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To cite this article: Gary Poole PhD , Colleen Poon MA , Marie Achille PhD , Kate White MA ,
Natalie Franz MA , Sandra Jittler MA , Kelly Watt BA , David N. Cox PhD & Richard Doll MSW MSc
(2001) Social Support for Patients with Prostate Cancer, Journal of Psychosocial Oncology, 19:2,
1-16, DOI: [10.1300/J077v19n02_01](https://doi.org/10.1300/J077v19n02_01)

To link to this article: http://dx.doi.org/10.1300/J077v19n02_01



Published online: 12 Oct 2008.



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Social Support for Patients with Prostate Cancer: The Effect of Support Groups

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ABSTRACT. Questionnaires were administered to 234 patients with prostate cancer (142 attended support groups, 92 did not) to determine their sources of emotional, informational, and practical support and the relationship between their satisfaction with this support and their self-reports of coping and quality of life. Attenders were significantly more likely to cite other patients as sources of all three types of support. Fur-

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The research was supported by grants from the British Columbia Health Research Foundation and the Social Sciences and Humanities Research Council of Canada.

thermore, attenders cited fellow patients as their most helpful source of informational support, whereas nonattenders cited medical staff. Satisfaction with social support was significantly correlated with coping and quality of life. No significant differences were found between attenders and nonattenders regarding coping, quality of life, or satisfaction with the three types of support. The results are interpreted according to individual differences in how the patients satisfied their needs for support. [Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: <getinfo@haworthpressinc.com> Website: <<http://www.HaworthPress.com>> © 2001 by The Haworth Press, Inc. All rights reserved.]

KEYWORDS. Social support, prostate cancer, support groups

It is widely recognized that psychosocial factors, such as social support and interpersonal relations, affect adjustment to cancer (Hislop et al., 1987; Spiegel, 1995a, 1995b; Waxler-Morrison et al., 1991). Over the years, the study of the buffering effect of social support on illness has evolved from a broad focus on quantity of social contacts and general satisfaction with support received (Wallston et al., 1983) to a more fine-grained approach aimed at identifying specific types and sources of support (Dakof & Taylor, 1990; Dunkel-Schetter, 1984). For example, Dakof and Taylor (1990) found that intimate others and nurses were most valued for their emotional support, whereas other cancer patients and physicians were most valued for their informational support. However, misguided support from these sources was perceived to be unhelpful. Dunkel-Schetter (1984) found that patients often perceived medical care as unhelpful unless it was accompanied by emotional and informational support. Although these patients also valued emotional support from their family, they found family members' advice and information unhelpful and sometimes bothersome.

REVIEW OF THE LITERATURE

Considerable research attention has been paid to the potential benefits of social support for female cancer patients (Bolger & Foster, 1996; Hislop et al., 1987; Hoskins, 1995; Northouse & Laten, 1995; Waxler-Morrison et al., 1991). Spiegel et al. (1989) found that patients with breast cancer who were randomly assigned to a support group survived an average of 36.6 months compared with 18.9 months for patients in a control condition. In Waxler-Morrison et al.'s study (1991), size of the social network, the number of sup-

portive friends, extent of contact with friends, and employment status were all predictive of survival among patients with breast cancer.

There is good reason to believe that men have different, though equally pressing, needs when it comes to social support. Large prospective studies have produced findings suggesting that the health-enhancing effects of other people's presence are often greater on men than on women (e.g., Isacson & Janzon, 1986). On the other hand, Billings and Moos (1981) showed that the predictive value of social support on adjustment to life stressors was less salient among men than among women. Furthermore, a review of the literature indicates that men prefer and seek different types of support and assistance than women do when faced with a major life stressor, such as cancer. For example, men were found to be more receptive than women to the empathic support provided by nurses (Dakof & Taylor, 1990). In addition, men were more likely to confide in only one other person, whereas women confided in several people (Harrison, Maguire, & Pitceathly, 1995). A study by Taylor et al. (1986) suggested that men living with cancer preferred support groups oriented toward educational information and family participation. Leiber et al. (1976) reported that men acknowledged the somatic and behavioral impact of their illness but not its impact on their emotions or need for affection. As a whole, this research suggests that it may be inappropriate to generalize conclusions regarding social support from women to men.

