

A Comparative study of Friendship Therapy Groups for Thais with Colorectal Cancer and Colostomies

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Abstract: Patients with cancer need strong social support to help them deal with life-threatening aspects of their illness and in Thailand The Friendship Therapy Group was initiated for this purpose in 2005. This comparative descriptive study explored and compared the perceived stress, stress appraisal, coping, and quality of life of patients with colorectal cancer and colostomies who participated in this group compared to those who did not. Of 87 patients with colostomies, 30 participated and 57 did not. Data were collected in three hospitals via six instruments: the Personal Information Form, the *Perceived Stress Scale*, the *Stress Appraisal Index*, the *Functional Assessment of Cancer Therapy-Colorectal Cancer*, the *Ways of Coping Questionnaire*, and the *Social Activity Participation and Evaluation Tool*; and analyzed through descriptive statistics, and MANOVA. Results showed that there were no significant differences in variables between groups. The mutually supportive activity was the group activity that they mostly preferred and thought it was helpful. Other activities may have been less related to mutual support; therefore the purpose of those activities of truly mutual support should not be lost. Understanding the stress, coping, and quality of life, of these groups will be useful to help nurses guide the development of future interventions for these patients.

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Introduction

Colorectal cancer and stoma operations cause changes in a patient's life because of the consequence of psychosocial disturbance, limitations of bodily function, and changes in personal daily living. Reported concerns include stoma complications, body image, gas and odor, tiredness, insomnia, and fear of recurrence.^{1, 2} These situations affect quality of life (QOL) as revealed by patients with cancer and colostomies, their QOL is worse than those who do

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not have colostomies.³ Therefore, social support is needed and has been shown as an important resource to reduce stress, and enhance coping abilities resulting in better QOL.⁴ This paper describes a study that relates to providing social support to patients with colorectal cancer and colostomies through Friendship Therapy Groups (FTGs) in Thailand.

Literature Review

A literature review regarding living with a stoma summarized that there are five dimensions: QOL, body image, sexuality, psychosocial adjustment, and practical adjustment, that negatively change a patient's life after having an ostomy.⁵ In addition, surviving patients with a stoma experienced significantly worse overall QOL than those without a stoma.³ Patients' concerns about their appearance and changes in body image induced psychological distress. Some changed their clothing style, avoided wearing bathing suits, and tried to conceal their colostomies.⁶ From all of the impacts and the special needs due to physical alteration, therefore, patients with colostomies need support for special needs. Tailored information from such patients and Enterostomal Therapy Nurses (ET nurses) is required to meet these special needs. Understanding of their stress and coping strategies is required so as to provide appropriate support for them.

The stress and coping of patients with cancer are typically reported in studies about living with cancer by survivors. While people with a history of cancer are living longer, there is a growing body of evidence demonstrating three types of late effects. First, the physiological late effects, include cognitive changes, cardiac dysfunction, physical disability, and sexual dysfunction. The second are psychological late effects, such as depression, anxiety, uncertainty, isolation, and altered body image. The third are social late effects, such as changes in interpersonal relationships, health and life insurance issues, and

financial burden. These long-term effects are critical situations leading to stress in cancer survivors.⁷ Regarding stress appraisal and coping, a meta-analysis study revealed the relationship between primary appraisal dimensions and coping strategies in people with cancer.⁸ It was reported that age, time since diagnosis, and type of cancer could moderate the relationship between appraisal and coping. The results showed that the length of time from the diagnosis significantly moderated the relationship between threat appraisals and problem-focused coping. The longer an individual has been diagnosed with cancer, the stronger the relationship between threat appraisals and problem-focused coping.⁸ Moreover, the strategies that survivors most often used for coping were planning, acceptance, and seeking social support; on the other hand, venting and denial were used least. Survivors who used venting or denial were found to have significantly higher levels of anxiety, depression, and cancer-related health worries than others. Use of seeking social support was significantly correlated with high anxiety levels as well.⁹

