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Abstract

Over 2000 DoD beneficiaries are diagnosed annually with breast cancer and approximately 1500 active duty service members received treatment for breast cancer during the past decade. This has major implications for immediate and long-term readiness of active duty personnel who are themselves diagnosed with breast cancer or experience this diagnosis within their families. An important component of treatment is psychosocial support for both patients with breast cancer and their partners/caregivers.

The WRAMC Department of Psychology and Clinical Breast Care Project (CBCP), in collaboration with the American Psychological Association (APA), developed a group psychosocial intervention program specifically designed for military beneficiaries – an 8-week intervention for patients with breast cancer, and a 6-week intervention for their partners. It is especially important that intervention is provided soon after initial diagnosis because the sooner an intervention is provided, the more effective in preventing long-term stress reactions in response to traumatic events.

In implementing this program at WRAMC, we have found that attendance is affected by a number of factors, thereby inhibiting the effectiveness of the intervention. Obstacles to a consistent participation in the program include treatment side effects (in approximately 25% of interested women), difficulty traveling to the medical center (approximately 32%), unavailability of psychosocial support services for personnel stationed in remote locations (12%) and TDY of active duty personnel who have returned to duty post- treatment (10%). Use of video-teleconferencing (VTC) in the WRAMC CBCP program has allowed participation by active duty service members stationed where no support services are available, but who are in proximity to a VTC site. Preliminary data provides proof of concept for participation in the WRAMC group program via telecommunications.

Final Results

Since receiving notification of funding from TATRC in April 2003, we made good progress on the Outcomes of Telehealth Group Psychosocial Interventions for Breast Cancer Patients and their Partners project. In order to obtain pilot data, we have provided these clinical services to participants in two groups over a four month period of time via the use of a PictureTel Concord System at WRAMC utilizing 384 Kbps. From April 2004 to February 2005, 116 new breast cancer patients were seen at the

WRAMC Comprehensive Breast Center. Of those 116 patients, 13 women participated in two 8-week support group from August 12 to October 7, 2004, and from January 14 to March 20, 2005. Furthermore, of the 116 new breast cancer patients, 16 women (14%) were active duty (3 of the active duty women participated in the support groups). Ongoing data analysis indicates that telehealth patients appear to benefit from the intervention as much as the face-to-face patients. For example, the following statements from participants illustrate this point: "This group gave me something to look forward to". "This group gives us that one thing, connection." "It's like being in another country and meeting someone you know from your own state." "Sure, it would be better if we could all be together in one room, but this is better than nothing at all." "The best aspect...was hearing the other members' experiences – this helped me prepare for treatment still ahead." "The group has been a totally different experience. I laugh now more than I have since my diagnosis." Thus, overall patients have considered their experience with each other a positive one, and feel that they have developed as much of a relationship with the telehealth patients as the face-to-face participants. In fact, one month after the end of a group, all the women (from the separate group sites) and their family members got together at the group facilitator's home for a potluck get-together. Thus, it appears that telehealth technology remains an effective way to deliver this type

Deliverable

The deliverable for this project is an ongoing viable clinical service, i.e., continued participation in the breast cancer support group program, via VTC. Upon completion of data collection, a thorough data analysis will be conducted targeting the feasibility and efficacy of conducting psychosocial support groups via telecommunications equipment. This includes an analysis of outcomes questionnaires with which we can compare the outcomes for the face-to-face group participants as compared with those group members who participated via VTC. We will examine changes in psychological and behavior functioning over time for telehealth participants and face-to-face participants, as well as whether these two groups demonstrate differences in psychosocial and behavioral changes over time. Lastly, we will investigate differences in participation rates and overall satisfaction with the group program