Not only do gender differences exist in social support, but there also are individual differences. A number of factors have been cited to explain these differences. For example, personality factors can account for differences in the extent to which people seek social support or attract it (Pierce et al., 1997). Butzel and Ryan (1997) identified "volitional reliance" as a person's willingness to seek out others in emotional situations. Cultural factors have also been cited as having an effect on this willingness with regard to the extent to which a culture is individualistic in orientation (Butzel & Ryan, 1997). These factors may contribute to why some men seek the support of many others in the form of a support group. A support group can be viewed as a unique source of support because its members share a common experience, such as cancer.

Limited research has been conducted on the effects of support group attendance on outcomes among patients with prostate cancer. Specifically, three studies have concluded that such groups are of considerable benefit to patients because they help the members feel more informed about the illness and involved in the treatment (Gregoire, Kalogeropoulos, & Corcos, 1997; Kaps, 1994), and they provide opportunities to talk with other patients about difficult issues (Gray et al., 1997). However, none of these studies compared patients who attended support groups with those who did not.

Taken collectively, the research to date indicates that social support is beneficial for coping with cancer. It also is possible that such support will benefit

some people more than others or at least that there are individual differences in the forms of social support that people seek and use. Three questions need to be answered in this regard concerning patients with prostate cancer. First, are patients who attend support groups receiving different types of support than are those who do not attend? Second, if attenders are receiving a different type of support, is this affecting their coping? And third, when it comes to personality, cognition, and culture, are there types of men who would be well advised to attend support groups and others who should not?

The present study, part of a larger project investigating patients' and spouses' perceptions of social support, was designed to answer the first two questions in preparation for an investigation of the third. Ultimately, our goal is to help guide patients toward resources that best meet their psychosocial needs. We hypothesized that positive correlations would exist between perceived social support and measures of well-being, including quality of life and self-reports of coping efficacy. In addition, we hypothesized that attenders would be more likely to cite other patients as sources of practical, informational, and emotional support and that both their quality of life and self-reports of coping efficacy would be higher. Given that there are other sources of support beyond support groups and that it is entirely possible that not all men would benefit from attending a support group, the latter portion of this final hypothesis is exploratory in nature.

METHOD

Participants

The study participants consisted of patients with prostate cancer in British Columbia, Canada, who were recruited through 13 of the province's prostate support groups, a local cancer agency's radiation treatment clinics, and an oncologist's urology clinic. In all, 240 patients participated in the study, representing an approximate response rate of 60% for men approached at support group meetings and 55% for men approached at clinics. For the purposes of this study, participants were categorized as attenders or nonattenders, based on their response to a questionnaire item asking if their attendance at support groups represented a regular commitment on their part. Attenders were defined as men who answered yes, whereas nonattenders were men who either answered no or had never attended a support group. This categorization yielded a sample of 142 attenders and 92 nonattenders. Six of the 240 participants were excluded from the analyses because they could not be categorized as either attenders or nonattenders.

The majority of participants were Caucasian, married, retired, and had a postsecondary education. The mean age of the sample was 67.7 years ($SD =$

7.9 years), and the average time since diagnosis was 27.0 months ($SD = 34.7$ months). More than half of the participants had had hormone therapy, surgery, or both. Significant differences between attenders and nonattenders were found for employment status ($\chi^2[3,1] = 8.14, p < .05$), age ($t[208] = -2.08, p < .05$), time since diagnosis ($t[203] = -2.80, p < .01$), and type of treatment (radiation: $\chi^2[1,1] = 16.81, p < .001$). The mean age of attenders was 68.6 years compared with 66.3 years for nonattenders. Attenders' mean time since diagnosis was 30.3 months versus 16.9 months for nonattenders. Table 1 lists the other demographic and medical characteristics of the sample.

