Core Themes in a Support Group for Spouses of Breast Cancer Patients

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Abstract

Spouses of breast cancer patients suffer from various symptoms that revolve around coping with their partner's illness. They are more vulnerable to depression and anxiety than are spouses of healthy women. Support groups for spouses of breast cancer patients are an important and essential tool for treating spouses, and by extrapolation - the patients' families, as well as the patients themselves.

This paper describes two support groups for spouses of cancer patients. The support groups for spouses of breast cancer patients were the first of their kind in Israel.

The paper describes different patterns that emerged within the couples' relationships and the manner in which they were dealt with in the group.

Core Themes in a Support Group for Spouses of Breast Cancer Patients

Introduction:

The American philosopher Ken Wilber, who fathered the school of transpersonal psychology, accompanied his wife Treya Killam Wilber after she was diagnosed with breast cancer. After five years of a long and joint struggle, Treya died. In a book that he published (Wilber, 2000) and which combined parts of her diaries with his additions, Wilber writes that the fact that a woman has cancer does not eradicate her spouse's problems but only pushes them aside. If the spouse refrains from caring for himself chance are he will leave, resort to various addictive "solaces", or lash out angrily at his wife.

The reason to opt for therapy rather than relying solely on friends and family is that it is very difficult to share the details of the disease and its repercussions with people who have not dealt with similar situations. The disease's chronicity exhausts not only the patients and their companions, but also their friends and family, as they, too, are exposed to the illness. The professional options that are available to spouses include personal treatment, couple's therapy, and sometimes support groups. Wilber asserts that the possibility to complain, vent anger, and accused the loved one within an understanding and supportive environment is one of the great advantages of support groups.

In this paper I shall describe two support groups for spouses of breast cancer patients. I will describe the modes of coping that characterize men whose spouses are ill, as well as the group's role in improving the existent communication and behavior patterns.

Support groups for family members of breast cancer patients are renowned as an effective and important therapeutic modality (Manne et al., 2005; Shields & Rousseau, 2004; Liu et al.,

2008; Scott et al., 2004). Yet while the effectiveness of the contribution of individual therapy for spouses as well as couples' therapy and psycho-educational groups have been documented, the documentation of support groups for spouses of breast cancer patients is rare, and their contribution is not emphasized enough.

Men have difficulty partaking in support groups in general, and particularly in support groups for spouses of cancer patients (Scott et al., 2004). The reasons for this are mainly gender-based, as men tend to opt less for psychotherapy and their socialization mechanisms bring them to believe more in their power to *act* than in their ability to *be* and to share their feelings. Many men doubt that they could benefit from such groups (Obrien et al., 2005; McCarthy et al., 2004; Addis & Mahalik, 2003; Blazina & Marks, 2001). In addition, even though therapy and support groups for men have proved to be effective, it is very difficult to convince men to take part in them and to gain support from them (Currat, 2006; Stein, 1983; Sternbach, 2001). Beyond the gender-related reasons, the group participants explained that men whose spouses are inflicted by an illness that requires so much attention and treatment find it difficult to take care of themselves, as they tend to focus their care entirely on their sick spouse.

The manner in which the facilitators conceptualized the group processes at work with the group and in supervision was psychodynamic (Rutan, 1992).

Review of the literature:

Breast cancer is the most common cancer type among women. According to the data provided by the Israeli Central Bureau of Statistics (Israeli Ministry of Foreign Affairs, 2007), one in nine women develops breast cancer. Due to the prevalence of the illness, many men find themselves coping with the effects of the illness and its treatment on their spouses, their families, and themselves.

Dealing with the illness over a prolonged period of time affects both partners' psychological states, including their individual conditions and their relationship with each other (Giese-Davis et al., 2000; D'Ardenne, 2004).

To date, very few studies have been conducted that deal with the effect of the illness and of coping with its treatment on cancer patients' spouses. The available studies show that male spouses experience emotional symptoms similar to those of their partners, the most common of which are existential anxiety, depression, a sense of helplessness during the initial coping stages, and fear of coping with the disease and its outcomes (Iqbal et al., 2001; Cochrane, 2005).

