Self-help groups: Oncology nurses' perspectives

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Abstract

During the past decade in North America, the number of self-help groups for cancer patients has grown dramatically. Nurses' knowledge and attitudes about self-help groups could influence their practice behaviours and the information they provide to cancer patients. However, little is known about oncology nurses' views regarding self-help groups.

This study used a cross-sectional survey to gather information about knowledge, attitudes, and practice behaviours of Canadian oncology nurses regarding self-help groups. A total of 676 nurses completed the survey (response rate of 61.3%). The respondents had spent, on average, 21.6 years in nursing and 11.6 years in oncology nursing. Results indicated that a large majority of nurses knew about available self-help groups. Approximately one-fifth of the nurses are speaking frequently about self-help groups with patients (20.7%) and are initiating the conversation on a frequent basis (22.0%). Overall, oncology nurses rated self-help groups as helpful with regards to sharing common experiences (79.5%), sharing information (75.6%), bonding (74.0%), and feeling understood (72.0%). The most frequently identified concern regarding the groups was about misinformation being shared (37.9%), negative effects of associating with the very ill (22.1%), and promoting unconventional therapies (21.2%). Implications from the study suggest that oncology nurses would benefit from learning more about the nature of self-help groups and being able to talk with patients about the self-help experience.

During the past decade in North America, the number of self-help groups for cancer patients has grown dramatically. This is particularly the case for women with breast cancer and men with prostate cancer (Gray, Fitch, Davis, & Phillips, 1997a, 1997b). In Ontario alone, there are more than 60 self-help groups for women with breast cancer (Gray et al., 1997a). Many of these groups have grown as grassroots efforts in response to perceived inadequacies in the cancer care system, especially around issues of access to information and support. In many locations across Canada, the availability of self-help support groups provides an additional opportunity for cancer survivors to meet with peers on a regular basis.

Self-help groups have been defined as "member-governed voluntary associations of persons who share a common problem, and who rely on experiential knowledge at least partly to mutually solve or cope with their common concerns" (Borkman, 1990, p.322). This definition specifically excludes groups run in any way by professionals, whether for support or psychoeducational purposes. From the self-help perspective, professionally-led or co-led groups, although operated with the same intention of providing support for cancer patients, are run using different models with different philosophies and practices (Wilson, 1993). These distinctions are often blurred within the

ABRÉGÉ: GROUPES D'ENTRAIDE: PERSPECTIVES DES INFIRMIÈRES EN ONCOLOGIE

Au cours de la dernière décennie, le nombre de groupes d'entraide pour les personnes atteintes de cancer a connu une augmentation fulgurante en Amérique du Nord. Les connaissances et les attitudes des infirmières relatives aux groupes d'entraide pourraient influer sur leurs comportements de pratique et sur l'information qu'elles fournissent aux patients vivant avec le cancer. Toutefois, on sait très peu de choses sur les vues des infirmières en oncologie concernant les groupes d'entraide.

Cette étude a utilisé une enquête transversale pour recueillir des renseignements sur les connaissances, les attitudes et les comportements de pratique des infirmières en oncologie canadiennes en matière de groupes d'entraide. En tout, 676 infirmières ont participé à l'enquête (soit un taux de réponse de 61,3 %). Les répondantes avaient œuvré, en moyenne, 21,6 années en soins infirmiers et 11,6 années en soins infirmiers en oncologie. Les résultats indiquaient qu'une majorité importante d'infirmières savaient quels groupes d'entraide étaient disponibles. Environ un cinquième des infirmières (20,7 %) parlent fréquemment de groupes d'entraide avec les patients et abordent souvent le sujet elles-mêmes (22,0 %). Dans l'ensemble, les infirmières en oncologie estimaient que les groupes d'entraide sont utiles pour le partage d'expériences communes (79,5 %), le partage d'information (75,6 %), la formation de liens affectifs (74,0 %) et la création d'un climat de compréhension (72,0 %). Les inquiétudes les plus souvent mentionnées au sujet des groupes étaient le partage d'informations erronées (37,9 %), les effets négatifs d'une association avec des patients extrêmement malades (22,1 %) et la promotion de thérapies non conventionnelles (21,2 %). Les résultats de l'étude suggèrent que les infirmières en oncologie y gagneraient en approfondissant la nature des groupes d'entraide et en étant à même de s'entretenir avec les patients de l'expérience d'entraide.