In Thailand, little is known about patients with colorectal cancer and colostomies regarding their stress, and coping and support after the treatment phase. Studies in this area have investigated the effect of supporting or educational programs on various outcomes in patients, such as stoma self-efficacy¹⁰ and body image perception.¹¹ The results from predictive studies also revealed that social support, number of roles, and perception of body image can explain role adaptation among women with colostomies.¹² In addition, there were the recommendations for patients with permanent colostomies to engage in regular social activities, especially talking about their problems and exchanging their knowledge and experiences with others.¹³ This kind of support group, or self-help group (SHG), is known to be helpful for cancer survivors. More than 75% of patients with cancer and non-cancer who joined ostomy support groups reported that they

were helpful.¹⁴ There is considerable evidence that cancer patients benefit from participation in support groups in term of improvements in QOL, coping ability, affect, and also more control over cancer.¹⁵⁻¹⁸

The first SHG group for patients with head and neck cancer was established in Thailand in 1990 by Junhavat¹⁹ for patients post total laryngectomy. These patients have to breathe through the stoma located at the neck and speak with no voice. Those experienced with their condition can help new ones to develop the ability to speak via stoma and give other suggestions regarding living with a stoma. This SHG was, therefore, initiated with the purpose of enhancing mutual support among laryngectomees. This group can maintain the essence of the SHG philosophy, whereby employing mutual support and having experienced patients function as leader as well as the experts of the group. After the first SHG, a group for breast cancer patients was initiated in 1993 by Lymthongkul.²⁰ Even though health care professionals played the lead role in the beginning, some breast cancer patients were trained and they finally could be group leaders. This group also kept the essence of the SHG philosophy and has functioned as a sustainable group until the present. In 2005, the FTGs were initiated by the National Health Security Office with the goal to embed mutual support in the groups. Mutual support is reciprocal sharing of common situations, problems and experiential knowledge about concerns. The FTG has expanded the concept of the SHG by adding many relaxing activities and volunteer activities to help other patients outside the group. The FTG was initiated based on the belief that bonding between friends can help support each other to get through an illness. Therefore, the meaning of "therapy" in this context emphasized psychosocial support rather than curing the disease. The activities included in the FTG were the illness discussion, and relaxation activities. Membership in FTGs was not limited to health care providers and patients; and lay persons who were volunteers could participate in this group. Healthcare providers play a

key role in providing information about disease and treatment, whereas experienced patients provide information about their experience in living with cancer.

A report from a working group by Panpakdee and her colleagues²¹ demonstrated the result of the implementation of an FTG in the central part of Thailand and group activities and benefits from the group are summarized in Figure 1. It is interesting that the various activities in group included mutually supportive activities and other relaxing activities. Mutually supportive activity is similar to the activity in SHG which the experienced patients and new cancer patients discuss about self-care and ways to solving their illness problems. There was only one official report regarding FTGs that published and described about the structure and outcome of the FTGs in general. The outcomes of the FTGs for specific types of cancer, such as colorectal cancer, were not investigated. Patients with colostomies have special needs and have to deal with a decrease of social functioning.²² FTGs may help them reach the adaptive outcomes for their lives. To further understand the outcomes of the FTG, this study focused on the outcomes of participating in the FTG for patients with colostomies. Understanding the stress, coping, and QOL, of these groups will be useful to guide nurses' development of future interventions for these patients.

Aims

The purpose of this study was to explore and compare the perceived stress, stress appraisal, coping functions, and QOL between groups of patients with colorectal cancer and colostomies who participated and did not participate in FTGs

Research questions

1. What are the perceived stress, stress appraisal, coping functions, and QOL of the patients

with colorectal cancer and colostomies who participated and did not participate in the Friendship Therapy Groups?

2. Were there differences in perceived stress, stress appraisal, coping, and QOL between these groups?

Theoretical Framework

Lazarus and Folkman's stress, appraisal, and coping model was used as the theoretical framework for this study.⁴ Stress appraisal is a cognitive process that a person uses to evaluate whether a situation he or she encounters is relevant to his or her well-being. Stressful appraisals include harm/loss, threat, and challenge. Dealing with stress resulting from the psychological and physiological changes associated with cancer requires an individual to use a variety of coping strategies.²³ Lazarus and Folkman have distinguished two functions of coping: emotion- and problem-focused. These coping categories are evaluated according to whether or not they effectively meet the demands of a given situation and are not considered as healthy or unhealthy strategies. Emotion-focused coping involves such strategies as distancing, self-control, escape-avoidance, accepting responsibility, and positive reappraisal. Problem-focused coping includes strategies such as confronting problems, planful problem-solving, and seeking social support. Social support is a coping resource caused by decreasing the likelihood of the occurrence of stressful events, altering the individual's perception of the situation, and modifying the linkage between stressful events and their effect. The prime importance of the appraisal and coping processes is their effects on adaptation. Three kinds of adaptation are social functioning, morale, and somatic health, therefore, these were seen as QOL for this study.

