed were during uncontrollable crying, overwhelming grief over the loss of a spouse, or feeling highly anxious or in crisis. Participants had described times when these same situations arose, and they were able to control themselves by using a relaxation approach. However, if they were "too wound up" or "didn't catch

themselves in time" they would be at a point emotionally where nothing could help them, and they would just have to let the situation pass, and allow some time before they were able to calm themselves. Often these situations seemed to "come from nowhere" or the participant was not in tune with how she was feeling, and all of a sudden her feelings became out of control.

The second type of situation where using a relaxation approach was difficult, was during medical procedures in which there were many interruptions. If treatments were being administered or the participant had to listen to commands from the doctor, participants often found it impossible to be relaxed or apply an approach. However, if there was time beforehand, participants tried to relax before the procedure, hoping to be generally more relaxed throughout it.

It did not seem that these instances in any way deterred participants from trying the approaches again. There had been many instances in which relaxation helped them immensely. A few bad experiences were not enough to lose trust in their ability to control their reactions through relaxation.

Specific Participants

The participants interviewed ranged widely in their experience with the relaxation group. Table Three represents each participant's length of attendance in the group, how long it had been since their last session, and what their use of the approaches looked like at the time of the interview.

Table Three: Participant Attendance

Participant	Months attended group	Months since last session (at time of interview)	Continued use of approaches at time of interview
1	14	Still attending	Regular practice spontaneous use
2	35	Still attending	Regular practice spontaneous use
3	24	2.5	Spontaneous use
4	36	12	Spontaneous use Bedtime use
5	24	1	Little use
6	7	42	Spontaneous use Bedtime use
7	1.5	1	Spontaneous use
8	36	48	Spontaneous use Bedtime use
9	6	48	Regular practice Spontaneous use
10	24	60	Spontaneous use

All participants were able to identify benefits from learning relaxation approaches and from being part of the group. Of the ten participants, eight identified that they still used the relaxation approaches on a regular basis – at least once per week. Participants one and two described regular practice at home, deliberate application of an approach in order to practice and perfect the technique. These two participants were still attending the group at the time of the interview, so relaxation was on the forefront of their minds. The second participant was also still in the midst of treatment, and was waiting for results from her recent round of chemotherapy, so anxiety and stressful situations were very much a part of her life.

Participants three, five and seven had stopped attending the group three months or less before the interview. Participant five had two years experience with relaxation but was not practicing very frequently at home since stopping her attendance. Participant five however described how she found it "easier going to something and doing it versus just doing it on my own. I guess I'm just that type of person whatever, I don't know, but I just find it easier doing it with other people rather than doing by myself." Personality played a role in this participants' long term use of relaxation, however there were no other participants who had attended for a significant amount time but had little use for it after the group ended, so it is difficult to compare why this may occur with others.

Participant seven had very little experience with the group and had stopped attending only a month before the research. She stated that she practiced less frequently than when she was attending the group. However one thing had stuck with her, the phrase "it's all right". That was the most significant piece she had taken from the group,

and she remembered this phrase in times of distress. This participant was not able to continue using the approaches as she had while in the group, but she took a phrase which was very comforting to her and has remembered it when she needs to be calmed. In a way, this is putting to use the approach of affirmations and suggestions, by repeating a phrase that induces calmness and helps to control a reaction to a situation. In a subtle way this participant is still using the approaches, most likely without even realizing it.

Participant three had attended for about two years and had attended her last session under 3 months ago. She was still practicing frequently but mostly in spontaneous situations. She had quite extensive experience with the group and had only terminated attendance a short time earlier. Through her exposure to yoga through a community facilitator in the mind/body group, she joined a yoga group and continues to attend that. Even though she was not attending the relaxation group, she was still incorporating mind-body approaches through the yoga class, and therefore was still quite aware and involved in keeping balance between mind and body.

The five other participants interviewed had not attended the group for one or more years, but were still incorporating the approaches into their lives in some form. Participants four, eight and ten attended for a significant amount of time and therefore had long standing exposure to and use of the approaches. They also reported using the approaches quite frequently outside of the group while they were attending. They attended at the height of the group, when there were consistently high numbers and there was a core group that promoted camaraderie outside of the group. These three participants reported being very involved in this group and gained great benefit from it, because they learned and used the approaches but also they had such a strong bond with

the others in the group at the time. Participant six also attended at the height of the group, however she clearly stated that she did not attend to make friends, she was there for herself and her own well being. She did have some relationships with participants outside of the group, but this was not what kept her at the group. She only attended for a short period of time, while she was off work for treatment, but she used that time to really devote herself to the approaches, use them frequently and practice them, and also share the approaches with her family and teach them how to practice and apply them. Her experience was a very short, but intense time, and it had a profound effect on how she coped with her situation. This participant seemed to appreciated the importance of the mind-body connection and this kept her continuing with regular use. She modified her approaches, and did not deliberately set aside time each day to practice, but she regularly used breathing to help calm herself when anxious, or to help her get to sleep at night.