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cancer literature (Guidry, Aday, Zhang, & Winn, 1997; Hitch, Fielding, & Llewelyn, 1994; van den Borne, Pruyn, & van Dam-deMey, 1986).

Since the 1970s, the self-help movement has escalated. Numerous self-help groups provide support and assistance, enabling members to deal with a wide range of health-related issues such as addictions, bereavement, chronic illnesses, disabilities, and mental health issues. The self-help or mutual aid process provides people who share a common experience or situation the opportunity to share a unique perspective that is not available from those who have not lived the same experiences. The primary functions of self-help groups include social support, information sharing and education, identity formation, affiliation and community, personal growth and transformation, and advocacy and collective empowerment. Hyndman (1997) provides an excellent review of evaluations conducted regarding the effectiveness of self-help programs across many illness situations.

The benefits of professionally-led support groups for cancer patients have been described systematically (Fawzy et al., 1993; Gordon et al., 1980; Helgeson, Cohen, Schultz, & Yasko, 1999; Spiegel, Bloom, Kraemer, & Gottheil, 1989). However, the benefits of cancer self-help groups have only been documented by a few authors (Falke & Taylor, 1983; Gray et al., 1997a, 1997b; Maisaik, Caine, Yarbro, & Josef, 1981; Pilisuk, Wentzel, Barry, & Tennant, 1997). From the perspectives of cancer survivors, the benefits of self-help groups include, among others, sharing information, sharing common experiences, having an opportunity to help others, feeling encouragement and reinforcement, and learning about complementary and alternative therapies (Gray et al., 1997a, 1997b; Pilisuk et al.; Stevenson & Coles, 1993). Despite the growth of these groups and the desire by group members to have the support of the professional cancer care community (Stewart, 1990), little has been written about the interface between self-help groups and the formal cancer care community (Bradburn, Maher, Young, & Young, 1992; Gray, Greenberg, McBurney, & Douglas, 1997; Kurtz, 1990; Lavoie, Borkman, & Gidron, 1994).

Oncology nurses have a responsibility to help cancer survivors learn about community resources and how to access the types of resources which could benefit an individual. Often patients will talk with nurses about resources they might use. Nurses' knowledge and attitudes about specific resources, in this case self-help support groups, could influence their practice behaviours and the information they provide to patients. However, little is known about oncology nurses' knowledge, attitudes, or practices regarding self-help groups.

Stewart (1989) explored the knowledge, attitudes, and referral patterns of hospital nurses and community health nurses in Nova Scotia concerning self-help groups for health promotion. Of the 72 respondents, 61.7% viewed their relevant level of knowledge about self-help groups as only fair. The most commonly cited reason for nonreferral was lack of information about the groups. Most respondents wanted more information about the groups (79.2%) and a directory of such self-help groups (91.7%).

The purpose of this study was to describe the knowledge, attitudes, and practice behaviours of oncology nurses who are members of the Canadian Association of Nurses in Oncology (CANO) regarding self-help groups. The findings of this study were intended to enhance understanding about oncology nurses' practices surrounding self-help groups and provide insight regarding opportunities for continuing education.

Method

The method utilized for this study was a cross-sectional survey. Both quantitative and qualitative data were gathered from a national sample of Canadian oncology nurses using the Dillman method for survey research (Dillman, Carpenter, Christenson, & Brooks, 1974). The Dillman method (described below) increases the response rate by reminding potential respondents about a study.

Sample and procedures

The sample for this study came from the 1996 membership list of the Canadian Association of Nurses in Oncology. Questionnaire packages were mailed to all 1,188 members. The questionnaire package contained a cover letter explaining the study, the questionnaire, and a postage-paid return envelope. Three weeks later, a reminder card was sent to all who had not replied. Then, three weeks after mailing the reminder card, a second full package was mailed to all who had not responded by that time or had not contacted the investigators to decline participation. From the original 1,188 nurses, 33 contacted the investigators in writing or by telephone to decline participation for reasons such as not working in oncology or not working in a role with direct patient contact. Additionally, 52 packages were returned because the individual had moved. A total of 676 completed questionnaires were returned for a response rate of 61.3%.

Questionnaire

The survey questionnaire was designed by the research team for the purposes of this study. The design was based on a previous survey designed and used successfully by the same team to assess the attitudes and practices of family physicians about self-help groups (Gray, Orr, Carroll, Chart, Fitch, & Greenberg, 1998). Items were added to the original survey regarding attitudes toward "nurse bashing" and "health care system bashing," and demographic items were altered to reflect nursing roles and work settings. All items were reviewed for clarity prior to distribution of the questionnaire. Reliability and validity estimates were not determined.