Problems Encountered

The overriding issue centers around the deployment of the project's principle investigator Dr. Debra Dunivin, to Task Force GTMO in Cuba shortly after the mid-term report was submitted in April 2004. An addendum was submitted to WRAMC DCI requesting modifications to the protocol. Dr. Dunivin was unable to complete the revisions DCI requested before her deployment. Dr. Leslie Cooper, the (then newly appointed) Psychologist for the WRAMC Comprehensive Breast Center Clinical Breast Care Project had been hired in April 2004 and did not have the necessary project details to complete the revisions. Thus, it was agreed by DCI and Dr. Dunivin that the project would be put on hold until Dr. Dunivin's return. Although the need to identify a plan to conduct the

project once Dr. Dunivin returns would be most ideal, communication with Dr. Dunivin has been challenging. At this time, details of a plan remain on hold.

To date the partners support group has not occurred for several reasons. Husbands/partners of breast cancer patients report the following reasons for their lack of participation: (1) no interest, (2) no need, (3) time away from work, (4) scheduling issues, (5) concerns about confidentiality and privacy, and (6) concerns about rank. Despite the assurance that the scheduling of the groups would accommodate the participants' concerns for the most accessible day, time and location via the use of video-teleconferencing equipment, there remains considerable resistance among the husbands/partners.

AMEDD-Wide Adoption Potential

Breast cancer is a major health problem in the general population as well as within the military. Unlike the civilian sector, frequent military deployments and relocations prohibit military personnel from participating in long-term therapeutic programs. This highlights the specific need within the military to develop targeted, time-limited and effective intervention programs such as this one. Being able to deliver this intervention soon after diagnosis and during active treatment is expected to enhance the recovery of active duty personnel (both breast cancer patients and their partners) by improving adjustment and reducing long-term traumatic stress reactions. This directly supports military readiness by improving adjustment among active duty personnel who are breast cancer patients. In addition this program supports military readiness by reducing stress and concern among service members whose wives or family members are diagnosed with breast cancer. Furthermore, TRICARE beneficiaries, depending on their location (e.g. Pacific Rim military personnel), travel significant distances for treatment, making consistent participation in this type of intervention virtually impossible. It is to be noted that not all TRICARE beneficiaries live in areas where distance is an issue. For beneficiaries living in areas where distance is not a factor, VTC will not be a necessary aspect of group intervention. Telehealth participation would provide an inexpensive and efficient way to improve the capability of the military health system, where needed geographically, to offer the comprehensive, integrated treatment for breast cancer that is currently the standard of cancer care.

Next Steps

The WRAMC Department of Psychology offers psychosocial assessment, individual and group counseling interventions to patients with breast cancer and their family members as an integrated part of the treatment in the WRAMC Comprehensive Breast Center. In collaboration with the American Psychological Association, a psychotherapy manual for providers and a participant resource manual have been developed and used consistently for several years. Moreover, telehealth communication continues to provide patients and their partners with the opportunity to participate in the breast cancer support groups despite their health status or their geographic location. The positive responses from

participants indicate the need to train providers from other MTF to incorporate this program into their existing treatment protocols in order to maximize this standard of care to their breast cancer patients and family members.

Conclusion

Breast Cancer is a major health problem in the general population as well as within the military. Unlike the civilian sector, frequent military deployments and relocations prohibit military personnel from participating in long-term therapeutic programs. This highlights the specific need within the military to develop targeted, time-limited and effective intervention programs. The ongoing telehealth group psychosocial interventions for breast cancer patients and their partners provide support and psychoeducation to participants during active treatment. Telehealth and face-to-face patients subjectively report that these groups enhance their recovery by improving adjustment and reducing long-term traumatic stress reactions both for themselves and their family members. For active duty patients, the group intervention allows them to return to military readiness more quickly. There has been resistance among the partners of the breast cancer patients regarding the efficacy of the group intervention for them. Video-teleconferencing appears to remove some of the pragmatic obstacles reported by the husbands/partners, i.e., time and location. It remains a goal of the project to provide training to other MTF providers to implement the existing protocol into the medical interventions.