TABLE 1. Demographic and Medical Characteristics of the Men Who Did and Did Not Attend Support Groups

Characteristic	Attenders ($n = 142$)		Nonattenders ($n = 92$)	
	Number	Percentage	Number	Percentage
<u>Marital status</u>				
Married/common law	119	84.2	71	76.7
Divorced/separated/widowed	13	9.0	10	11.1
Single	9	6.0	9	10.0
Other	1	.8	2	2.2
<u>Education</u>				
Elementary	2	1.5	2	2.2
Junior high school	20	14.0	10	11.1
High school	41	28.7	28	30.0
Technical/college/university	77	54.4	46	50.0
Other	2	1.5	6	6.7
<u>Employment status*</u>				
Retired	114	80.1	59	64.4
Full time	17	11.8	24	25.6
Part time	7	5.1	5	5.6
Unemployed	4	2.9	4	4.4
<u>Ethnicity</u>				
Caucasian/European	133	93.9	89	96.7
Native Indian	2	1.5	0	
Asian	1	.8	2	2.2
Indo-Canadian	1	.8	0	
Other	4	3.1	1	1.1
<u>Type of treatment</u>				
Hormonal	90	63.1	49	53.8
Surgery	74	52.1	43	46.3
Radiation**	55	38.5	62	67.1

* $p < .05$ ** $p < .001$

Missing data occurred randomly across respondents, with minor effects on sample sizes for some variables. The only variables for which missing data were a problem were those involving disease status. Data for these variables were too incomplete to include in any analysis. No hypotheses involved disease status; however, the correlations between social support and coping were stronger than those between disease status and coping, although missing data made it impossible to compare the strength of these relationships reliably in the present study.

Measures

Perceptions of Support Survey–Patient Version. The PSS-P was developed for the unique purposes of the present study: namely, to assess social support among patients with prostate cancer. This instrument is well-grounded in social support theory and research in oncology (Dakof & Taylor, 1990; Dunkel-Schetter, 1984) and is compatible with other well-researched social support questionnaires, such as the Social Support Questionnaire (Sarason et al., 1983, 1987). The PSS-P asks patients to indicate in a checklist the people in their lives who provide them with emotional, informational, and practical support. Emotional support is defined as the existence or availability of people on whom the patient can rely and who care about, value, and love the patient. Informational support refers to providing useful information and education about the patient's illness and how to deal with it, expressing optimism, and acting as a positive role model. Practical assistance refers to assistance with daily living, such as running errands for the patient, driving the patient to and from appointments, and assisting the patient with bandages or medication. Patients also rate their satisfaction with each type of support and with their overall support using a six-point scale ranging from "Very dissatisfied" to "Very satisfied."

The PSS-P also contains open-ended questions asking patients to identify the most helpful and unhelpful things other people have said or done as well as the personal qualities that helped them cope with their cancer. Finally, patients are asked questions about their attendance or nonattendance at support groups.

Social Support Questionnaire. The SSQ-6 (Sarason et al., 1987) is a 6-item short form of the original 27-item Social Support Questionnaire (Sarason et al., 1983). It measures perceived available support that taps both availability of a social network and perceived satisfaction with the support available (Barrera & Ainlay, 1983; O'Reilly, 1988). Research suggests that both the original and the 6-item versions are among the best measures of social support with regard to reliability and validity (Larson, 1993).

Functional Assessment of Cancer Therapy–Prostate, Version 3. The FACT-P takes a modular approach to assessment of quality of life incorporating both

disease- and site-specific issues (Cella, 1996). The measure consists of a general or core portion containing 33 items that measure the following dimensions: physical, functional, emotional, and social well-being and relationship with the physician. The portion of the instrument specifically about prostate cancer contains 13 items. The measure is designed to assess actual functioning as well as the extent to which these different dimensions affect overall quality of life. The questionnaire items are measured on five-point Likert scales and on numerical analogue scales from 0 to 10. Overall quality-of-life scores can range from 0 to 164.