A number of studies have examined the effects of the illness and its treatment on the patient and her spouse. Fifty men whose partners were diagnosed with breast cancer over the previous two years took part in a research carried out at the Hadassah hospital in Jerusalem (Kadmon et al., 2008). An analysis of the questionnaires filled out by the participants showed that one fifth of the men expressed varying degrees of stress and worry, one half reported economic difficulties, three quarters reported change in their relationships with their partners, and over a third reported lower levels of communication with their families. In another study (Hilton et al., 2000), in which interviews were carried out with eleven spouses, two main themes emerged pertaining to their lives in view of the illness. The first was a focus on the woman's illness and concern for her well-being and recovery, while the second was the preservation of the family's normal routine. A study that dealt with depression among spouses of breast cancer patients (Lewis et. al, 2008) found that spouses were more likely to be depressed if they were older, less educated, recently married, overly concerned with their wives' quality of life, more troubled by their vocational performance, and less secure about their futures. Another factor that was found

to predict spouses' depression was the state of the couple's relationship before the illness. The researchers concluded that newly diagnosed breast cancer patients' spouses should be screened in order to help them cope with the psychological burden that coping with their wives' breast cancer entails. Another paper (Wagner et al., 2006) examined the quality of life among 79 husbands whose wives were ill and compared them to 79 husbands whose wives were healthy. The husbands with the ill wives received a lower score on general health, vitality, emotional state, and psychological well-being. One of the conclusions drawn was that husbands are particularly vulnerable and experience a great deal of stress because they are the main source of support for their wives.

The present review thus clarifies the need to offer supportive intervention for spouses who are vulnerable to psychological difficulties due to their partners' illnesses. The significance of therapeutic interventions with spouses is also based on the influence that the spouse's mental health bears upon the couple's relationship, and so on the ill partner's mental state, her strength, and her ability to recover (Ben-Zur et al., 2001). One must realize that the couple deals with breast cancer together (Walker, 1997).

Studies have mapped out the variables that affect the quality of the couple's relationship, its survival potential in face of coping with the disease, and its ability to influence each of the partner's states. These variables are:

The state of the relationship before the illness (Taylor-Brown, 2000). It seems that the more the couple's relationship was experienced as stable and good before diagnosis, so the chances grow that it will serve as a source of support during the course of the illness.

The partners' levels of psychological distress (Bolger et al., 1996). Each of the partners experiences and deals with the illness and with the coping involved uniquely. Anxiety, vulnerability to depression, and personality characteristics affect both the level of psychological distress experienced by each of the partners and the burden experienced by the couple.

Matters pertaining to the sexual relations between the partners (Patricia & Spiegel, 2009; Schover, 1991). Breast cancer is damaging to the feminine self-image; the aggressive treatments, often including partial or double mastectomies, as well as hormonal treatments that bring about menopausal phenomena, affect the woman's body and her self-image. It also influences the manner in which her partner relates to her body.

The partners' capability to communicate with each other openly and supportively (O'Mahoney & Carroll, 1997). The issue of free communication and the ability to discuss difficulties surrounding the illness within the relationship is highlighted to in a number of studies. Women have reported difficulties on their partners' parts to express their emotions and to communicate supportively regarding the cancer. The male spouse was experienced as having difficulty sharing his emotions and was felt to leave his partner alone, without a sense of support. While the female partner might feel close to her spouse and expect his support following diagnosis, her spouse will often clam up and defend himself from coming in contact with the grave emotions associated with the illness (Walsh et al., 2005). Accordingly, it has been found that many men cope with their partners' illness by avoiding openly discussing the issue with her and with others (Badr, 2004).

