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THERAPEUTIC NORMS AND PATIENT BENEFIT: CANCER PATIENTS IN
PROFESSIONALLY DIRECTED SUPPORT GROUPS

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ABSTRACT
This study examines the relationship between cancer support groups' normative regulation and
patient outcomes. Cancer patients (N = 289) in 54 groups were studied through the use of a
cross-sectional, treatment dosage design. Outcomes were assessed by the Center for
Epidemiological Studies Depression Scale and the Functional Assessment of Cancer Therapy, a
quality of life measure commonly used in studies of cancer patients. The framework for
assessing normative regulations was based on the degree to which patients matched leader
norms. This approach to indexing members' perceptions of normative regulations proved to be a
successful strategy. The more a participant view matched those of the leaders, the greater the
likelihood they benefited from the group. The content of the norms added an independent effect
on positive outcomes. Participants who saw their groups as approving of aggressive–competitive
behaviors and the intense expression of emotions were less likely to show positive outcomes.

INTRODUCTION
Most leaders conducting groups directed toward repair, change, or growth would agree with the
proposition that the therapeutic work accomplished in small face-to-face groups is influenced by
group-level conditions. Clinical theories are replete with advice for enhancing the cohesiveness
of the group, for paying attention to how the group develops over time, and for influencing
prochange norms. Normative regulations are a critical group characteristic. A group norm is an
implicit or explicit shared agreement among group members about relevant behaviors, ways of
thinking, and modes of affective expression. Norms and associated sanctions provide a certain
amount of stability and predictability in social life; members of the social system know what to
expect of each other. Although group members seldom discuss the group's norms, they
nevertheless serve as a simple substitute for interpersonal pressures and influence tactics; they
are, in effect, an unwritten social contract that can be invoked when troublesome behavior arises.

As a shared idea of appropriate behavior in a particular social system, norms not only influence
participants but also are perceived by each member as being accepted by most others in the
system. Behavior that violates such ideas of what is the "right way" to behave is ordinarily
treated as deviant and is sanctioned by some means or another to reduce its occurrence, and thus
to return the system to its prior equilibrium. Ordinarily, sanctions do not need to be exerted;
rather, the anticipation of sanctions is often effective in controlling deviant behavior. The success
of groups directed toward change depends, in large respect, on the creation of a tiny society that
is separated and marked off from the surrounding culture. Generally, personal change groups
create norms that may be counter to those of the larger culture. For example, in psychotherapy
groups, talking about interpersonal or inner feelings is generally viewed as a decisively good
idea, and avoidance of such behavior is ordinarily defined as bad. Similarly, therapeutic groups
often support norms that encourage closer relationships than are typical of ordinary social
transactions.

The current study examined the relationship between a support group's normative regulation and

its members' outcomes. We tested the hypothesis that group members whose perception of normative regulations closely resembles that of the group leader will show better outcomes. In addition, we asked two questions about normative regulation: (a) What norms have the most effects on outcomes? and (b) Do members' expectations based on prior experiences in psychotherapy or support groups shape their perceptions of the current group norms?

BACKGROUND
In reviewing published articles from the group therapy, support group, and growth group literature, one finds that the construct norm is used in a variety of ways. Frequently, the issue is to counteract the societal norms the person carries into the group from his or her culture that could interfere with the full functioning of the group. Patients from other than Western countries present a challenge to the therapist because of specific society norms that may interfere with therapeutic processes (Haerdtle & Schneider, 1999; Ina, 1997; Polemi-Todoulou, Vassiliou, & Vassiliou, 1998; Reyes, 1998; Salvendy, 1999). Other investigators have examined gender differences and the distinction of language styles expressed in change-oriented groups (Kravetz & Marecek, 1996; Rose, 2002). Still other investigators see the emphasis on the substitution of a new referent group and its associated norms for the patient's "old" referent group (Jackson, 2001).