Participant nine gave quite a different interview than all the other women. She had much experience with relaxation, professionally and personally, in practice and in theory. Therefore, she did not feel the need to practice the approaches in between sessions in order to become more proficient. Instead, she took the idea of connecting the mind and body and applied that to her everyday life in much more abstract ways. She reported often benefiting from the community practitioners more so than the regular facilitators. For example, one community practitioner did a story telling session. From this, the participant modified the story to fit her life, and used this as a way of changing her thinking. She reported being able to change her perspective of her body from being her enemy to her friend, through the use of abstract thought and applying not the specific approaches, but the idea of relaxation, to her everyday life. She therefore continued to use

these ideas as ways for her to continue to have a positive relationship with her body and to change her perspective on herself and on life, after experiencing a diagnosis of cancer.

Facilitator Findings

The intention of interviewing the facilitators was to get their perspective on the objectives of the group and their observations on participants in-group experiences and sharing of at home experiences. Coding of the facilitator findings was done in the same manner as the participants. However when it came to grouping into categories, themes, and eventually the theory, these findings did not quite fit in. Therefore, they were left out of the analysis and will be discussed separately.

Four facilitators were interviewed, all female, with varying degrees of experience working within a cancer facility and with facilitating the group. They had been practiced in the cancer area for anywhere from two to 28 years, and had facilitated the group from one year to 10 years. All four facilitators described the purpose of the group as to teach relaxation techniques experientially, with the hopes of helping those in the group gain control and develop a way to manage stress and anxiety. The facilitators felt that those diagnosed with cancer face an endless list of issues:

- fear of mortality
- loss of physical and emotional control
- feeling vulnerable
- experiencing loss and grief
- facing challenges of uncertainty and loneliness.

Facilitators also reported that the intervention targeted these issues by providing education to group participants on techniques to manage stress, relaxation and to gain

some control over responses to situations. Facilitators substantiated the findings from participant interviews that there were many secondary benefits from attending the group. They concurred that the group provided opportunity for participants to reduce their isolation, form relationships and friendships and find camaraderie among others who experienced similar situations. They shared stories of cancer treatments, of using relaxation at home, of trials and tribulations with family and friends, and the hard reality of watching others around them die, as well as gaining hope by seeing others recover and be cancer free. Although this was not the purpose of the group, these secondary benefits definitely contributed to the duration of the group.

Facilitators all agreed that they encouraged participants to practice at home and they observed participants encourage each other. One facilitator expressed the great need for practice "If someone doesn't practice it everyday, I'm not sure how effective it is as far as lessening anxiety", but "for the hour that they were there (at the group), I think certainly the anxiety is lessened." Facilitators believed that many participants used the approaches outside of the group, but also felt that it is likely hard for many to do so, especially if they are inexperienced with the approaches. One facilitator felt that those who attended the group for a long time, and who practiced more at home, were able to access it more readily and quickly in and out of the group. Another facilitator stated "as opposed to consciously saying, I think, now I'm going to relax. I think that with more practice people were doing it without necessarily planning to do." This statement corresponds with much of what the participants reported. Many participants used relaxation long after they stopped attending the group. Oftentimes there was one thing that they took with them, either a phrase or a favourite approach, or simply the lesson to

remember to breathe, and it stuck with them for years, and they were able to put it to use when needed, and without necessarily thinking about it. So the long lasting effects of using relaxation often showed up in subtle ways, but were still with the participants.

CHAPTER FIVE: CONCLUSIONS AND RECOMMENDATIONS

Comparison of the Theory with Literature

The theory presented centred on use of relaxation approaches outside of the learning environment. This theory stated that the presence of three factors led to the most ideal conditions for maximum use of relaxation outside of the group learning environment. These three factors are: (a) presence of stress/anxiety producing situations, (b) external motivation (peer support, facilitator encouragement, regular routine of attending the group), and (c) personal motivation (personal experience of the benefits of relaxation). When these factors were not present, however, there was some retention and continued application of the skills learned, but in a modified fashion. Also important to note is that participants generalized the use of the approaches and described cancer and non-cancer related situations in which they were applied. The following section will discuss how the literature substantiates this theory.

Psychosocial Interventions

It was encouraging to find that recent literature supports the benefits of using psychosocial interventions. Learning relaxation can reduce anxiety (Antoni et al, 2006; Cheung, Molassiotis & Chang, 2001; Laidlaw & Willet, 2002) and help with sleep disturbances (Richardson, 2003). But there is some evidence that these relaxation approaches may show most significant results on those participants who have initially higher than average levels of anxiety (Krischer, Xu, Meade & Jacobsen, 2007).

When one fully incorporates learning and using relaxation approaches into their lives, the benefits will be even more likely (Keefer & Blanchard, 2002). During the one hour weekly group, participants reported they felt like they were "on a vacation", that

they had set aside time for themselves to feel better and be distracted from the endless stressors that come with a cancer diagnosis. Many participants felt the power of relaxation after the first few sessions and wanted to feel this more often so they incorporated the group into their weekly routine. They also found encouragement from peers' stories of benefits of using relaxation. This reinforced the idea that relaxation can work for them. Facilitators also stressed the importance of using relaxation outside of the group and encouraged practice and use on a frequent basis. All these factors promoted total integration of the group and relaxation approaches into their lives.