Yet despite the aforementioned and contrary to common attitudes, which are promulgated by the media and popular culture (Taylor-Brown, 2000), it seems that the rate of divorce is no higher among couples in which the female partner has breast cancer (Taylor-Brown, 2000; Dorval et al., 1999). A number of studies have reported psychological growth among male spouses following the trauma of coming to terms with the illness. One study investigated psychological growth following the trauma among 162 couples a year and a half after diagnosis. It showed that the more extensive the dialogue about the illness and its causes, the more the partners granted

emotional expression to aspects of the illness, and the more the emotional and cognitive issues were processed by both partners, the greater the psychological growth that stemmed from the illness and its aftermath (Manne et al., 2004). In another study that consisted of 72 spouses of breast cancer patients, correlations were found between growth following trauma and social support available to the spouses, support offered to them by their partners, the depth of their commitment to their partners, growth following the trauma in the female partners, and participation in therapeutic sessions. The study showed that under certain circumstances both partners have the potential for growth following the trauma (Weiss, 2004).

It seems that therapeutic interventions, such as support groups, psycho-educational groups, and individual and couple's psychotherapy, can affect and assist the emotional coping of spouses and couples. A research that set out to examine the results of a short-term (5 session) psycho-educational intervention for spouses of breast cancer patients immediately after diagnosis found an improvement in functional ability, less depressive and anxious states, and adaptation to the new marital situation among those who partook in the therapeutic sessions. Interviews with the female partners showed an improvement in the sense of support they were awarded by their spouses, as well as lessened tension between the partners and an improvement in the quality of the relationship (Lewis et al., 2008). A research that explored the emotional effect of mastectomy on the male spouse found that men who participated in a support group were more willing to share their feelings about the new situation with their partners (Sabo et al., 1986). A heightened need for emotional assistance was found during the initial year following diagnosis, but there also seems to be difficulty in seeking out such assistance due to the complete focus on the female partner's medical treatments (Northouse et al., 2001). It is important to note that no studies were found on the influence of psychodynamic groups on participants.

The group's formation:

The group participants were recruited by the "1 in 9" association, whose breast cancer patients were invited to offer their spouses to partake in a support group. The needs that emerged in a focus group that preceded the support group were: Practical and tangible assistance in fulfilling formal rights, a need for general information about the illness, help in coping with the medical establishment, and the need for psychological help due to the distress emanating from the ongoing care for the female partners. Following the focus group a decision was made to form a support group, facilitators were appointed, and a supervision setting was instituted. The focus group members and others were invited to take part. The applicants underwent a screening interview in order to present the group and to assess the applicants' suitability.

Group description:

This paper describes two series of sessions, each consisting of 15 one-and-a-half hour weekly meetings. Seven participants took part in the first group, and the second, which immediately succeeded the first, consisted of five participants, two of which had taken part in the first series as well. All of the participants but two were married to women with local rather than metastatic breast cancer; the other two, whose partners had metastatic breast cancer, retired after a few sessions. This led us to conclude that it is advisable to separate spouses of women with metastatic breast cancer from spouses of women with local breast cancer. Such division was impossible in this case because the small number of applicants was insufficient for the

formation of two separate groups.

Some of the participants joined when their partners were in the first stage of the illness, that is, around the time of surgery and chemotherapy, but most joined at later stages. As far as illness duration, the group consisted of men whose partners had been diagnosed a few days earlier at one end, and those whose partners were five years into remission on the other.

The participants' ages ranged from thirty two to seventy four. The group divided evenly into two halves as far as age is concerned – older and younger, with the younger group ranging from the early thirties to the early forties, while the older group consisted of men over fifty. The vast majority of the participants were functional fathers and workers, who were married for the first time. The age gaps between the group members and the differences in the times elapsed since diagnosis did not harm the group, but actually enhanced it. The older members contributed their life experience, and those whose partners had been diagnosed a long time ago could share their perspectives with the others due to their prolonged coping. At the same time, spouses of long-time patients had an opportunity to reprocess their experiences upon exposure to new coping stories.

Group aim:

The group was initially defined as a support group for spouses of breast cancer patients. The group's nature became more therapeutic in the second series, although the setting did not fully meet the criteria for a therapy group: Relations between group members were permitted outside the setting and the group members did not pay to participate. It seemed as though the group still consisted of a supportive element, while the participants were also able to tackle questions of identity vis-à-vis their partners and the illness on a deep psychological level. This fitted in with the facilitators' motivation to come in contact with the intrapsychic and dyadic material as presented by the participants.