Method

Design: We used a comparative descriptive design

Ethical considerations: The research study was approved by the Institutional Review Board (IRB) of Faculty of Medicine, Ramathibodi Hospital, Mahidol University, and the two hospitals and one cancer center. All participants received information about the study, including its purposes, benefits, risks, confidentiality, and the right to withdraw from participation in the study if so desired. Moreover, the patients were asked for permission to access data related to diagnosis, treatment, and comorbidity in their medical records, and assured that their confidentiality would be respected at all times. All participants signed a consent form and could withdraw from the study at any time without prejudice.

Sample and setting: The study was conducted in three hospitals, two in the Bangkok metropolitan area and one cancer center in Eastern Thailand. These settings had already provided resources for cancer patients by setting up Friendship Therapy Centers and they all had ET nurses taking care of patients with colorectal and colostomies. Group activity regarding mutual support was provided in the three settings. For the tertiary care hospital, the schedule for group meeting at the Friendship Therapy Center was set up if there were many patients with colostomies available in that week. In the past, there were group activities around three times per year. For the National Cancer Institute, the schedule for the group activity regarding mutual support was set up once a month. For the Cancer Center in the rural area which had the responsibility of taking care of cancer patients from nine provinces in South-East Thailand, there was no formal schedule for the meeting of the patients but there were some patients who were experienced with colostomies who acted as volunteers, providing information for other

new attendees. Therefore, group activity regarding the mutual support was informally done.

The target population was patients with colorectal cancer and colostomies. Convenience sampling was used to obtain potential participants who were recruited using the following inclusion criteria: adults age 30 years and older; having a colostomy for no less than 6 months; and orientated to time, place, and person. Sample size was based on a conventional significant alpha of .05, a power of .80, and an medium effect size calculated from previous related research²⁴. The sample size needed for this study was about 29 participants per group. Based on the registration records at the ostomy clinic, it was estimated that the proportion of participants that would and would not participate in the FTG would be about 1:2. By adding 10% attrition, therefore, the estimated sample size for the participant and non-participant group was 32 and 64 participants, respectively.

Instruments: This study employed six questionnaires described below

The Personal Information Form was developed by the principle investigator (PI) to collect the demographic data, and included age, marital status, religion, years in school, income, occupation, type of cancer, time since diagnosis, and stage of cancer.

The Perceived Stress Scale (PSS) was developed by Cohen and colleagues²⁵ on the basis of a common assumption that “the impact of objectively stressful events is determined by one’s perceptions of their stressfulness” There are 14 items using a 5-point Likert scale for measuring the degree to which the situations in one’s life are appraised as stressful. Participants were asked to estimate how often they felt or thought with the negative and positive situations in each item. For this study, the Thai version of the PSS translated by Sangon,²⁶ which reported very good reliability when used with Thai women (Cronbach’s alpha = .94), was used without any modifications. Item examples were “In the last month, how often have you been upset because of something that happened

unexpectedly?” and “In the last month, how often have you felt confident about your ability to handle your personal problems?” Participants were asked to rate items in the following format: 1=almost never, 2=sometimes, 3=fairly often, and 4=very often, then all item scores were summed up to be a total score. Total possible scores ranged from 0 to 56. The higher the scores, the higher the stress level. For the current study, the reliability of this instrument was .77.