The importance of practicing the approaches outside of the group was stressed by facilitators in this group. Home practice is often a part of most relaxation training programs offered (Decker, et al., 1992). In a study that evaluated the contribution of home practice in the treatment of tension headaches, those who had a home practice component to their relaxation training showed better ability to become relaxed in group, but not necessarily improvement in dealing with tension headaches (Blanchard, et al., 1991). Autogenic training (AT) is a self-hypnotic procedure with the specific purpose of strengthening independence from the therapist and giving control back to the individual (Linden, 2007). The purpose of discussing autogenic training here is not to compare it to the relaxation approaches presented in this research, but to look at the impact regular practice has on individuals' abilities to master this intense training program. In autogenic training, relaxation is described as a skill that requires practice, just as learning to throw a ball or play the piano is. For those learning AT, practicing twice daily and at regular times is considered essential (Linden, 2007). This of course can be very difficult to adhere to, but highlighting successes, praise of regular attendance to training sessions and

use in spontaneous situations can be motivating, as can sharing of success stories with others. Mindfulness Based Stress Reduction also incorporates a similar requirement of home practice and practical application. It has been found that those who attended all training sessions during a seven week program and followed the homework assignments, showed better outcomes on decreased stress symptoms (Speca, et al, 2000).

As the theory presented here states, when participants attended the group, when they were faced with many stressful situations, and when there was consistent reminders and encouragement of the benefits of using relaxation, participants were then applying approaches to specific situations and fulfilling the purpose of the group; to help deal with stress and anxiety. However, there came a time when participation in the group ended, and the consistent exposure to relaxation was no longer available. Despite this, participants continued to use the approaches, although less frequently and in more modified ways. Participants had experienced the benefits of the approaches enough to know that it was good for them to keep using them. Once the group ended, adherence to a practice routine slowly waned with time and most common uses of the approaches were at bedtime to help with sleep or during spontaneous situations. There have been some studies on adherence to previously learned relaxation approaches. A study by Antoni et al. (2006) reported that those who were part of a closed group that experientially taught relaxation and assigned at-home practice had significant reduction in cancer related intrusive thoughts, overall anxiety and overall negative mood. Most interestingly, these effects lasted at least nine months after the intervention. In a follow-up study on participants who were taught the relaxation response in order to combat symptoms of irritable bowel syndrome (Keefer & Blanchard, 2002), those participants who had

continued to use the relaxation method, especially when stressed or to be re-energized, reported that it had become easier for them to relax and they were better able to control their symptoms of irritable bowel syndrome. It was also noted that long term effects were most beneficial when participants continued to fully incorporate the approach into their lifestyle. It is promising to find that there are long term positive outcomes for those exposed to relaxation techniques, which substantiates findings in this research.

When participants were no longer attending the group, use of the approaches decreased with some participants, while others continued to use the approaches in a modified capacity. Breathing techniques were described as a common, long term approach that was applied to stressful situations. In the group setting, breathing was incorporated into all relaxation approaches taught and therefore was something that seemed almost engrained into the minds of many participants. They often remembered the breath and could quickly engage in this approach when faced with an anxious situation. In a study by Laidlaw and Willett (2002), participants were introduced to either progressive muscle relaxation or slow breathing rhythm. Participants in both groups showed decreased incidents of acute anxiety attacks, however those in the slow rhythm breathing group also showed increased positive mood states and fewer negative mood states. So despite the fact that participants in this research were not using the approaches to the fullest extent, simple breathing exercises were very beneficial to them.

Many participants also continued to use the approaches over a long-term to help with sleep disturbances. Reports of a "racing mind" and inability to fall asleep were common problems for participants. Studies have shown that mind-body approaches were

beneficial in reducing fatigue and improving sleep quality (Cohen & Fried, 2007; Carlson & Garland, 2005).

Psycho-educational Groups

Those with cancer often look to groups for support and help in coping with their cancer experience. Many groups exist, with different focuses and goals. The mind-body group in this research was an educational group, it's purpose being to experientially teach three mind-body approaches. The goal was to teach a skill that would hopefully help participants cope with stress and anxiety. Evidence tells us that individuals who participate in a group with a learning component benefit more than those in strictly support groups (Fawzy & Fawzy, 1998). Structured intervention focusing on illness related problem solving skills, increasing decision making skills, and active coping help those with early diagnosis learn to live with cancer (Fawzy, et al., 1995).

Although the RMBG in this research was an educational group, participants discussed how peer support played a big role in their continued attendance, and therefore continued integration of the group and the approaches in to their lives. Participants discussed how they enjoyed hearing others' success stories in using relaxation approaches in specific situations and how they enjoyed hearing their experiences with relaxation within the group. They also reported that the camaraderie of their peers was a big motivator in keeping them coming back to the group. As they continued attending the group, they became more proficient with the relaxation approaches. This led to deeper appreciation for the benefits of relaxation and motivation to use them outside of the group. This is the cyclical piece of the theory that was presented earlier in this paper.

When all conditions were present and integrated with each other, participants used the relaxation to their greatest potential.

Limitations of the Study

The sample size for this research was small, and this limitation was noted from the beginning. In addition, there were many variations among participants on several factors, such as how long they had attended, their previous experience with relaxation, how long it had been since their last group attendance, and what their use of relaxation was like after they were no longer a part of the group. If the study population had been larger, there would have been greater opportunity to get more breadth of information on a wider variety of experiences with the relaxation group.

It was also impossible to determine if the sample of participants was representative of those who had attended the group over its ten year duration. These participants volunteered to be a part of the study and it is unknown why these people volunteered and others did not. However, eight of the ten participants were not actively involved in treatment and had had good prognosis or had been cancer free for quite sometime at the time of the interview. All had reported beneficial experiences while attending the relaxation group and continued benefits from what they had learned.