The spouse's perception of the illness:

In order to grasp the dynamics created between men and their partners surrounding treatment of the women's cancer and the coping involved, it is necessary to comprehend how the partners perceive the illness and what it represents to them. Based upon the group participants' statements it would seem that for these men, cancer represents death and their own existential anxiety. It also represents the danger of losing a partner and the solitude that might ensue. Cancer signifies the limit of men's ability to help their partners, since they cannot overcome the cancer in their partners' bodies. In other words, the cancer represents the men's narcissistic wound and a defect in their sense of omnipotent wholeness.

Since we are dealing with a group of men, it is important to note gender roles in the context of the spouses' perception of the illness: A large proportion of spouses expect themselves, as men, to act as saviors and to always be strong, in control, and fully functional. These are the expectations they were raised on and serve as a test of the spouse's very masculinity and self-worth (Frosh, 1992).

What I have referred to as a narcissistic defect is basically a distortion in self-esteem and self-worth. A healthy sense of self-worth has to do with the ability to maintain a sense of worthiness even though one is imperfect. It is not based on what you can do, but on the very fact of your existence. A healthy sense of worth is based on the assumption that all of us were born equal,

and no-one is better than anyone else (Kohut & Wolf, 1985).

A man who has difficulty in cultivating the ability to internalize love will turn to external sources in order to experience such love. Behind the self-assuredness that such a man presents in relation to his wife's cancer lay concealed vulnerability, shame, and anxiety in case he will not be able to help his partner; consequently, he will not be awarded the love he needs so much, since he believes he is worthy of love only if he can meet his partner's needs. As far as the spouses are concerned, not being able to cope with the cancer is a shameful wound, as it exposes weakness and helplessness. Cancer, just like any life-endangering event, destabilizes the person's sense of self-worth because of its sheer intensity and the primal existential fears that it arouses. The narcissistic vulnerability that exists in all of us was exposed in the spouses as it arose in the context of coping with the illness. I shall use this conceptual framework, which combines a gender perspective with a psychodynamic understanding of coping with illness, in order to explain these men's modes of coping with their partners' breast cancer.

The representation of breast cancer among men as described breeds three main communication patterns in couples' relationships (more patterns might exist that were not salient in the group). As will be delineated further, these patterns are different modes of coping with the difficult emotional experience that the cancer causes for the spouse within the couple's relationship. Besides the defenses they offer, these patterns obstruct the relationship, draw the partners away from each other, and to not promote either partner's ability to receive assistance and support. They hinder the creation of intimacy, understanding, and closeness between the partners. These patterns can exist in any couple's relationship, becoming a pattern because of a covert, unconscious collusion between both partners' emotional avoidance (Lachkar, 1992; Manne & Ostroff, 2008). The assumption that these patterns, involving splitting, projection, and projective identification, exist within the relationship prior to diagnosis and are intensified once the cancer is detected, fits in with the facilitators' impression of the group members.

The couples' relationship patterns:

I will present the three main patterns that emerged in the couples' relationships, as well as within the group. Based on the assumption that sexual relations attest to the quality of a couple's relationship in general, I will also show how each pattern is expressed in the sexual relations between the partners.

The man as the strong savior versus a weak and helpless woman

This pattern is usually associated with the initial stage of coping with the illness. Due to the anxiety surrounding the diagnosis of the illness, the man deposits his weak and helpless parts in his partner, and helps her while perceiving himself as strong and omnipotent. His difficulty feeling helpless and anxious leads him to feel powerful, strong, and able to cope with the illness, as he denies his weak parts. This pattern is intensified by social and gender-related expectations from men to be strong and to stand by their wives.

This stage presents itself from the moment of diagnosis and onwards throughout the major treatments that follow: Surgery, chemotherapy, and radiotherapy. During this period the spouse focuses on doing everything that he can to help treat his partner. The men who took part in the group reported having taken leave of absence from work during this period, which lasted approximately a year, and they also ceased all activities that were not crucial for the family's survival; they accompanied their partners to consultations with doctors, to surgery, and to the other medical treatments. Some of the participants reported having lost weight during this period, as well as difficulty falling asleep and other signs of the immense stress that they were

experiencing. These testimonies are in line with research findings, described above, concerning the ways in which spouses conduct themselves during the first year following diagnosis.