The FACT-P and its subscales demonstrated acceptable to high internal consistency and reliability (Cella et al., 1993; Esper et al., 1997), were sensitive to clinical changes over time, and were able to discriminate patients at different stages of disease (Esper et al., 1997). The core measure's convergent validity was supported by moderately high to high correlations with measures of quality of life (the Functional Living Index–Cancer developed by Schipper et al., 1984), distressed mood, and activity level (Cella et al., 1993).

Coping. The coping questionnaire consists of four questions adapted from Helgeson and Taylor (1993) tapping self-perceived ability to cope with cancer, both psychologically and physically, on a seven-point Likert-type scale.

Demographic data. The demographic questionnaire includes such items as birth date, marital status, number of children, education, employment status, income, ethnicity, and religious affiliation. Information regarding the status of patients' illness, such as date of diagnosis, stage of disease, type of treatment, and course of treatment, also was obtained.

Procedure

The method of recruitment varied depending on the source. For support groups, research assistants made arrangements with group leaders to attend one of the group's meetings. All patients with prostate cancer who attended the meeting were eligible to participate in the study. At the local cancer agency, the radiation oncology study nurse identified eligible patients by reviewing patients' records and then informed research assistants about the eligible patients' next radiotherapy appointment. At the urology clinic, the oncologist or the receptionist approached eligible patients and introduced the research assistants to them. Eligible participants from the cancer agency and urology clinic consisted of men who had been diagnosed within the previous 18 months.

In all cases, on meeting the patients, the research assistants introduced the study and asked them whether they would be interested in participating. After obtaining their informed consent, interested patients were asked whether they preferred to complete the questionnaire package at that time or whether they wanted to take the package with them and mail it back. Completion time for

the questionnaires was approximately 30 to 45 minutes. Clinic participants were more likely to take the questionnaires home for completion, and patients who attended a support group were more likely to complete the questionnaires right away.

RESULTS

Most Helpful Sources of Social Support

Because one goal of the present study was to identify differences in the nature of support for group attenders and nonattenders, a profile was created consisting of the sources respondents cited as being most helpful in the provision of emotional, informational, and practical support. As Table 2 illustrates, attenders and nonattenders alike cited their spouse or partner far more often than other sources as being most helpful in providing emotional and practical support. However, differences emerged regarding informational support. For this support, attenders were significantly more likely to cite fellow patients as being most helpful and were significantly less likely to cite medical staff than were nonattenders. Nonattenders cited medical staff most often in this category.

TABLE 2. Most Helpful Sources of Social Support, by Type of Support and Support Group Attendance (Yes, $n = 142$; No, $n = 92$)

Source of Support	Emotional Support		Informational Support ^a		Practical Support ^b	
	Yes	No	Yes	No	Yes	No
Spouse/partner	84.2%	82.2%	17.4%	12.5%	78.4%	73.3%
Other family members	4.3%	5.6%	2.9%	4.5%	5.6%	8.0%
Friends	1.4%	3.3%	.7%	8.0%	4.0%	2.7%
Fellow cancer patients	7.2%	1.1%	42.8%	11.4%	6.4%	0
Medical staff	2.7%	7.8%	30.4%	56.8%	4.8%	10.7%
Other	0	0	5.8%	6.8%	.8%	5.3%

^aDifferences between attenders and nonattenders were significant at $p < .001$ for sources of informational support.

^bDifferences between attenders and nonattenders were significant at $p < .05$ for sources of practical support.