The demographic information of the participants was also limited. The research was open to all participants however only women volunteered to be interviewed. The results may have been different if men who had attended the group had been included in this research. Cultural practices were not discussed in determining their influence in using relaxation approaches. Finally, income and education level were not included in the

interview questions, and although this would not have changed the theory or the sample, it would have given a bit more comprehensive look at those who participated.

As is with qualitative research, the theory applies to these particular participants of this specific RMBG. Replication of this study on other relaxation groups may or may not result in the same conclusions. However, further studies could be conducted to compare with or give insight to what has been presented here.

Despite these limitations, this research has produced evidence on the usefulness of relaxation approaches for those with cancer and the long term retention of some of the skill obtained while in the group. It also speaks to the types of situations in which participants apply the approaches, strengthening the premise that relaxation approaches can be used is a variety of situations.

Recommendations for Future Research

The theory presented in my research is based on accounts and recollections of past involvement with a relaxation group. Studying practice behaviours of individuals when they were actively involved in the RMBG group could have provided more accurate accounts of the benefits and impact of attending the group and using the skill in daily life. A longitudinal study following participants through their involvement with a relaxation group and beyond could provide beneficial information on long-term patterns in the use of approaches as well as the factors that may determine this use. This would allow for pre and post measures as well as follow up for long term retention and use of the approaches. However, forming a theory based on participants' experiences adds to the body of qualitative literature on psychosocial interventions, an area commonly dominated by quantitative research.

Another area of study that could shed light on use of relaxation approaches is an examination of the amount of training required before significant benefits can be measured. In this research, participants had varying degrees of involvement with the group, but most used the approaches outside the group and long after their attendance stopped. So the question remains, can those who have minimal exposure to relaxation identify the benefits and transfer the skill to daily situations? Comparative studies on brief exposure and extensive experience with relaxation approaches, including follow up of both groups, may fill this gap.

Recommendations for Social Work Practice

Psychosocial interventions are increasingly important in the health care field as professionals recognize the importance of overall well-being. Oncology social workers deal directly with the psychosocial well being of those diagnosed with cancer. Anxiety is a common response to a diagnosis of cancer and should be addressed as soon after diagnosis as possible. This then requires education for professionals in medical settings and cancer centres. As doctors and nurses are often the first professionals individuals encounter during the diagnosis stage, awareness of the importance of referrals to psychosocial departments is imperative. The oncology social worker would then offer supports and interventions to assist the individual with psychosocial well being. As anxiety and stress are common issues to address, and relaxation to reduce stress is well noted as an intervention for those with cancer, social workers in the health field should also understand this connection. Being aware of literature on mind body approaches and applying them with education and understanding of their effects is important. This research presented here can give insight into individuals' practical application of mind

body approaches, conditions that were necessary for optimum use of the approaches, and what motivates individuals to continue using the approaches once the intervention is no longer available.

Appendix A

INFORMATION SHEET

INTERESTED IN SHARING YOUR EXPERIENCES FROM THE RELAXATION MIND-BODY APPROACH GROUP?

My name is Jane Emberly. I am a Social Work Graduate student at the University of Manitoba. My thesis research will focus on the impact of attending this relaxation group. I am interested in understanding what role this group plays in your life and how you have been able to use the skills learned in everyday situations. I plan to do this through **INTERVIEWING** interested individuals who have or have had cancer and have attended this group.

The decision to participate is completely up to you. We will meet in a place and time that is convenient for you for approximately one and a half hours, depending on how much you wish to share. The interviews will be audiotaped then transcribed. At any time during the interview, you can refuse to answer a question. You can withdraw at any time.

The information in the interview is **CONFIDENTIAL.** It will only be seen by myself, a transcriber, and possibly my research advisor. Any identifying information, including names, will not be used. The information from the interviews will be used for my thesis and any future related papers or presentations. Information will be kept in a locked filing cabinet, accessible only by myself. The facilitators of the relaxation group will not have access to the information nor will participating in I jeopardize your participation in the relaxation group.

To offset any costs of attending the interview (transportation, parking, childcare etc.) there will be a small **HONORARIUM** given at the end of the interview.

If you are interested in participating, please leave your **NAME AND NUMBER ON THE SIGN UP SHEET** and I will contact you as soon as possible. If you have more questions, please feel free to contact me at xxx-xxxx.

PLEASE TAKE THIS INFORMATION SHEET WITH YOU FOR FUTURE REFERENCE.

Thank you for your time.

Jane Emberly

Appendix B

Sign Up Sheet for Research on Introduction to Relaxation mind-body Techniques

Please leave me your name and phone number that is most convenient to contact you at. I will be in touch with you as soon as possible to set up an interview time at your convenience.

Thank you. Jane Emberly

Name	Number
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________
____________________	________________

Appendix C

INTERVIEW NUMBER __________ DATE______________________

Intro Section

We will begin with some basic information about yourself.

- Age of participant
- Marital status: Single, common-law, divorced, dating, married, widowed
- Are there any other medical issues you are dealing with, besides the cancer?
- Before talking about the relaxation group, I will be asking you about some issues that may be difficult to talk about. We'll be discussing some terms that you may have heard before when talking about cancer and I want to hear what these terms mean to you.
- So first let talk about your cancer diagnosis and what you know about it. (cancer diagnosis, prognosis, stage of cancer, year of diagnosis, treatments, etc)
- How long have you/did you been attending this RMBG?
- How often have/did you attended this group(for example in the last six months)?
- Do you have previous experience with relaxation mind-body techniques? Describe.
- Are you attending any other groups?
- Receiving individual psychosocial help? If so describe each.