At this point the man, feeling strong and indispensable, does his utmost for his wife. One of the group members described this well by saying that he became "the anxious soother": While he experienced much fear, he had to present a strong persona and to calm his wife. Another example is the vast amounts of knowledge that the group members exhibited concerning their partners' treatments, medications, and physicians. One participant said that since the men's involvement was so great, it was sometimes difficult to determine within the group whether the woman or the man was sick; this example stresses the lack of separation between men and their ill spouses, as well as their identification with the ill women.

The price paid by the spouse for acting so strong in the first stage becomes evident after it passes. He feels tired, anxious about the future, a need to share and process everything he has gone through, as well as a feeling that he is worthy of respect for what he has gone through. When these needs remain unsatisfied – whether due to his inability to express them or as a result of life circumstances – he may feel a great deal of rage, which quickly becomes guilt, because he neither understands nor accepts the rage he harbors against his sick partner. "I clean the house feeling angry, take care of the kids and feel angry," says one of the participants. "I know she can't do these chores, but I'm angry with her anyway. How dare I be angry with a sick woman?" Another participant spoke of how he "mistakenly" broke the kitchen sink faucet, so that he can no longer wash the dishes. Now "there is no choice" but to buy an electric dishwasher instead of his having to wash the dishes.

The burdensome role of savior, referred to in relation to the partner, also appeared in the participants' relation to the group itself: Due to the relatively small number of participants they felt they had to attend for the group to survive. Instead of the group helping them, it felt to them like another burden on their backs. The rage towards the group remained unfelt by the participants and was not expressed directly. Accordingly, when members complained of having to leave a quiet evening at home or stop in the middle of some event in order to make it to the group, or when they explained that their late entry was caused by the trouble they had finding parking, they were unwilling to accept interpretations that pointed at their anger at the group or their current frustration with it. The facilitators were also protected from criticism. Even when they attempted to encourage the group members to criticize or express whatever they felt towards the facilitators, they were faced with a protective response, while their resilience to anger remained untested – as though they themselves were the vulnerable, ill partner.

Men in this stage said that the cancer would disappear once the treatments ended and life would go on as though nothing happened. Other group members explained to them that they still had a long way to go. One of the group's roles was to assist its members in coming to terms with the wish to leave the illness behind and to forget about it, as well as helping the members to process the fact that their partners are ill and that the need to cope with the illness and its accompanying fears would last for a long time yet.

A weak and helpless man versus a strong woman

This pattern is the opposite of the previous one, usually appearing after the acute stage of coping with the illness. Here the man feels weak while the woman is perceived by him as strong. The man's sense of weakness has two sources: The first is the understanding that even if his wife has "defeated" the illness for the moment, he cannot defeat the threat of its return – only learn to live with it. At the end of the first series of 15 sessions one of the group members expressed

his understanding that the disease might return and that he will have to go on living with this threat. Another participant said that his wife "would soon recuperate" and that she "only has to get radiotherapy, and that's that." A fellow participant, whose wife has been in remission for years but is very fearful of relapse replied that "there is no 'that's that'" in coping with the illness.

A second source of weakness for spouses is the power that female partners derive from being ill, or from recovery. The women sometimes feel that their roles as spouses and as family caretakers are precisely what caused the illness. The illness and its resultant wish to recover and prevent its recurrence bring about changes in the partners' behavior, while the male spouses feel compelled to go along with them; after all, the partners are ill and the male spouses do not want to harm them, let alone be responsible for the return of the illness due to the stress that the female partners would experience if their spouses did not agree with them. One of the men explained: "When my wife was sick I fought the institutions and the doctors so that she would get what she deserves. Now she wants to go abroad for a few months. She says it's important for her recovery. I'm worried that she'll lose her job, that I'll stay the sole provider. I'm also worried that something will happen to her there, but I can't tell her anything. She says, 'I was sick, and now I can.' How can I argue with that?" The sense in the group was that at times the men were weak and that if they became stronger they would either leave or voice their opinions. Group members were jealous of other men, who are not tied down to an ill woman, and so are freer to do as they wish without being considerate or weakening themselves in the name of protecting their partners. The group's role at this stage was to empower its members and to show them their potency within their relationships with their partners.