The Stress Appraisal Index was derived from the Appraisal Index constructed by Moore in 1991 and was based on three categories of stress appraisal stated by Lazarus and Folkman⁴. It was translated into Thai by Wonghongkul²⁷ to assess the perception of the breast cancer survival experiences of patients in her study. This instrument consists of three visual analog scales, which were on a line 10 centimeters long. The left end indicated 0=not at all, and the right end indicated 10=very much. Each scale represented a different stress appraisal: harm, threat, or challenge. Participants were asked to mark a vertical straight line “ | ” on each scale in order to indicate how they presently appraised their stress from their cancer situation. The score was calculated by measuring the length from 0 to the marked “ | ” on each scale. A higher score determined a higher level of harm, threat, or challenge.

The Functional Assessment of Cancer Therapy-Colorectal Cancer (FACT-C) was developed by Cella et al. in belief that QOL is subjective and multidimensional, and can only be understood from the patients’ perspective.²⁸ The FACT-C is used for assessing QOL of patients with colorectal cancer. There are 36 items, including four general dimensions and one additional dimension for colorectal cancer. Examples of the items are: “I am able to work (including doing work at home)” and “I am embarrassed by my ostomy appliance.” Participants were asked to indicate the extent to which they agreed with each of the items, using the following response format: 0=not at all, 1=a little bit, 2=somewhat,

3=quite a bit, and 4=very much. Scores ranged 0-144, and a higher score reflected the better QOL. The FACT-C has been translated into almost 30 languages including into Thai by Sirilertakoonet al.²⁹ A pilot study with Thai cancer patients reported good reliability for the total scores in the general part (Cronbach's alpha = .87) and acceptable reliability for the colorectal subscale, with a Cronbach's alpha equal to or greater than 0.66.²⁹ The reliability of the FACT-C for the current study was .76.

The Ways of Coping Questionnaire (WOCQ) was used for assessment of the coping strategies. This questionnaire was developed by Lazarus and Folkman³⁰ to describe cognitive and behavioral strategies, which were divided into two types: problem-focused and emotion-focused coping. An example of a problem-focus item is: "I tried to analyze the problem in order to understand it better" and an emotion-focused item: "I told myself things that helped me to feel better." There are 66-items, which 50-items are scored using 4-point Likert scales (0=not used, 1=used some of the time, 2=used quite a bit, 3=used a great deal). The possible range of scores is 0-150. For this study, the Thai version of the WOCQ, translated by Sithimongkol et al. in 2004, was used³¹ and our reliability of the questionnaire was .88.

Social activity participation and evaluation tool: This instrument was developed by the PI to assess the activities the participants had joined in during the previous year, and to consider which group they should placed in this study, FTG group or No-FTG group. All activities posing in this instrument were selected by literature review and FTG observation. The content and instrument format were verified by senior nurses in FTGs and a professor in the FTGs surveying team. All of them were masters in FTG activities. This tool was used for assessing the frequency and helpfulness of social activity of patients in this study. For FTG group this was those who had participated in social activities at least three times during the past year and one of those three times had participated in the mutually

supportive activity. Members of the No-FTG group had never participated in that activity. There were approximately 11 activities, including mutually supportive activity, health education/conference, handicrafts, traveling, religious activities, and music therapy. Participants were asked to identify the frequency of their participation in activities within the last year and also evaluate the helpfulness of each activity on a score ranging from 1-4 (1=least helpful and 4=most helpful). Therefore, this tool was not only use for dividing the participants into the FTG group and No-FTG group but also to report their perceptions on the helpfulness of each activity. The higher the scores, the more helpful of the activity.

Procedures: The PI contacted participants either within the FTG group or in out-patient units for the No-FTG group to determine their inclusion criteria fit, and seek study consent. They were then asked to complete the questionnaires, which took around 45-60 minutes.

Data analysis: Questionnaire data were checked for completeness of content as well as normality of the data. Demographic data were analyzed with descriptive statistics and reported separately for the FTG and No-FTG groups. The differences of perceived stress, stress appraisal, coping, and QOL between both groups were analyzed by using descriptive statistic and MANOVA. For the latter, all variables except challenge were analyzed because it was not normal distribution and could not be transformed to normal distribution.