Impact of Group Attendance

Now we will discuss the role that attending the group has played in your life

- What are some issues you have been dealing with due to your cancer diagnosis? (physical, emotional, how are they dealt with)

- What role has/did this RMBG played in coping with these issues?
- What techniques do you/have you experienced in the group? (experienced each technique, understand there are 3 techniques, comfort level of practicing techniques in group)
- There are a few facilitators in the group. Do/did you find that the facilitator impacts your attendance or feelings about the group?
- Occasionally, a community practitioner facilitates the group. Have there been any of these weeks that you have really enjoyed? Would you like to see this facilitator again?
- Is/was there anything about the group that impacts your attendance – why you come or don't come?
- Is/was there anything in your life that impacts why you come or don't come?
- Is there anything else about the experience with the group that you would like to share? (any other tool you've taken, what is it, why, how)

Home Practice

We will now talk about practicing the techniques learned in the group outside of the group. So this will look at whether or not you actually sit down and purposefully go through a relaxation technique that you have learned in the group.

- Other than during the weekly groups, do you practice the techniques? (which ones, how often, how long each time, where, when, practice alone or with guidance,)
- Is there a specific reason why you practice these techniques? (manage stress, to sleep etc)

- What/who encourages you to practice outside of the group (in what way, who – spouse, facilitators, why you enjoy practicing)?
- How has practicing these techniques been beneficial?

Transfer of Techniques

Practicing the techniques and using them to help you cope with a situation are two separate issues. This final section we'll talk about how you have been able to put the techniques to use in everyday situations, related to cancer or not.

- Have there been specific situations where the use of these techniques is helpful (when did you start doing this, comfort level with putting the techniques to use)?
- Is there a certain technique that you find easthe research to use outside of the group (which ones, why, for what situations)?
- Are there times when you would like to use a technique to help cope with a situation but find you could not do so? Why?
- That is the end of the interview. Is there anything else you would like to add about your experience with the group?

Appendix D

Facilitator Interview

- How long have been working in cancer field
- How long have been working at Cancer Care
- How long did facilitate the open, on-going mind/body group (compare to how long group was running)
- What do you feel were some of the initial goals and purposes behind creating this group
- Through the structure of the group, how do you feel that these goals and purposes were addressed (educational format, open ended, on-going, choosing of those who would facilitate)
- My research is only focusing on those participating in the group that have or have had cancer. In your experience with those with cancer, what do you feel are some of the biggest issues that a patient deals with after a diagnosis
- How do you feel that this mind-body group targets these issues
- Do you feel that these issues bring people to the group in the first place? What else contribute to joining this group?
- As you have been facilitating the group, I'm sure you've watched newcomers join the group and grow as they continually attend. Can you describe how you see that process – use a specific example, general terms – and what do you think contributes to how a person grows as he/she continues to participate in the group. What do you see when comparing experienced participants and new participants.
- I talked with participants about two different, but sometimes overlapping issues - practicing the approaches that they are exposed to in the group and actually applying those skills to help them get through a particularly difficult situation. Can you give some insight into how you see these concepts incorporate themselves into the participants lives.
- I have begun to see some patterns emerge from my interviews with participants. One huge theme is that of control. What role do you see control play in a person's experience after being diagnosed with cancer
- In what way do you feel that the mind-body group can target this issue
- Although the group's format is set up to primarily focus on the mind/body approach, there is a bit of an intro at the beginning and a sharing piece at the end of each week. How do you feel that has impacted the effectiveness of the mind/body group and the experiences that participants have gained from it.
- Any general remarks on the experiences of participants and of the group itself.

Appendix E

Consent Form for Research on Relaxation Mind-body Techniques Group.

I have read the information sheet on I and understand that Jane Emberly is conducting research as part of her Master's of Social Work requirements at the University of Manitoba. The study will focus on the experiences of members of the Introduction to Relaxation Mind-Body Techniques group.

I understand that this interview will be audio taped then transcribed by a typist. I understand all information will remain confidential. I understand that any identifying information will be disguised to protect my identity and any reference to myself in written form will be in the form of a number.

I understand that discussing issues surrounding cancer may be uncomfortable or distressing. I know that I will be referred to psychosocial oncology if needed following this interview. I understand I am free to withdraw from the study at any time, and/or refrain from answering any questions I wish. I know that participating in I will not in any way effect my treatment or my attendance in the relaxation group. The facilitators will not be aware of my responses.

I understand that a fixed amount of money, $15, will be presented at the end of the interview to offset any costs of attending the interview.

I understand that the data collected will be stored in a locked filing cabinet with access only to the primary researcher, Jane Emberly. This data will be destroyed once the thesis and any publications that may ensue have been completed.

I know I may contact Jane Emberly, her advisor, Tuula Heinonen, or The Research Ethics Board Secretary at the University of Manitoba at if I have any questions or concerns.