The perceived importance of normative regulations in therapeutic groups is not mirrored by extensive research documenting their impact on outcomes. The most extensive study of normative regulation is the early study by Lieberman, Yalom, and Miles (1973). Their randomized study of 20 encounter groups examined the relationship between norms and outcomes using a 48-item behavioral questionnaire that asked participants how appropriate or inappropriate certain behaviors would be in their encounter group. The items reflected group procedures, content, interaction style, leader behavior, relationship among members, group boundaries, and the expression of emotions. The responses to this questionnaire were subjected to a principal-components factor analysis with varimax rotation. Five normative dimensions were extracted: (a) intensity of emotional expression, (b) boundaries, (c) aggression–confrontation, (d) counterdependence–dependence, and (e) peer control. Lieberman et al. found that normative regulations of boundaries and peer control were critical in effecting outcomes. More powerful was the finding that groups that have high numbers of unregulated behaviors were less likely to be productive change settings than groups that have a wide range of normed behaviors. In a subsequent study, Lieberman (1989) examined the linkages between norms, a specific therapeutic process, and patient outcome in a study of 72 spousal self-help bereavement groups. Seven hundred twenty-one participants responded to a similar behavioral inventory used to define norms; outcomes were based on Time 1–Time 2 differences on a series of 11 measures, indexing depression, anxiety, somatic symptoms, abuse of psychotropic medication, coping mastery, well-being, self-esteem, target problem rating, stigma, and several measures of role stress and strain. Findings suggest that normative characteristics were linked to a moderator variable, reciprocal social exchange, that influenced positive outcome. In another study, Lieberman (1990) examined 36 homogeneous peer support groups that failed to benefit the majority of participants. Participants were women who had given birth in the past 1 or 2 months. They were administered measures of mental health, marital adjustment, and motherhood role adjustment prior to and 1 year after entering the groups. Although the type and number of normatively proscribed and prescribed behaviors matched those found in other studies of

effective self-help groups (Lieberman, 1989), it was found that member behavior was not readily controlled by such norms.

In an early study, Talland and Clark (1954) presented a list of 15 common topics to 11 groups of outpatients and their therapists at Maudsley Hospital in London. Rankings were made according to the usefulness of the topics, and patients also guessed at the therapist's rankings. There was no evidence of group norms shared by the therapist with his patients, and patients differed consistently with their therapists in at least four content areas. Luke (1972) asked members of sensitivity training groups to identify the normative patterns that govern member behavior. He used these perceptions to examine the relative influence exercised by trainer and member over the group's norms and found that the facilitators exercised the most influence. McCanne (1977) asked members (N= 79) of sensitivity training groups to report their goals, expectations, and perceptions of the group experience and found that participants do begin their group with expectations that impact on the group's norms. Medvene and Teal (1997) explored the extent to which self-help group leaders endorsed beliefs that group members should primarily take care of themselves (a need-based norm) and that group members have an obligation to help others (an equity-based norm). Group-level variables, rather than personality variables, were most strongly associated with their endorsements of need-and equity-based norms. Whitaker and Lieberman (1964), in their study of psychotherapy groups, presented findings showing that many group norms developed in association with groups addressing and resolving issues such as what can be talked about in psychotherapy groups, the level of intimacy appropriate in the group, power sharing, and relationship of the members to the therapist. Larsen and Abu-Laban (1968) examined the relationship between proscriptive, prescriptive, and nonproscriptive norms and deviant drinking behavior guidance groups. The results showed that the degree of deviation varies according to the type and the source of norms. Heavy drinking tends to be highest in the nonproscriptive normative environment, lower in the prescriptive environment, and lowest in the proscriptive normative environment. Bond (1984) examined the relationship between size of group membership and degree of norm regulation in group therapy. Very small groups had the most positive regulation, and small groups had the least. Negative regulation was linearly related to group size, with smaller groups having greater negative regulation. A moderate degree of norm regulation is suggested as a necessary but not sufficient condition for members to benefit from group therapy.

The research portfolio examining normative regulation in therapeutic groups is limited. Much of the research was published many years ago; studies from the past decade are rare. There is, unfortunately, no theoretical consensus and even less empirical evidence about the specific areas of normative proscription and prescription. At the extremes of behaviors, agreement can be found among the diverse therapists about norms that interfere with productive therapy; there appears to be less agreement on prescriptive (valued) norms.