Results

Eventually, 91 participants completed all of the questionnaires which were included for analysis. While checking the data, four participants having extremely high scores on QOL were considered outliers, so those data were eliminated in order to retain the normality of the overall data. Therefore, 87 participants were included in this study and their characteristics are

presented in **Table 1**. Fifty seven (65.5%) participants were in the No-FTG group and Thirty (34.5%) participants were in the FTG group. Their overall characteristics were: the FTG group was younger; most were married, and percentage of participants receiving

current treatment in the No-FTG (29.8%) was two times larger than those in FTG (13.3%). Comparing the difference between groups, the mean age and duration of illness of the participants was significantly different ($t = -2.52$, $p < .05$; $t = 4.06$, $p < .001$, respectively).

Table 1 Demographic data of FTG and No-FTG group participants

Characteristics	FTG (n = 30)		No-FTG (n=57)		χ^2	t
	N	%	N	%		
Gender					.000	
Male	15	50	30	52.6		
Female	15	50	27	47.4		
Status					.013	
Single/Divorce/Widowed	9	30	15	26.3		
Married	21	70	42	73.7		
Education level					12.36*	
Illiterate	-	-	2	3.51		
Primary school	6	20	33	57.89		
Secondary school	13	43.3	13	22.81		
Undergraduate and Graduate	11	36.7	9	15.79		
Working status					.678	
Working	24	80	41	71.9		
Not Working	6	20	16	28.1		
Income/month (baht)					.534	
Lower than 5,000	8	26.7	18	31.6		
5,001 – 10,000	6	20	13	22.8		
10,001–20,000	8	26.7	14	24.6		
more than 20,001	8	26.7	12	21.0		
Current treatment					2.08	
No	26	86.7	40	70.2		
Yes	4	13.3	17	29.8		
	mean	SD	mean	SD		
Age	50.8	9.5	60.5	10.8	4.06**	
Duration of illness	8.2	7.1	4.6	4.9	-2.52*	
Number of family in the same household	4.3	2.1	5.1	2.4	1.53	

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

Table 2 Comparison of mean scores on perceive stress, stress appraisal, coping, and QOL between FTG and No-FTG group participants

Variables	FTG (N=50)		No-FTG (N=67)		F ^H	t
	Mean (SD)	Mean (SD)	Mean (SD)	Mean (SD)		
Perceived stress	20.0 (7.89)	19.52 (7.21)			.80	
Stress appraisals (positioned by rank)						
Challenge	7.87		7.72			-
Harmful	4.68		4.97		.22	
Threat	4.41		4.35		.005	
Emotional-focus coping	58.1 (13.12)	53.3 (12.98)			2.61	
Accepting responsibility	6.23 (2.22)	4.89 (1.92)				-2.92*
Distancing	10.13 (2.50)	10.47 (3.04)				.53
Self-controlling	10.53 (2.58)	9.26 (3.50)				-1.75
Escape-Avoidance	7.13 (2.69)	7.03 (3.24)				-.14
Positive reappraisal	13.27 (3.33)	11.35 (3.62)				-2.41*
Problem-focus coping	16.7 (3.92)	14.42 (4.15)			6.15	
Confrontive	6.13 (2.28)	5.51 (2.40)				-1.26
Planful problem solving	10.57 (3.09)	8.91 (3.90)				-2.32*
Seeking social support	10.80 (3.85)	10.26 (3.11)				-.70
QOL	109.05 (15.80)	108.88 (14.02)			.033	
Physical well-being	21.76 (4.44)	21.94 (4.56)				.18
Social/family well-being	20.48 (4.01)	21.40 (3.32)				.11
Emotion well-being	19.63 (4.04)	19.42 (4.11)				.23
Functional well-being	21.73 (4.55)	20.03 (4.77)				-1.63
Additional concern about CA colon	25.43 (3.97)	26.07 (4.09)				.70

*p<.05, ^H = Hotelling T² = .09 (p = .34)

As noted in Table 2, those in both groups had moderate scores in perceived stress (FTG: mean=20, No-FTG: mean=19.52, possible range=0-56) and the FTG group had slightly higher scores of perceived stress. Both groups appraised the situation of having cancer in three aspects and the scores of these were arranged in a similar way, challenge, harmful and threat respectively. The FTG group had higher scores in both problem and emotion-focus coping than the No-FTG group. However, the relative scores of coping in both groups were in similar proportion (FTG problem: emotion = 0.32:0.68, No-FTG problem: emotion = 0.34:0.66).