Participant name: ________________	Researcher: ____________________
Signature: ________________	Signature: ____________________
Date: ________________	Date: ____________________

Appendix F

Resource Information

It is understood that recalling stories related to your cancer experience can be stressful and painful. Retelling these stories in the interview may have brought up feelings that may be difficult to deal with. Talking with someone about these feelings may be helpful for you.

Please contact the psychosocial oncology department if you feel you need to speak with someone.

Thank you for your participation.

Sincerely

Jane Emberly

References

Association of Oncology Social Workers (2007,). Retrieved Aug 5 2008 from http://www.aosw.org/power/index.php.

Achterberg, J. (1985). *Imagery in healing: Shamanism and modern medicine.* Boston & London: New Science Library.

Andrykowski, M.A. & Manne, S.L. (2006). Are psychological interventions effective and accepted by cancer patients? I. Standards and levels of evidence. *Annals of Behaviour Medicine, 32(2),* 93-97.

Antoni, M.H., Wimberly, S.R., Lechner, S.C., Kazi, A., Sifre, T., Urcuyo, K.R. et al. (2006). Reduction of cancer-specific though intrusions and anxiety symptoms with a stress management intervention among women undergoing treatment for breast cancer. [Electronic version]. *American Journal of Psychiatry, 163(10),* 1791-1797.

Arnold, E. M. (1999). The cessation of cancer treatment as a crisis. *Social Work in Health Care, 29,* 21-38.

Astin, J.A. (1998). Why patients use alternative medicine. [Electronic version]. *Journal of the American Medical Association, 279(19),* 1548-1553.

Auerbach, J. (1990). Hypnotic suggestions with cancer. In D. C. Hammond (Ed.). *Handbook of hypnotic suggestions and metaphors* (pp. 204-205). New York: Norton & Company.

Baider, L., Uziely, B., & Kaplan De-Nour, A. (1994). Progressive muscle relaxation and guided imagery in cancer patients. *General Hospital Psychiatry, 16,* 340-347.

Benson, H. (1984). *Beyond the relaxation response.* New York: Times Books.

Benson, H. (1976). *The relaxation response.* New York: William Morrow.

Berger, J. (1984). Crisis intervention: A drop-in support group for cancer patients and their families. *Social Work in Health Care, 10,* 81-92.

Blanchard, E. B., Nicholson, N. L., Taylor, A. E., Steffeck, B. R., Radnitz, C. L. & Appelbaum, K. A. (1991). The role of regular home practice in the relaxation treatment of tension headache. *Journal of Consulting and Clinical Psychology, 59,* 467-470.

Brice, G. L. (1987). Hypnosis for an operation phobia – A case study. *The Australian Journal of Clinical Hypnotherapy and Hypnosis, 8,* 97-104.

Bridge, L. R., Benson, P., Pietroni, P. C., & Priest, R. G. (1988). Relaxation and imagery in the treatment of breast cancer. *British Medical Journal, 297,* 1169-1173.

Brigden, M.L. (1995). Unproven (questionable) cancer therapies. [Electronic version]. *The Western Journal of Medicine, 163(5),* 463-469.

Brown, N. W. (1998). *Psycho-Educational Groups.* USA: Accelerated Development.

Bruss, K. (2000). *American Cancer Society's Guide to Complementary and Alternative Cancer Methods.* Atlanta:American Cancer Society.

Bultz, B.D. & Carlson, L.E. (2005). Emotional distress: The sixth vital sign in cancer care. [Electronic version]. *Journal of Clinical Oncology,* 6440-6441.

Canadian Cancer Society (2008, August 17). Canadian Cancer Statistics 2008. Retrieved August 18, 2008 from http://www.cancer.ca/Manitoba/About%20cancer/Cancer%20statistics/Stats%20at%20a%20glance/General%20cancer%20stats.aspx?sc_lang=en&r=1

Carlson, L. E. & Garland, S. N. (2005). Impact of mindfulness-based stress reduction

(MBSR) on sleep, mood, stress and fatigue symptoms in cancer outpatients. *International Journal of Behavioural Medicine, 12(40),* 278-285.

Carlson, L.E., Ursuliak, Z., Goodey, E., Angen, M., & Speca, M. (2001). The effects of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients: 6-month follow-up. *Support Care Cancer, 9,* 112-123.

Charmaz. K. (2006). *Constructing Grounded Theory: A Practical Guide Through Qualitative Analysis.* London:Sage.

Cheung, Y.L., Molassiotis, A., & Chang, A.M. (2001). A pilot study on the effect of progressive muscle relaxation training of patients after stoma surgery. *European Journal of Cancer Care, 10,* 107-115

Cohen, M., & Fried, G. (2007). Comparing relaxation training and cognitive-behavioural group therapy for women with breast cancer. [Electronic version]. *Research on Social Work Practice, 17,* 313.

Coleman, H., & Unrau, Y. (1996). Analyzing your data. In L. Tutty, M.A. Rothery, & R.M. Grinnell jr. (Eds.). *Qualitative Research for Social Workers* (pp. 88-119). Boston: Allyn and bacon.

Crasilneck, H. B. & Hall, J. A. (1990). Hypnotic suggestions with cancer patients. In D. C. Hammond (Ed.) *Handbook of hypnotic suggestions and metaphors* (pp. 205). New York: Norton & Company.

Creswell, J. (1998). *Qualitative inquiry and research design: Choosing among five traditions.* Thousand Oaks, CA: Sage Publications.