The questionnaire consisted of 21 items about self-help groups (eight about general self-help groups and 13 about cancer-specific self-help groups) and 10 demographic items. The self-help group items focused on knowledge of any self-help groups including cancer self-help groups specifically, nurse practices regarding conversations about self-help groups with patients, and attitudes about benefit and harm in patients attending self-help groups. The attitude questions elicited responses regarding a variety of negative and positive features of self-help groups. These features were derived from two previous studies regarding experiences of cancer survivors in self-help groups and attitudes they had heard expressed by health care providers about their participation in the groups (Gray et al., 1997a, 1997b). For the positive features, nurses were asked to rate helpfulness on a five-point Likert scale (1 = not helpful, 5 = very helpful). For the negative features, nurses were asked to rate how concerned they were that these features would occur in self-help groups (1 = not at all concerned, 5 = very concerned). A final open-ended question provided respondents with the opportunity to write any additional comments they had about self-help groups. The definition of self-help groups was included at the beginning of the survey, as well as an exclusionary comment about professionally-run groups.

Analysis

For the quantitative data, the analysis was primarily descriptive. Means, medians, and frequencies were calculated for all items and selected tests of significance were conducted for demographic and practice pattern variables. The written responses to the open-ended question were subjected to content analysis. Selected quotes are shared in the text to illustrate the salient perspectives identified by the nurses who responded.

Results

Sample

A total of 676 CANO members provided data for this study (response rate of 61.3%). Their demographic characteristics are presented in Table One. The respondents had spent, on average, 21.6 years in nursing and 11.6 years in oncology nursing. Slightly less than half (46.0%) were diploma prepared. More than half (58.1%) worked in an ambulatory or outpatient setting, and a third (33.3%) worked in an inpatient hospital unit.

The majority (78.1%) of these nurse respondents worked with adult cancer patients exclusively. Almost two-thirds (64.3%) indicated that more than 95% of the patients in their current practice were cancer patients. When asked to indicate the types of cancer disease sites with which they worked, 19% stated they cared for patients in one or two sites, and another 19% indicated they cared for patients in all 12 disease sites listed on the survey (see Table One). When asked to estimate the number of cancer patients they had cared for in the past year, the respondents' estimates ranged from zero to more than 1,000. Almost half (48%) had cared for more than 100 cancer patients in the past year. Only 2.8% had not provided care for cancer patients in the past year, but had done so prior to that time.

Table One: Selected demographic and practice characteristics of oncology nurses in sample (n = 676)

Characteristic	% of Sample
Highest level of nursing education	
Diploma	46.0
Bachelor/Post-Basic	32.5
Masters	13.2
Doctorate	1.8
Other	5.3
Work setting	
Urban	76.0
Suburban	12.7
Rural	7.4
Hospital - inpatient	33.3
Regional cancer centre	25.4
Outpatient - ambulatory	32.7
Community	9.8
Primary nursing	51.6
Team nursing	27.1
Case management	11.2
Patients in practice	
Adult patients only	78.1
Adult and pediatric patients	15.4
Pediatric patients only	6.5
Type of cancer practice	
Work in one disease site	10.1
Work in two disease sites	8.4
Work in three disease sites	8.0
Work in four disease sites	7.2
Work in five or more disease sites	66.0
Number of cancer patients in practice (in past year)	
0	2.8
1-20	20.2
21-100	29.0
102-300	19.4
301-1,000	16.7
>1,000	11.9

Almost a third (n = 217) of the oncology nurses had attended a self-help group in a professional capacity, 65 had attended in a personal capacity, and 56 attended in both a professional and personal capacity.

Knowledge and practices related to self-help groups

General self-help groups

In the survey, nurses were asked if they knew about general self-help groups, organized for various reasons such as addiction, abuse, and trauma. A list was provided and the nurses checked as many groups as they knew existed. Most responding nurses were aware of at least one general self-help group in the area where they worked (n = 620) or the region where their patients lived (n = 629).