When comparing the differences in perceived stress, stress appraisal, coping, and QOL between the both groups, it was found that these were not significantly different (Hotelling's $T^2=.09$, $p=.34$). However, there were three coping strategies that the FTG group used significantly more than the No-FTG group: acceptance responsibility, planful problem solving, and positive reappraisal ($p<.05$).

Discussion

From the result regarding stress appraisal, it was revealed that patients with colorectal cancer and colostomies had high scores of stress appraised as a challenge. This finding is congruent with cancer survivors who live longer than 5 years reflected on as living a normal life³² and the greatest challenge was living with an ostomy.³³ In comparing variables, it was noticed that mean scores of perceived stress, emotion-focused coping, problem-focused coping, QOL were higher in the FTG than those in the No-FTGs. On the other hand, mean scores of stress appraisal as harmful and threat in the FTGs was lower than those in No-FTGs. Regarding perceived stress scores, this was higher in the FTGs than in the No-FTGs. This may be because people who perceive higher levels of stress are more likely to seek social support.³⁴ Both problem and emotion-focused coping in the FTGs was much

higher than the No-FTGs. This reason may be because of the difference of age between two groups as members of FTGs were younger than the No-FTGs. Findings from systemic review article³⁵ regarding stress, coping, and aging, and the relationship between age and coping was analyzed, support the finding of this study. For example, older persons more likely to think rigidly, therefore, they are prone to use a limited type of coping. Additionally, older adults mentioned that they used fewer kinds of coping responses than younger persons when facing a stressful life event.³⁵ The older adult might have less energy reserves than younger adults, therefore they select to use only coping strategies that they think are most effective to them.³⁶ The reason why supported coping used by the FTGs may be because they knew many relaxing activities and the ways to deal with stress from people in FTG, and particularly from people experiences with colostomies. As shown in **Figure 1** there were many kinds of activities in FTG.

Some interesting results are shown in regarding participants in FTG using three coping strategies of planful problem solving, accepting responsibility, and positive reappraisal, significantly more frequency than those in the No-FTG. These can support the results of a study of FTG conducted by Panpakdee and colleagues²¹ in which participants were accepting of their illness, gaining knowledge for problem solving as well as having good mental health for positive reappraisal of their situation. From analyzing relative scores of coping functions, the result showed both groups used a similar proportion of coping effort in emotion-focused and problem-focused coping. This finding supports the notion that both emotion- and problem-focused coping are always utilized mutually in order to deal effectively with the stressful life events. As noted by Lazarus, coping may not be judged as good or bad. People use different kind of coping depending on the context, and this will change over time as situations in life are dynamic. Moreover, problem- and emotion-focused coping can mutually

facilitate the coping process of person when confronting any stressful situations.³⁷ Lazarus and Folkman also gave explanations about different reasons for using coping functions. Emotion-focused coping is more

likely to be employed when the situation is detected as intractable or difficult to control, whereas, problem-focused coping will be employed when situation is appraised as amenable to change.⁴