Cwikel, J G. & Behar, L. C. (1999). Organizing social work services with adult cancer

patients: Integrating empirical research. *Social Work in Health Care, 28,* 55-76.

Davis, E. (1994). The unconscious power of affirmations – A hypnotherapist's perspective. *The Australian Journal of Clinical Hypnotherapy and Hypnosis, 15,* 53-65.

Decker, T. W., Cline-Elsen, J., & Gallagher, M. (1992). Relaxation therapy as an adjunct in radiation oncology. *Journal of Clinical Psychology, 48,* 388-393.

Eisenberg, D.M., Davis, R.B., Ettner, S.L., Appel, S., Wikey, S., Rompay, M.V., et al. (1998). Trends in alternative medicine use in the united states, 1990-97. [Electronic version]. *Journal of the American Medical Association, 280(18),* 1569-1575.

Fawzy, F.I., & Fawzy, N.W. (1998). Group therapy in the cancer setting. *Journal of Pyshosomatic Research, 45(3),* 191-200.

Fawzy. F. I., Fawzy, N. W., Arndt, L. A., & Pasnau, R. O. (1995). Critical review of psychosocial interventions in cancer care. *Archives of General Psychiatry, 52,* 100-113.

Garland, S.N., Carlson, L.E., Cook, S., Lansdell, L., & Speca, M. (2007). A non-randomized comparison of mindfulness-based stress reduction and healing arts programs for facilitating post-traumatic growth and spirituality in cancer outpatients. *Support Care Cancer, 15,* 949-961.

Gitterman, A. (1982). The use of groups in health care. In A. Lurie, G. Rosenberg, & S. Pinsky (Eds.), *Social Work with Groups in Health Settings* (pp. 6-24). New York: Neale Watson Academic Publications, Inc.

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for*

qualitative research. Chicago, Il: Aldine Publishing Company

Hammond, D. C. (Ed.). (1990). *Handbook of hypnotic suggestions and metaphors.* New York: Norton & Company.

Helgeson, V. S., & Cohen, S. (1999). Social support and adjustment to cancer: Reconciling descriptive, correlational, and intervention research. In R. M. Suinn & G. R. VandenBos (Eds.) *Cancer patients and their families: Readings on disease course, coping, and psychological interventions* (pp. 53-80). Washington: American Psychological Association.

Helgeson, V. S., Cohen, S., Schulz, R., & Yasko, J. (2000). Group support interventions for women with breast cancer: Who benefits from what? *Health psychology, 19,* 107-114.

Helgeson, V. S., Cohen, S. Schulz, R., & Yasko, J. (1999). Education and peer discussion group interventions and adjustment to breast cancer. *Archives of General Psychiatry, 56,* 340-347.

Jacobsen, P.B. & Jim, H.S. (2008). Psychosocial interventions for anxiety and depression in adult cancer patients: Achievements and challenges. *A Cancer Journal for Clinicians, 58,* 214-230.

Jacobson, E. (1938). *A physiological and clinical investigation of muscular states and their significance in psychology and medical practice.* Chicago, IL: The University of Chicago Press.

Kabat-Zinn, J., Lipworth, L. & Burney, R. (1985). The clinical use of mindfulness meditation for the self-regulation of chronic pain. *Journal of Behavioural Medicine, 8(2),* 163-190.

Kabat-Zinn, J., Massion, A.O., Hebert, J.R., & Rosenbaum, E. (1998). Meditation. In J.C. Holland (Ed.) *Psycho-oncology* (pp. 767-779). New York: Oxford University Press.

Keefer, L,. & Blanchard, E.B. (2002). A one year follow-up of relaxation response meditation as a treatment for irritable bowel syndrome. *Behaviour Research and Therapy, 40,* 541-546.

Korn, E. R., & Johnson, K. (1983). *Visualization: The uses of imagery in the health professions.* Homewood, IL: Dow Jones-Irwin.

Krischer, M.M., Xu, P., Meade, C.D., & Jacobsen, P.B. (2007). Self-administered stress management training in patients undergoing radiation. [Electronic version]. J*ournal*

of Clinical Oncology, 25, 4657-4662.

Laidlaw, T.M., & Willett, M.J. (2002). Self-hypnosis tapes for anxious cancer patients: An evaluation using personalized emotional index (PEI) diary data. *Contemporary Hypnosis, 19(1),* 25-33.

Lewis, H. R., & Lewis, M. E. (1972). *How your emotions can damage your health.* New York: The Viking Press.

Liburd, E. (1984). The cancer experience: Tasks in caring for the elderly. In L. H. Suszycki, M. Abramson, E. Prichard, A. H. Kutscher, & D. Fisher (Eds.). *Social work and terminal care* (pp. 43-52). New York: Praeger.

Linden, W. (2007). The autogenic training method of J.H. Schultz. In P.M. Lehrer, R.L.Woolfolk, & W.E. Sime (Eds.). *Principles and Practice of Stress Management (3rd edition)* (pp. 151-205). New York: The Guilford Press.

Loscalzo, M. J., & Zabora, J. R. (1996). Oncology social work and palliative care in the United States. In N. Berkowitz (Ed.). *Humanistic approaches to health care: Focus on social work* (pp. 49-70). London: Venture Press.

Luebbert K., Dahme, B., & Hasenbring, M. (2001). The effectiveness of relaxation training in reducing treatment-related symptoms and improving emotional adjustment in acute non-surgical cancer treatment: A meta-analytical review. *Pycho-Oncology, 10,* 490-502.