Tests of the Three Hypotheses

Hypothesis 1. Social support will be positively correlated with measures of well-being. Spearman rank-order correlations were calculated to test the relationship between well-being and satisfaction with social support. These correlations are presented in Table 3, broken down by type of support, measure of well-being, and support group attendance. The correlations presented in the table indicate strong relationships between satisfaction with social support and quality of life, as measured by the FACT-P, thus supporting the hypothesis. Statistically significant, though weaker, correlations also were found between social support and perceptions of general coping with cancer.

Hypothesis 2. Men attending support groups will be more likely than nonattenders to cite other patients as sources of all three types of social support. In addition to asking participants to identify the most helpful source of support (see Table 2), participants were asked to identify all the people who provided emotional, informational, and practical support. Table 4 presents the percentage of respondents who cited other patients as a source of support, broken down by support group attendance and type of support. The percentages indicate that attenders were significantly more likely to cite fellow patients as sources of all three types of support.

Hypothesis 3. Quality of life and coping will be better for support group attenders than for nonattenders. The first two hypotheses addressed the nature

TABLE 3. Spearman Rank-Order Correlations Between Measures of Well-Being and Satisfaction with Social Support by Support Group Attenders and Nonattenders^a

Type of Support	Total (N = 234)	Attenders (n = 142)	Nonattenders (n = 92)
<u>Overall quality of life</u>			
Emotional	.41	.32	.46
Informational	.41	.36	.44
Practical	.43	.42	.40
Overall ^b	.40	.34	.39
<u>General coping with cancer^c</u>			
Emotional	.39	.39	.35
Informational	.30	.27	.31
Practical	.30	.31	.25
Overall	.30	.28	.32

^aAll correlations are significant at $p < .05$ or better.

^bOverall quality of life was measured using the FACT-P total score.

^cGeneral coping with cancer was measured using the response to "Evaluate how well you are coping or dealing with cancer at the present time?" (7-point scale).

TABLE 4. Percentage of Respondents Citing Other Patients as Sources of Support by Type of Support and Support Group Attendance^a

Group	Type of Support ^a		
	Emotional**	Informational**	Practical*
Attenders (<i>n</i> = 142)	85.8	88.0	26.6
Nonattenders (<i>n</i> = 92)	48.9	44.6	12.2

^aStatistical significance was tested using the chi-square test for support group attendance by source of support.

p* < .01 *p* < .001

of support for patients who either attended or did not attend support groups. Hypothesis 3 addressed possible differences in the benefits of that support. To test this hypothesis, analysis of covariance (ANCOVA) tests were carried out on mean differences between attenders and nonattenders on variables associated with coping, quality of life, and satisfaction with support. Because the two groups also differed significantly in time since diagnosis, that value was entered as a covariate. Table 5 presents mean values for coping, overall quality of life, and satisfaction with the various types of social support, broken down by support group attendance and with time since diagnosis controlled for. None of these mean differences was statistically significant, indicating that men who attended support groups were no more likely to report better coping, better quality of life, or more satisfaction with their social support than were men who did not attend such groups. Separate ANCOVAs using the subscales of the FACT-P yielded similar results. Thus, Hypothesis 3 was not supported by the data.

Possible Confounding Factors

A perusal of Table 1 reveals that support group attenders and nonattenders also differed significantly in age, employment status, time since diagnosis, and treatment history (whether they had received radiation treatment). Thus, a series of analyses were conducted to determine whether these factors affected coping, quality of life, or patterns of social support, either on their own or by interacting with support group attendance.