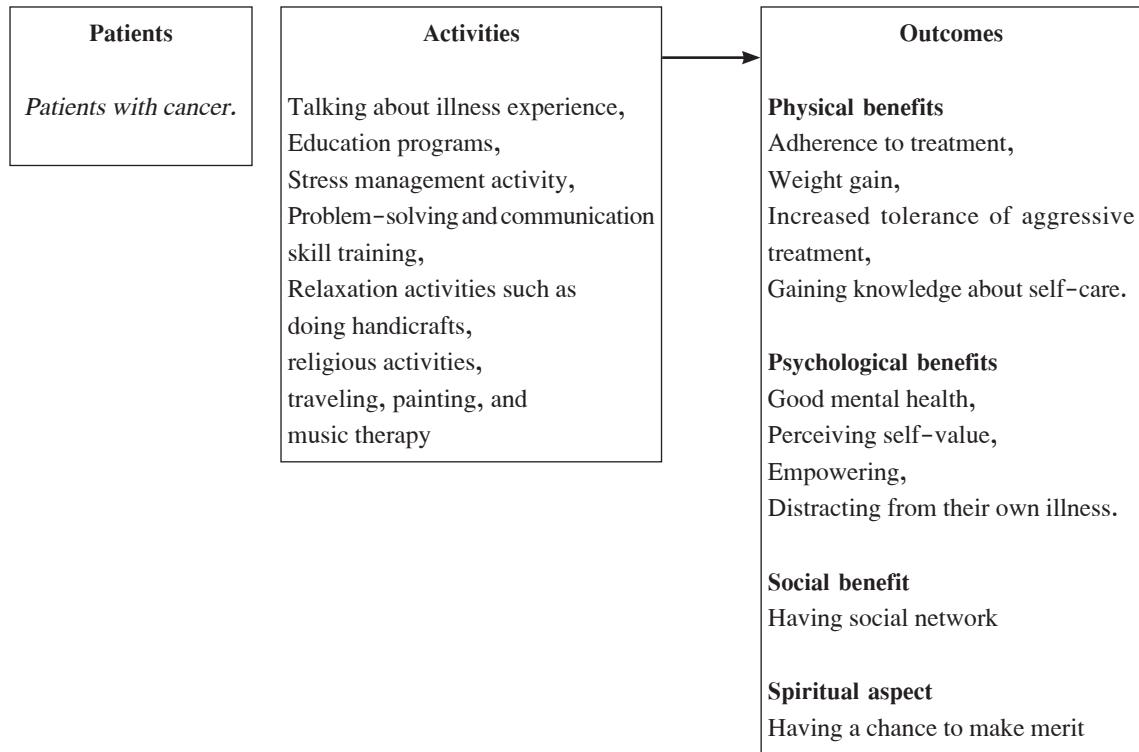


Figure 1 Activities and outcomes of participants in the FTG²¹

Quality of life scores were good for both groups. As the mean score of duration of illness of participants in this study was more than 5 years, this is congruent with the result from previous studies which report that QOL in patients with colorectal cancer who live longer than 5 years after surgery is similar to normal persons.³² However, there was no significant difference between groups regarding perceived stress, stress appraisal, the two functions of coping, and QOL. This finding may not be congruent with previous studies regarding the effectiveness of a peer support group on the positive psychological adaptation among patients with cancer, such as reframing their situations,

improving their coping responses³⁸, and QOL.³⁹ The conclusion of a survey study of cancer support groups in the United Kingdom indicated that a greater benefit of group participation was achieved through regular and long-term attendance.⁴⁰ In the current study, the fact that there was no effect of the FTG on QOL may be because they participated in the FTG less frequently than those previously, and because some settings did not provide a regular time for group meetings. Moreover, the differences between the group activities of the FTG and the SHG were also taken into consideration. The FTG provides many activities, such as health education sessions, religious activities, music

therapy, and doing handicrafts. This might not emphasize the purpose of mutual support within those activities, which is essential to the SHG. Therefore, other activities may dilute the effectiveness of this essential purpose, and the significant effect of FTG participation on positive outcomes will thus be obscured. Moreover, the participants in the current study were long-term cancer survivors whose life was stable, and therefore the responses to their illness situations may have been different.

Limitations

Some limitations in this study need to be considered. First, because of the limited number of potential participants at the time of the data collection, it was not possible to get equal comparable participants between two groups. Therefore, this may have caused lack of clarity in terms of how the FTG participation affected their lives. Secondly, the inclusion criteria which was set at participating in mutually supportive activity at least once a year was too little to show the effect of FTG on stress coping and adaptational outcomes. The last limitation is that the ability to generalize the results to other patients with colorectal cancer and colostomies in Thailand is limited because of the use of convenience sampling and the small sample size.

Conclusion and Recommendations

FTG was modified from SHG for Thai context and their effect on stress, coping and adaptational outcomes was not supported in this study. This may be that only a one-time participation in a mutually supportive activity per year may not enough to show the effect. Also, in organizing various activities, the purpose of those activities of truly mutual support should not be lost. In addition, this activity should be set up regularly every month as is done for sustainable groups such as SHG for women with breast cancer²⁰

and people after laryngectomies¹⁹. Suggested further research should focus on the development of specific mutual support interventions and conducting a randomized control trial to test the FTG effectiveness in Thailand.