Only 35 of the respondents indicated they never spoke with patients about general self-help groups and 59 indicated they never initiate the conversation about them (see Table Two). At the other end of the continuum, 46 said they frequently spoke about self-help groups and 57 indicated they initiated the conversation on a frequent basis. Overall, approximately a fifth of the respondents (n = 140) are speaking about general self-help groups with patients and initiating the conversation (n = 149) on a fairly frequent basis. Most oncology nurses (n = 553) reported discussing self-help groups proportionately more often with women.

Many nurses reported suggesting general self-help groups to patients. Table Two shows the percentage of nurses who suggested different types of general self-help groups over the previous year. Only 54 nurses indicated they had not suggested any self-help group in the past year to their patients. Nurses were asked to indicate on a five-point Likert scale (where 1 = not at all and 5 = a great deal) how much their work setting, and in particular the attitudes of the physicians, influenced their suggestions about self-help groups. Half of the nurses (n = 343) indicated that their work setting does not influence their suggestions about self-help groups at all. The remainder of the group rated the work setting influence as follows: 17.8% rated two, 12.0% rated three, 10.2% rated four, and 5.5% rated five (indicating a great deal).

Cancer self-help groups

When asked specifically about cancer self-help groups, the majority (n = 603) of the respondents were aware of cancer self-help groups in the area where they work and 588 were aware of local cancer self-help groups in the regions where their patients lived. Of the 588 nurses who were aware of local groups, 95.9% (n = 564) indicated they knew how to direct patients to that local group. Of these nurses who

Table Two: Type of self-help groups and how frequently oncology nurses suggested them to patients in the past year (n = 676)

Type of self-help group	Percentage of oncology nurses suggesting group in past year
Physical health problems (including cancer)	81.4
Bereavement	65.4
Traumatic events	17.9
Addictions	17.3
Separation or divorce	13.3
Mental health disorders	13.2
Physical disability	9.2
Abuse (physical/sexual)	9.0

were aware of local groups, 79 spoke frequently with patients about cancer self-help groups and 72 frequently initiated the conversation.

Attitudes towards self-help groups

Overall, oncology nurses rated self-help groups as helpful. On a five-point Likert scale (where 1 = not at all helpful, 5 = very helpful), nurses rated helpfulness with the following results: 0.7% rating one, 4.9% rating two, 24.4% rating three, 25.9% rating four, 27.2% rating five, and 14.3% indicating "don't know." In another question regarding harmfulness of self-help groups, 2.3% indicated some harm could befall patients who attended self-help groups (rated four or five on a five-point scale).

The features of cancer self-help groups that were rated by the respondents as predominantly helpful included sharing common experiences, sharing information, bonding, and feeling understood (see Table Three). Oncology nurses also had the opportunity to indicate their concerns about possible negative features of self-help groups. The most frequently identified concern regarding cancer self-help groups was about misinformation being shared (n = 256), negative effects of associating with the very ill (n = 150), and encouraging the use of unconventional therapies (n = 143) (see Table Four).

Forty-two per cent (n = 284) of the respondents wrote additional comments about self-help groups. About a third (n = 90) were positive comments about the benefits of self-help groups and another third (n = 89) were a mixture of positive and negative comments. Only 35 were negative comments. The remaining 70 were comments classified as neutral, speaking to other issues concerning cancer care or the work environment rather than the topic of self-help groups.

The positive comments respondents wrote emphasized the benefits from self-help group participation of sharing and meeting others who are experiencing the same situation:

Self-help groups tend to lift the feeling of isolation which illness and living with illness makes you feel. When you listen to others describe their lives, you know you are not alone and others walked this road before you. This gives you added strength to face your tomorrows.

The cancer self-help groups meet many needs for patients: help…dealing with isolation, prevents patients from staying home and losing confidence – meet other people who are struggling with other diseases of cancer like they are – don't feel as alone, get encouragement to keep trying to live as well as possible, stability, confidence, hopefulness and courage. All are greatly enhanced.

The negative comments focused primarily on anecdotes nurses had heard from patients who had attended groups and were not satisfied or encouraged by the experience:

I believe that cancer self-help groups are not tailored for everyone's needs..for many breast cancer patients we have seen, they go to seek hope and leave discouraged with anecdotal stories confusing issues.

I have found that most of my patients who have attended groups came back and reported negative feedback, from stories of failed treatment to venting sessions. They usually did not find any comfort or support. I believe…an individual may have to try several before finding their right one. By that time, however, damage to the person's own well-being or confidence in treatment can be harmed.