Of course, social psychology has generated a wide variety of theoretical and empirical research on norms. For over 50 years, social psychology has pursued theoretical and empirical studies on small groups as well as large social systems. Illustrative findings from small group studies relevant to the current study include investigations of factors influencing the formation of normative regulation and the effects of norms on deviant member behaviors and on the group's productivity. Influences on the development of group norms have been studied in experimental

problem-solving groups, psychotherapy, sensitivity, and self-help groups. Bettenhausen and Murnighan (1985) investigated the development of norms in newly formed decision making groups (N . 19) of five members each. They found that uncertainty over appropriate behavior led members to use their past experiences in similar social settings as scripts for choosing current behaviors. Abrams, Marques, Bown, and Henson (2000) studied members who evaluated others who deviated in either an anti-or a pronormative direction. Pronorm deviance was perceived as less "atypical" than antinorm deviance. Blascovich and Ginsburg (1974) investigated the idea that risky shifts depend on both intra-and interindividual processes. Risk levels changed as a function of risk norms. Bonacich (1972) hypothesized that group norms and group solidarity are mechanisms groups devise to increase cooperation in a prisoners' dilemma experiment. He found that an increase in the potential for conflict within groups can lead to strengthened group norms and cohesion. Feldman (1984) concluded that groups are likely to bring under normative control only those behaviors that ensure group survival, increase the predictability of group members' behavior, avoid embarrassing interpersonal situations, or give expression to the group's central values. Krichevskii (1977) found that the more a group member's behavior conforms to the leadership norms, the higher will be the member's rank on a leadership scale. Postmes, Spears, and Lea (2001) studied Internet communication and concluded that the content and form of communication is influenced by group norms. Conformity to group norms increases over time. Postmes, Spears, and Cihangir (2000) investigated the impact of group norms for maintaining consensus versus norms for critical thought on group decisions. Critical thought norms improved the quality of decisions, whereas consensus norms did not. Spich and Keleman (1985) developed and demonstrated an application of an explicit norm-structuring procedure designed to increase group influence over the individual member.

On the basis of the previous studies discussed, the current state of knowledge suggests several conclusions:

     1. There is no substantial conceptual model for defining areas of normative regulation that are important in groups directed toward change or repair. Often the areas of normative regulation examined are specific to a study's goal—for example, Postmes, Spears and Cihangir's (2001) study of the impact of group norms for maintaining consensus versus norms for critical thought on group decisions. Several investigators (Feldman, 1984; Whitaker & Lieberman, 1964) have developed models that norms developed in small groups address only those behaviors that ensure group survival, increase the predictability of group members' behavior, avoid embarrassing interpersonal situations, or give expression to the group's central values.

     2. The measures used to study norms vary widely. Most frequent are questionnaires in which the respondent is asked to judge the existence of a series of "rules" in his or her group.

     3. There is general agreement that the specific norms in a group are a product of the attitudes, values, and prime referent groups that individual members bring into the "new" group (expectations) and interactions within the group.

     4. The central person, leader, or therapist has a substantial effect on a group's normative regulations. However, little headway has been made to quantify the extent of such influence and the conditions affecting variations of influence on norms.

     5. Normative regulation is related to the level of group cohesiveness.

     6. Most studies examining the relationships of normative regulation and person outcomes and/or adequacy of group functioning have shown positive results. It is in this context—of shared agreement among group therapists about the importance of group norms and the

limitations of empirical studies of clinical samples demonstrating the linkage between the existence of specific norms and patient benefit—that the current research was undertaken.

The present study extends the research between normative regulations and outcomes and the role that the group leader plays in normative regulation.

METHOD

SAMPLE The study was conducted using a sample of patients from The Wellness Community (TWC). Since 1982, TWC has been a free program of psychological and emotional support for cancer patients and their families. Central to the goals of TWC program are encouraging patients to become empowered by partnering with their physician, developing a new attitude toward the illness, making changes in their lives that they think are important, and accessing resources by making active choices in their recovery, as well as reducing unwanted aloneness, loss of control, and loss of hope. There are now 21 facilities that serve over 25,000 people with cancer each year. Participants in this study were members of ongoing participant groups. These groups are weekly, committed, 2-hr support groups consisting of 12 adult cancer patients with mixed diagnosis, gender, and age, facilitated by a licensed psychotherapist (social worker, psychologist, or marriage, family, and child counselor) specially trained in TWC's methodology. Procedure Questionnaires were sent to 17 TWC facilities. Because time in group was the central variable for exploring outcomes, we requested that questionnaires be distributed to three TWC support groups—one made up of new members and two with members who had participated for at least 6 months. All questionnaires were anonymous.