Table 4 indicates that support group attenders were significantly more likely to cite fellow patients as sources of all three types of support. Given that attenders and nonattenders differed regarding time since diagnosis, a series of three ANCOVAs were conducted with support group attendance as an independent variable and the likelihood of choosing fellow patients for each type of social support as the dependent measure, with time since diagnosis entered

TABLE 5. Mean Values (SDs) for Self-Reports of Coping, Quality of Life, and Satisfaction with Support by Support Group Attendance

Self-Report	Support Group Attendance		<i>F</i> [1,200] ^a	<i>p</i> -Value
	Yes (<i>n</i> = 142)	No (<i>n</i> = 92)		
<u>Coping^b</u>				
Physical	5.83 (.92)	5.60 (1.14)	1.69	.19
General	6.03 (1.02)	6.13 (1.11)	.68	.41
<u>Quality of life^c</u>	130.18 (18.18)	129.24 (19.69)	.02	.89
<u>Satisfaction with support^d</u>				
Emotional	5.21 (.90)	5.16 (1.27)	.10	.76
Informational	4.87 (1.04)	4.71 (1.27)	1.10	.29
Practical	5.05 (.96)	4.93 (1.27)	.51	.49

^a *F*-ratios were calculated using ANCOVAs in which time since diagnosis was first entered hierarchically as a covariate.

^b Measured on a 7-point scale in which higher scores indicate better coping.

^c Total score on the Functional Assessment of Cancer Therapy–Prostate version. Higher scores mean better coping.

^d Measured using the Perceptions of Support Survey–Patient Version. Higher scores indicate more satisfaction.

as a covariate. The significant differences between attenders and nonattenders in their tendency to cite fellow patients as sources of these forms of support was unaffected by the addition of time since diagnosis as a covariate.

Table 5 shows that attenders did not differ significantly from nonattenders regarding self-reports of coping, quality of life, or satisfaction with social support. As we mentioned earlier, these analyses were conducted with ANCOVAs in which time since diagnosis was first entered hierarchically as a covariate.

The treatment histories of attenders and nonattenders also differed: nonattenders were significantly more likely to have had radiation therapy. To test the possibility that treatment history was a possible confounding factor, a 2 H 2 ANCOVA was conducted with support group attendance and radiation treatment as independent variables and with age entered as a covariate. This test revealed no significant main effect for treatment history (did or did not have radiation) on self-reports of coping, quality of life, or tendency to rely on fellow patients for informational support. In addition, no significant interaction between treatment history and support group attendance was found for these dependent measures. Similarly, no significant effects were found when treatment history was operationally defined as the total number of different types of treatment a patient had experienced (radiation, hormonal, and surgery). Finally, a 2 H 2 ANCOVA with support group attendance and employment status as independent variables and with age entered as a covariate revealed no significant

main effect for employment status or interaction effects on self-reports of coping, quality of life, or patterns of social support.

DISCUSSION

Results from the present study indicate that for patients with prostate cancer, significant differences exist between those who attend support groups and those who do not regarding the nature of their social support. Specifically, attenders relied more on fellow patients than nonattenders did, especially for informational support. However, attenders did not report being better off than nonattenders concerning their quality of life, coping, or satisfaction with social support. Thus, it seems that the two groups of men were using different means to get to the same place. In other words, the composition of their social networks may have differed, but their beneficial effect did not.

On the average, the men were doing well; however, there was considerable variance among attenders and nonattenders in their quality of life and coping efficacy. This finding suggests that some men who are not attending groups should be doing so and, perhaps, some who are should not be. Although the present study featured a sample with more attenders than nonattenders, it should be noted that the sample was not representative of patients with prostate cancer in general. Rather, it is our experience that between 10% and 30% of patients attend groups regularly. Therefore, the number of nonattenders who should be attending probably outnumbers the attenders who should not be attending.

The fact that we did not find significant differences in coping and quality of life between attenders and nonattenders in the present study does not mean that support groups have no value. A more reasonable conclusion is that, given the different sources of support evident for attenders and nonattenders, certain patients have needs for support that are met best by interacting with fellow patients. For at least two important reasons, it is worth exploring why this might be the case. First, future research will be guided by such exploration. Second, the results of such research may help to guide patients to helpful support in the form of a support group.