Matchim, Y. & Armer, J.M. (2007). Measuring the psychological impact of mindfulness meditation on health among patients with cancer: A literature review. *Oncology nursing Forum, 34(5),* 1059-1066.

Morse, J. M. & Field, P. A. (1995). *Qualitative research methods for health professionals (2nd ed.).* Thousand Oaks, CA: Sage Publications.

Northern, H. & Kurland, R. (2001). *Social work with groups (3rd ed.).* New York: Columbia University Press.

Noyes JR, R., Holt, C.S., & Massie, M.J. (1998). Anxiety disorders. In J.C. Holland (Ed.) *Psycho-oncology* (pp. 548-563). New York: Oxford University Press.

Pilsecker, C. (1990). Terminal cancer: A challenge for social work. In K. W. Davidson & S. S. Clarke (Eds.). *Social work in health care: A handbook for practice; part II (pp. 415-428).* New York: Haworth Press.

Post-White, J. & Fitzgerald, M. (2002). Imagery. In M. Snyder & R. Lindquist (Eds.). *Complementary/alternative therapies in nursing (4th ed)* (pp. 43-57). New York: Springer Publishing Co.

Rehr, H. (1984). Health care and the social work connection. In H. Rehr, G. Rosenberg

& S. Blumenfield (Eds.). *Creative social work in health care: Clients, the community and you organization* (pp. 7-20). New York: Springer Publishing Company.

Richardson, S. (2003). Effects of relaxation and imagery on the sleep of critically ill adults. [Electronic version]. *Dimensions of Critical Care nursing, 22(4),* 182-190.

Scott, D. W., Donahue, D. C., Mastrovito, R. C., & Hakes, T. B. (1986). Comparative trial of clinical relaxation and an antiemetic drug regimen in reducing chemotherapy-related nausea and vomiting. *Cancer Nursing, 9,* 178-187.

Siegel, K. (1990). Psychosocial oncology research. *Social Work in Health Care, 15,* 21-43.

Silverstone, B. (1984). Social work practice with the dying: Where are we and where are we going. In L. H. Suszycki, M. Abramson, E. Prichard, A. H. Kutscher, & D. Fisher (Eds.). *Social work and terminal care* (pp. 3-14). New York: Praegner.

Sloman, R. (1995). Relaxation and the relief of cancer pain. *Nursing Clinics of North America, 30,* 697-709.

Snyder, M. (2002). An overview of complementary/alternative therapies. In M. Snyder & R. Lindquist (Ed.). *Complementary/alternative therapies in nursing (4th ed)* (pp.3-15). New York: Springer Publishing Co.

Sparber, A., Bauer, L., Curt, G., Eisenberg, D., Levin, T., Parks, S., et al. (2000). Use of complementary medicine by adult patients participating in cancer clinical trials. *Oncology Nursing Forum, 27(4),* 623-630.

Speca, M., Carlson, L.E., Goodey, E., & Angen, M. (2000). A randomized, wait-list

controlled clinical trial: The effect of a mindfulness meditation-based stress reduction program on mood and symptoms of stress in cancer outpatients. *Psychosomatic Medicine, 62,* 613-622.

Stark, D.P.H. & House, A. (2000). Anxiety in cancer patients. *Journal of Cancer, 83(10),* 1261-1267.

Stark, D., Kiely, M., Smith, A., Velikova, G., House, A., & Selby, P. (2002). Anxiety disorders in cancer patients: Their nature, associations, and relation to quality of life. *Journal of Clinical Oncology, 20(14),* 3137-3148.

Stern, P. N. (1994). Eroding grounded theory. In J. M. Morse (Ed.). *Critical issues in qualitative research methods* (pp. 212-223). Thousand Oaks, CA: Sage Publications.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded theory procedures and techniques.* Newbury Park, CA: Sage Publications.

Strauss, B. S. (1990). Suggestions and metaphors for support and ego-strengthening in cancer patients. In D. Corydon Hammond (Ed.). *Handbook of hypnotic suggestions and metaphors* (pp. 203). New York: Norton & Company.

Sullivan, V. C. (1988). Suggestive therapy in hypnosis. *The Australian Journal of Hypnotherapy and Hypnosis, 9,* 29-34.

Syrjala, K. L., Cummings, C., & Donaldson, G. W. (1992). Hypnosis or cognitive behavioral training for the reduction of pain and nausea during cancer treatment: a controlled clinical trial. *Cancer Pain, 48,* 137-146.

Toseland, R. W., & Rivas, R. F. (2001). *An introduction to group work practice (4th ed.).* Boston: Allyn Bacon.

Veach, T. A., Nicholas, D. R., & Barton, M .A (2002). *Cancer and the family life cycle: A practitioner's Guide.* New York: Bruner-Routledge.

Wallace, K. G. (1997). Analysis of recent literature concerning relaxation and imagery interventions for cancer pain. *Cancer nursing, 20,* 19-87.

Wren, K. R., & Norred, C. L. (2003). *Real world nursing survival guide: Complementary and alternative therapies.* Philadelphia: Saunders.

Zahourek, R. P. (Ed.). (1988). *Relaxation and imagery: Tools for therapeutic communication and intervention.* Philadelphia: Saunders.