Demographics

Two hundred eighty-nine patients responded to the survey. Table 1 shows their characteristics. Forty-one percent of the participants were new to TWC and had participated for less than 6 months (M . 2.9 months; SD . 1.6 months). Fifty-two percent of the participants had been TWC members for 6 months or longer (M . 18.8 months; SD . 10.9 months). In addition to the sample of participants, 53 facilitators who led the groups also answered surveys. Seventy percent were female, with an average age of 52.2 years (SD . 10.6). The facilitators averaged 5.5 (SD . 3.9) years of experience. Nine held PhDs, 23 had master's degrees in psychology, and 21 had master's degrees in social work. Outcome Measures We used a proxy measure, time in the group, to assess outcomes in our cross-sectional design. Outcomes were assessed by two standardized questionnaires.

Table 1

MEASURES:OUTCOMES

Quality of life (Functional Assessment of Cancer Therapy; FACT–G). The FACT–G (Cella, McCain, Peterman, Mo, & Wolen, 1996) is a multidimensional quality of life questionnaire developed for cancer patients. The FACT–G contains five subscales: (a) Physical Well-Being, (b) Social/Family Well-Being, (c) Relationship With Doctor, (d) Emotional Well-Being, and (e) Functional Well-Being. The total score alpha coefficient for this sample was .90, with subscale alphas ranging from .63 to .86. Concurrent validity was demonstrated by Dapueto et al. (2001), and Ferrell, Dow, and Grant (1995) showed construct validity in discriminating known groups of cancer survivors.

The Center for Epidemiological Studies Depression Scale (CES–D). The CES–D (Radloff, 1977) is a 20-item, self-report measure of depressive symptomatology. Respondents rate symptoms in the past week on a 4-point scale of intensity or frequency. A cutoff score of 16 identifies individuals with clinically significant depression, correlates highly with self-report and clinician ratings of depression, and shows good internal consistency (Husaini, Neff, & Stone, 1979). The total score alpha coefficient for the study sample was .92.

Proxy Outcome Variable The first test was how well time spent in the TWC support groups linked to better FACT–G and CES–D scores. A multivariate analysis of variance, testing time in group, resulted in an overall F(3, 284) of 2.97, p . .01. In examining the univariate tests, we found that patients who had spent longer in the TWC groups (over 6 months) had lower scores on the CES–D, F(1, 286) . 4.06, p . .05, and reported less severe physical symptoms, F(1, 286) . 14.99, p . .00; a better relationship with their doctor, F(1, 286) . 6.02, p . . 02; higher well-being, F(1, 286) . 2.91, p . .09; and better functional performance, F(1, 286) . 6.64, p . .01. There was no difference in the quality of social relationships.

To simplify the analysis of norms and outcomes, we subjected the six "outcome" scales (the five FACT–G and one CES–D scores) to a principal-components analysis with varimax rotation. Two factors accounted for 61% of the total variance: Factor I, Well-Being and Good Functioning, loaded greater than .75 positively, and CES–D and Physical Problems loaded negatively. Factor II was defined by Good Social Relationships. Only Factor I was used in the analysis, because Factor II did not show any differences between the two groups based on length of participation.