The results of the present study show that differences in support networks for attenders and nonattenders are most pronounced in the area of informational support. Clearly, men who attend support groups rely much more heavily on fellow patients for information than nonattenders do, and attenders rely much less on medical staff. This does not necessarily mean that attenders are obtaining more information, though some of them might argue that they are. Neither can the present study draw conclusions about the accuracy of that information. We do know, however, that both attenders and nonattenders are

satisfied with the information they are receiving. With this fact in mind, exploring the men's approaches to information seeking might explain why some attend groups and others do not.

Patients with prostate cancer might perceive the nature of information presented by medical staff to be different from the information they would receive from fellow patients. For example, fellow patients may be more detailed in their descriptions of treatments and side effects. Patients who are "monitors" might seek out this detail, whereas "blunters" would not (Miller, Brody, & Summerton, 1988). If so, it would seem reasonable for future research to assess the extent to which seeking information is part of attenders' and nonattenders' coping style.

Another way that support groups provide information is through social comparison. Comparing himself to those around him allows the patient to assess the nature of his own situation. Patients who benefit from upward comparisons that suggest they can get better or patients who benefit from downward comparisons that remind them they could be worse off would be more likely to attend a support group. On the other hand, patients who find upward comparisons discouraging because they feel worse off or find downward comparisons depressing because they see themselves declining to that state would not be likely to attend. Future research must investigate these processes in attenders and nonattenders.

In the present study, support group attenders differed from nonattenders in treatment history, age, employment status, and time since diagnosis. Remember that most nonattenders were solicited from clinics, whereas support group attenders were solicited from actual group meetings. Given these differences, it is important to emphasize that none of these factors affected quality of life or perceptions of coping, either by themselves or in interaction with support group attendance. Only when we looked at patients' tendencies to use other patients as sources of informational support did an interaction emerge between time since diagnosis and support group attendance. Attenders were more likely to cite fellow patients as sources of informational support, and this tendency was even greater for those whose time since diagnosis was longer than 12.5 months.

Therefore, the decision to attend a support group may depend on stage of disease to some extent. In the first few months after diagnosis, patients may have immediate concerns they do not believe can be addressed best by going to a support group. As time passes, however, this may change. Post hoc analyses cast doubt on the notion that the benefits of support group attendance may depend on the timing of that attendance. However, we did find that recently diagnosed nonattenders were the ones least likely to cite other patients as sources of informational support.

One must remember that, in the present study, support group attendance was defined operationally in dichotomous terms—patients either attended regularly or did not attend at all. However, attendance also can be conceptualized on a continuum or by categories such as “rarely,” “sometimes,” and “often.” Future research must investigate possible differences in patterns of social support for men at various points along this continuum. Future research also should investigate the possibility that patients who score high on measures of internal locus of control (Wallston, Wallston, & DeVellis, 1978) would be drawn to support groups if these groups were viewed as a way to cope with cancer independently from the “powerful others” found in the medical establishment. Administration of the MHLC scale might yield some interesting findings in this regard.

Patients who attend support groups may do so, not because they value the interaction with fellow patients, but because they do not value their interactions with medical staff. They generally may lack faith in the medical establishment. The group may be viewed as a source of alternative treatments. Our own experience with support groups is not consistent with this explanation, however. Instead, rather than rejecting the medical establishment, members of the medical staff are brought in regularly as guest speakers.

Furthermore, men may attend support groups because they are dissatisfied with their personal support networks or a network does not exist for them at all. By attending a support group, they simply bring their satisfaction up to the level reported by those who do not attend. However, the present study did not assess the extent to which the participants attended support groups because they were dissatisfied with their personal networks.

CONCLUSION

The present study showed that there are distinct differences between the support networks of group attenders and nonattenders, especially in the area of informational support. The fact that a corresponding difference in coping or satisfaction with support was not found indicates that there might be a “goodness of fit” between some men and prostate cancer support groups. Future research must explore this possibility, paying close attention to monitor-blunter constructs, social comparison processes, and locus of control beliefs.

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Received: May 14, 2000

Accepted: August 13, 2000