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การศึกษาเปรียบเทียบการใช้กลุ่มมิตรภาพบำบัดในผู้ที่ป่วยด้วยโรคมะเร็ง สำหรับผู้ป่วยและสำหรับผู้ที่มีทวารเทียม

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บทคัดย่อ: การเจ็บป่วยด้วยโรคมะเร็งก่อให้เกิดความต้องการการสนับสนุนจากสังคมที่จะช่วยให้บุคคล ผู้เจ็บป่วยสามารถเชื่อมกับโรคได้ ในประเทศไทยมีการจัดตั้งกลุ่มมิตรภาพบำบัดขึ้นตั้งแต่ปี พ.ศ.2548 เพื่อเป็นการสนับสนุนทางสังคมอีกรูปแบบหนึ่งให้กับผู้ป่วยมะเร็ง วิจัยครั้งนี้เป็นการศึกษาแบบพรรณนา เชิงเปรียบเทียบโดยมีวัตถุประสงค์เพื่อแสดงถึงความแตกต่างของตัวแปร ความเครียด การประเมินภาวะเครียด การเชื่อมความเครียด และคุณภาพชีวิตของผู้ที่ป่วยด้วยโรคมะเร็งสำหรับผู้ที่เข้าร่วมและไม่ได้เข้าร่วมกลุ่มมิตรภาพบำบัดผู้เข้าร่วมในงานวิจัยมีจำนวน 87 คน แบ่งออกเป็นผู้ที่เคยเข้ากลุ่มมิตรภาพบำบัด 30 คนและไม่เคยเข้ากลุ่ม 57 คน เครื่องมือที่ใช้ประกอบด้วย แบบสอบถามข้อมูลทั่วไป แบบสอบถามการรับรู้ระดับความเครียด แบบประเมินการรับรู้ความเครียด แบบประเมินภาวะเครียด แบบสอบถามวิธีเชื่อมความเครียด และแบบประเมินคุณภาพชีวิตของผู้ป่วยมะเร็งสำหรับผู้ที่เข้าร่วมและไม่ได้เข้าร่วมโดยใช้ สติ๊ติบรรยาย และ MANOVA พบร่วมมิตรภาพแตกต่างของ การรับรู้ความเครียด การประเมินภาวะเครียด การเชื่อมความเครียด และคุณภาพชีวิต ของผู้ป่วยทั้ง 2 กลุ่ม อย่างไรก็ตามพบว่า คะแนนการเชื่อมความเครียดในรูปแบบ การยอมรับต่อปัญหา การวางแผนเพื่อแก้ปัญหา และการประเมินสถานการณ์ใหม่ให้เป็นไปในทางบวก ของผู้ที่เข้าร่วมกลุ่มมิตรภาพบำบัดมีค่ามากกว่าผู้ที่ไม่ได้เข้ากลุ่มอย่างมีนัยสำคัญทางสถิติ กิจกรรมพูดคุยแลกเปลี่ยนประสบการณ์เป็นกิจกรรมที่ผู้ป่วยส่วนใหญ่ชอบ และคิดว่าเป็นประโยชน์กิจกรรมอื่นๆ อาจลดthonความสำคัญของการแลกเปลี่ยนประสบการณ์ลง ผลการวิจัยครั้งนี้ช่วยให้เกิดความเข้าใจผู้ที่ป่วยด้วยมะเร็งสำหรับผู้ป่วยและมีทวารเทียมมากขึ้น โดยเฉพาะในเรื่องความเครียด การเชื่อมความเครียด คุณภาพชีวิตและแหล่งช่วยเหลือสนับสนุนทางสังคมที่ผู้ป่วยได้รับ อีกทั้งยังได้ข้อมูลที่เป็นประโยชน์ต่อการพัฒนากลุ่มมิตรภาพบำบัดสำหรับผู้ป่วยในกลุ่มนี้

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คำสำคัญ: กลุ่มมิตรภาพบำบัด; การเชื่อมความเครียด; คุณภาพชีวิต; มะเร็งสำหรับผู้ป่วยและสำหรับผู้ที่มีทวารเทียม;

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