The comments classified into a mixed category contained both negative and positive comments. The nurses described factors that they thought play a role in whether or not a group is helpful. Many of these comments emphasized the importance of the leader's facilitation skills, concern that some group members have their own agenda, and the mix of group members who have new and recurrent disease can be worrisome:

I feel self-help groups are a wonderful avenue for patients who are on a cancer journey - my worry is that not all groups have a person with 'facilitation skills" leading the group and when this happens there can be negative effects to patients as well as result of losing focus for the group.

Positives include decreasing isolation. Concerns are that without some health care facilitator input, misinformation and negative thinking can occur - participants can become quite frightened and may be swayed to use "therapies" with no value whatsoever.

Table Three: Oncology nurses' ratings of perceived helpfulness of positive cancer self-help group features (n=676)

Group features	Percentage of ratings with scores of 4-5*	Mean scores (5-point Likert Scale)
Sharing common experience	79.5	4.3
Sharing information	75.6	4.2
Bonding	74.0	4.2
Feeling understood	72.0	4.3
Overcoming isolation	67.7	4.1
Sharing laughter	61.0	4.0
Providing hope	53.2	3.8
Communicating with health professionals	51.2	3.7
Becoming more assertive	46.5	3.7
Opportunities for advocacy	42.1	3.6
Dealing with death/dying issues	37.1	3.5

* rated on a 5-point Likert scale
where 1 = "not at all helpful" and 5 = "very helpful"

Table Four: Oncology nurses' ratings of concern regarding negative features of cancer self-help groups (n=676)

Group features	Percentage of ratings with scores of 4-5*	Mean scores (5-point Likert Scale)
Providing misinformation	37.9	3.2
Negative effects by associating with the very ill	22.1	2.6
Encouraging unconventional therapies	21.2	2.6
Dwelling on illness	20.9	2.6
Doctor bashing	18.2	2.4
Health care system bashing	17.9	2.5
Cultivating false hope	15.0	2.4
Nurse bashing	12.3	2.2

* rated on a 5-point Likert scale
where 1 = "not at all helpful" and 5 = "very helpful"

Discussion

This study was undertaken to identify the knowledge, attitudes, and practice behaviours of oncology nurses practising in Canada regarding self-help groups. The survey was mailed to all members of the Canadian Association of Nurses in Oncology with a reasonable return rate of 61.3%. As with all mailed surveys, it is those with an interest in the topic who are most likely to have responded.

Those who responded to the survey represent a very experienced group of nurses both in terms of the years in nursing and their years in oncology practice. Many work almost exclusively with cancer patients.

Overall, a large number of the nurses who responded to this survey were aware of various self-help groups both in the area where they worked and in the area where their patients lived. Although half reported being aware of more than four groups in their work area or in the area where their patients live, this suggests an informational gap for respondents in this survey. Given the large number of self-help groups that exist, there are clearly many more groups than these nurses know about. Table Five lists contact numbers for self-help clearinghouses across Canada where nurses can find out more about self-help groups.

In spite of the level of awareness about self-help groups in general, relatively few nurses either spoke with patients about the groups or referred patients to them for reasons other than bereavement or physical health problems. This is in contrast to family physicians who reported referring to all types of self-help groups at much higher rates than these nurses (Gray et al., 1998). Family physicians may have over-reported their referral rates, but the scope of their practice is also different from that of oncology nurses. The scope of practice for oncology nurses may mean they see issues such as addiction, physical abuse, or mental health disorders as issues to be assessed and referred rather than issues to be handled by them. Oncology nurses may refer patients with these issues to a social worker or a psychologist within the cancer centre, rather than initiating a conversation about general self-help groups. Talking about cancer self-help groups and bereavement groups may be easier because the nurses may be more knowledgeable and comfortable with these topics and perceive they fall within the scope of their practice with cancer patients.

Nurses in this study had a high level of awareness about the existence of cancer self-help groups, although several did suggest they needed more information about how the groups worked. In Canada, information about cancer self-help groups may be obtained over the telephone from the toll-free Cancer Information Service (1-888-939-3333).