Avoidant man versus avoidant woman

This pattern is essentially schizoid. It refers to different feelings and issues that the couple refrains from speaking about, and presents itself from the initial diagnosis or acute stage onwards. The male spouse feels intimidated and distances himself from the emotional relation to his partner, as he fears any emotional communication regarding the illness. An avoidant pattern takes over the relationship when the partners cannot share their feelings with each other, and they become alienated and distanced. This pattern manifesed itself among group members via the wish to detach from their partners, either by getting divorced or by remaining preoccupied with things other than communicating, such as work or child rearing. The wish for a long vacation without the partner with whom it is difficult to communicate was also voiced. The men expressed their fear that the relationship with their partners, as well as the partners themselves, would collapse rather than endure, and they therefore felt that they had to keep their feelings to themselves. Emotional communication was also avoided because needs were experienced as shameful and inexpressible. Once the waters subsided, the magnitude of the burden became clear and a sense that the load was too heavy set in as related issues remained unexpressed. These include sexuality, bearing more children, and fear of death. In these situations the female partners tend to feel frustrated due to the lack of emotional communication, eventually detaching themselves. The relationship empties of its feelings and so dies out emotionally. There were men who also avoided sexual relations with their partners. Fantasies of adultery were raised in the group on a number of occasions, along with various temptations that the men experienced and coped with. In one session a member presented a fantasy of this kind:

Member A.: "Yesterday a woman at work hit on me, and I thought to myself, 'Boy, that could be so nice and easy.'"

Member B.: "I flirted with a woman on Facebook, but stopped just before actually proposing

to meet her."

Member C.: "I sometimes fantasize about a woman with perfect breasts, and it makes me feel so guilty."

Facilitator: "Every man can find himself fantasizing about another woman. Your wives' illness can both increase the temptation and make you feel even guiltier."

Avoidance was clearly present in group members' absences, while they were unable to supply an emotional explanation for the absence. The members' caution was strongly felt in their avoidance of expressing negative emotions towards each other and towards the facilitators. Criticism, anger, frustration, and rage were expressed indirectly or through actions, such as absence, fiddling with cellphones while another group member spoke, or leaving the session in the middle for one reason or another. When a group member took up much time by speaking at length - no one stopped him. After the end of the session one of the members announced that if the former would continue talking that much, he would stop attending. No criticism was expressed towards the facilitators, even when it was due. Once a session was canceled and the facilitators forgot to notify some of the participants, who arrived and were left unattended; even this event did not evoke criticism or expressions of anger by the participants.

The role of the group with regard to the different relationship patterns:

The group had a central role in identifying the couples' relationship patterns and in the attempt to transform them into communication between the partners. The relational patterns were identified by the participants themselves with respect to each other as well as by the facilitators. Parallel relations (Sachs & Shapiro, 1976) were drawn between the participants and the group or another group member on the one hand, and their relationships with their partners on the other hand. One's spouse is often the closest person. How can one possibly complain about the closest person when the problem is in her body? The group permitted the members to express themselves freely in a protected and enabling atmosphere. They could share their feelings, frustration, anxiety, and pain with the other members without being judged. This allowed for the identification of the group members' relational patterns, and the members could learn from each others' patterns. The communication between the group members helped and encouraged the spouses to cultivate dialogues with their partners about their needs surrounding the illness and its treatment. The significance of cultivating such dialogue lies mainly in the consequent possibility to differentiate between the woman and her illness. The manner in which the woman is then perceived becomes less stereotypical and more complex and multidimensional. A parallel process transpired between the participants as they gradually ceased to mirror only one aspect of each other and became complex subjects, who could engage in deeper dialogue.

As shown by the previously cited studies, intimacy and a relationship that promotes dialogue between the partners play an important role in preserving the spouse's mental state and safeguard him from depression and stress. The group first enabled its members to speak to each other and then to do so with their partners. A member who felt that his partner did not understand that he had work a lot harder at home due to her illness and objected to his hiring paid help to do the housework, found it difficult to speak to her about it; since she was ill he did not want to cause her any extra strain.

Member A.: "She doesn't understand how hard I work."

Member B.: "Can you tell her?"

Member A.: "I don't want to impose myself on her, she's having a hard time as it is."

Member B.: "What about getting some hired help?"

Member A.: "She won't be willing to."

Member C.: "My wife didn't agree either – until I shouted at her. Do you want to wait till that happens?"

Facilitator: "Here too it is difficult for you to hold your own. Just as you spoke here and received help, you could talk to your wife and expect her to understand."

This parallel process helped him understand his *modus operandi*. The members encouraged him to speak to her and showed him the price he was paying for feeling that he had to protect her.

Group development

As the group members' sense of security, their trust in each other and in the facilitators, and the facilitating environment intensified, they shifted from focusing on technical and concrete activity towards personal and intimate communication.

Stages in group development:

Stage 1: As mentioned, the first sessions were replete with much involvement in the sharing of technical and concrete information.

Stage 2: This stage consisted of the emotional level of coping with the illness.

Stage 3: In this stage the members pondered the manner in which the illness affected both them and their marital relationships.

Stage 4: This stage was characterized by an improvement of personal and marital coping, so that optimism for the future set in. The movement from the technical to the emotional repeated itself every time a new member joined the group, and also when members spoke of accompanying their partners to examinations or treatments. Only after the technical details were covered could the members share their traumatic experience: The moment of diagnosis, the chemotherapy and the hair loss after the treatment, the surgery and the partner's scarred chest, as well as the repeated checkups and the associated stress. These difficult experiences were processed by the group.

Conclusion:

This paper presented two support groups for spouses of breast cancer patients. The patterns that emerged in the couples' relationships as manifested in the group were: Strong man and weak woman, and vice versa, weak man versus strong woman, and mutual avoidance within the relationship. The group provided a space for examining these patterns and their associated costs as well as a space for creating an alternative. The preferred alternative is communication within the partnership and the cultivation of dialogue concerning needs and feelings within the relationship.

Support groups for spouses of breast cancer patients are an important means in treating spouses and therefore for treating the patient's family, as well as the patient herself. We must not view the patient as detached from her close surroundings, and we must be aware of the effects of the illness on the family and on the spouse. And yet it is highly difficult to recruit participants for such groups due to men's gender-based difficulty in seeking therapeutic aid and because of the specific difficulty that spouses of ill women have to let go of caring for their partners so that

they can take care of themselves.

The support groups for spouses of breast cancer patients described here were the first of their kind in Israel. The groups enhanced the participants' capability to cope, emotionally and concretely, with their personal and familial distress. The groups also confronted the members with their need for additional mental assistance. Following the group work, the members' ability to communicate with their spouses grew, resulting in higher levels of intimacy. However, at termination of the group processes it seemed that some of the couples' relationship patterns remained insufficiently altered. It seems that a long-term group is needed in order to alter deep-rooted and stubborn patterns of communicating. These patterns are ones that have been embedded in the couples' relationships for many years, and so require gradual work for their transformation.

It seems that there is a lack of scientific documentation of groups of this type and their effects on the spouses who take part. There is need for a more prolonged group processes. It is advisable to create more focused groups, such as ones intended for spouses of patients with metastatic breast cancer, as well as groups for younger spouses versus groups for older spouses. Such divisions into subgroups might promote the closeness experienced between the group members as well as providing for more common language between the members. In addition, it is possible to explore the effects of such groups not only on the female partners, but on the entire families. Group facilitators need to be able to identify unconscious group processes, an ability to cope with near-death experiences, a systems approach to couples and families and knowledge concerning gender variables in coping with distress and illness.

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