Despite the awareness about cancer self-help groups, however, only about a fifth are speaking to cancer patients or initiating conversations with any degree of frequency. This leaves a large proportion of nurses who are not consistently talking with patients about support groups. Given the views that these nurses have about the helpfulness of self-help groups, it is surprising that the topic does not emerge during nurse-patient interactions with greater frequency. Other than the more obvious reasons, such as some nurses do not know about groups, some are working in areas where there are no groups immediately available, and some believe the groups are harmful, the most likely reason could relate to the increasing patient numbers and workload nurses are experiencing. Nurses may not have the time to engage in these types of conversations in the midst of busy clinical settings. As a result, neither the assessment of the patient need nor the conversation about how self-help groups can help actually take place. This begs the discovery and implementation of creative mechanisms for patient education and interactions between nurses and patients outside the context of a clinic appointment with a physician.

Overall, the nurses responding to this survey viewed cancer self-help groups in a positive light. Clearly they had observed benefits to patients in attending the group sessions. The types of benefits they cited mirror those cited by family physicians (Gray et al., 1998) and by patients themselves (Bauman, Gervey, & Siegel, 1992; Gray et al., 1997a, 1997b).

Most of the concerns nurses expressed about harm from self-help groups concerned group activity not meeting patient need, leadership within the self-help group, and mixing newly diagnosed patients and those with advanced disease. Unfortunately, we do not know how often these issues occur and actually create difficulties. They may occur with much less frequency than we imagine (Phillips, Gray, Davis, & Fitch, 1996). Members of self-help groups have also voiced concern about those issues and have tried to deal with them through facilitation training for group leaders and organizational strategies at group meetings (Gray et al., 1997a, 1997b; Phillips et al., 1996).

The perception that some of the nurses expressed concerning the need for a professional presence at the group meetings for the purposes of monitoring or providing leadership reflects a fundamental misunderstanding about self-help groups. A core principle of self-help groups is self-determination and member empowerment. The group is actually a place where members can have their say and control how things will be done. For cancer patients, such an experience of control may help to offset the loss of control and heightened sense of uncertainty they frequently feel during their journey with cancer (Gray, Doan, & Church, 1991). To insert professional leadership and control is likely to undermine the potential healing features of the self-help experience.

Table Five: Self-help centres and contacts across Canada

British Columbia
The Self-Help Resource
Association of British Columbia
(604) 733-6186

Alberta
Support Network
(403) 482-0198

Manitoba
Manitoba Self-Help Clearinghouse Inc.
(204) 772-6979

Ontario
Self-Help Resource Centre of Greater Toronto
(416) 487-4355

Quebec
Centre de référence du Grand-Montréal
(514) 527-1375

New Brunswick
Self-Help Community Service
(506) 634-1673

Nova Scotia
Self-Help Connection
(902) 466-2011

Prince Edward Island
Family Support and Self-Help Program
Canadian Mental Health Association
(902) 566-3034

Clinical implications

The findings of this study have both educational and clinical implications. Clearly, there are nurses who could benefit from learning more about self-help groups: which ones exist, and how they operate. In particular, understanding the nature of self-help groups and the principles under which they work could be useful if nurses are to appreciate their place in the fabric of support and to explain to patients how they might be useful.

Nurses have a role in understanding the support a patient requires and talking with that patient about how best to acquire what is necessary. This will demand an understanding of the type of benefit that may be found in a self-help group experience, as well as the potential difficulties a patient might face. Talking with a patient about the self-help experience can help the patient decide if attending a group is an avenue he or she might pursue. Patients or their family members may not be aware of which groups exist, or they may be labouring under false ideas about what happens at a group. Nurses can help to clarify misperceptions about self-help groups and provide a list of existing groups. There may be benefit in developing a small written hand-out about existing groups to provide to the patients in one's practice. Prior to using the hand-out, the self-help groups should agree to the promotion of their activities in this way.

Nurses may also have a role in responding to requests from self-help groups to provide information or resources. Occasionally, groups may wish to have a presentation from a nurse or to receive written material about cancer or coping. If a group is just beginning, a nurse may assist by providing reference material on running a group. An excellent resource for new groups was produced by the Ontario Breast Cancer Network entitled, "Self-Help Manual: Hands-on Help."

Nurses may also perform a role with regards to clarifying information a patient gathers during a group meeting or discussing the patient's experiences with the group. Above all, nurses need to recognize that patients will cope with their cancer in different ways. An intervention that will be helpful to one person will not be useful to another. The nursing role regarding self-help groups is one of ensuring the patient has the correct information and is in a position to make an informed decision about his or her own course of action. With continued health system cuts, the need for low-cost supportive care services is increasing. Self-help groups are in a position to play an important role in the lives of cancer patients.

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