GROUP NORMS MEASURE. A group norm is an implicit or explicit shared agreement among group members about relevant behaviors, ways of thinking, and modes of affective expression. There is no agreed-on method among investigators of how to assess group norms. A group leader may be able to uncover norms by asking participants what behaviors would be acceptable or unacceptable in the group. Studies reporting on normative behavior in small face-toface groups have used either observational methods (where inferential judgments are made by observers about the group's norms) or individual respondent reports (where participants rate the appropriateness of specific behaviors in the group). Because norms are constructs representing system properties, judgments must be made about how to translate individual responses into group characteristics. This study used the individual respondent strategy. Assessment of group norms was based on a 65-item behavioral inventory that asked both group members and facilitators to judge, on a 4-point scale, the appropriateness of specific behaviors if they occurred in the group. The 65 items used in this study were based on a 48-item inventory developed by Lieberman et al. (1973) in a study of encounter groups. In that study of 171 participants, using a factor analysis, the items reflected five normative dimensions: (a) intensity of emotional expression, (b) boundaries, (c) aggression–confrontation, (d) counterdependence–dependence, and (e) peer control. Bond (1984) used the 48-item measure to examine 505 respondents in drug abuse groups. Lieberman and Bond (1976) expanded the original measure in their study of 1,700 women who were members of consciousness-raising groups by adding 10 items important in self-help groups. Lieberman and Borman (1979) used the expanded measure to study a variety of self-help groups. The behavioral checklist used in the current study was based on these items. Moreover, the same five dimensions that were found in the original study by Lieberman et al. (1973) were used in the current study: intensity of emotional expression (75), boundaries (54),

aggression–confrontation (.81), counterdependence–dependence (71), and peer control (.69).

Measuring normative expectations. In the demographic questionnaire, participants were asked whether they had participated in any other psychological help for their cancer (individual, group, or family psychotherapy or support) prior to or while in their TWC group. A simple yes or no division of the sample based on prior psychotherapy was used to test the influence of prior expectations on participant normative perceptions. Analysis Assessing leader–member fit. Much like an anthropologist would, we asked a number of people—both participants and leaders, from what we defined as a single culture, TWC (not the 54 separate support groups studied)—what behaviors are appropriate in a TWC support group. The culture bearers' (leaders') consensus defined the TWC support group norms. Norms were defined as agreement by 75% of the facilitators, the criteria of agreement used in all of the previous studies described above. This produced three different norm categories: those that were rated as approved in their groups (ratings of 3 or 4), those not approved (ratings of 1 or 2), and those without consensus. Empirically, of the 65 items on our norm measure, leaders reached a very high consensus on 25 (M . 84% agreement, Mdn . 85%, mode . 85%). At the opposite end, 25 items were perceived by the leaders as inappropriate (M . 86%, Mdn . 89%, mode . 91%). Thus, for the 65 items, 50 had very high agreement among the leaders and thus little variation among groups. Consensus was not reached for 15 items; these were dropped from the matching hypothesis.

Table 2 shows the items used in this study and the facilitator consensus on each item. The normative characteristics of the participants were measured by each individual's match to the facilitator's report of norms in their TWC group. The number of matches to the leaders were computed for each participant. A match was a simple binary variable: agree or disagree with the leader. Unregulated norms by the leaders were omitted from the scoring. Thus, the agreement score for a participant ranged from a possible 0 (no agreements with the leader) to 49 (total agreement on the 49 regulated norms; 16 of the original 65 did not reach consensus among the leaders). This score was converted in the analysis to a percentage.

In addition, we used each participant's score on the five normative dimensions, that is, the content of norms. Included in the items assessing normative properties are behaviors that were assumed to be prescriptive (approved behaviors)—important in enhancing the therapeutic work of a small face-to-face group—as well as proscriptive items (disapproved behaviors), which, if they were to occur, could interfere with the development of a functioning personal change setting. The norm dimensions were (a) intensity of emotional expression, (b) boundaries, (c) aggression–confrontation, (d) counter-dependence–dependence, and (e) peer control.

Table 2

Testing the central hypothesis. We predicted that members whose perception of normative regulations closely resembled those of the group leader would show better outcomes. A linear regression with outcomes as the dependent variable was used for this analysis. At Step 1, length of time the patient had participated in the support group was entered; at Step 2, scores based on the match to the leader-defined norms were entered; at Step 3, the five dimensions of norms were entered. Normative expectations. To test this question, we performed a multivariate analysis using the normative dimensions as the dependent variable, with professional help versus no help as the independent variable.

Results Testing the Central Hypothesis We believed that members whose perception of normative regulations closely resembled those of the group leader would show better outcomes. Table 3 shows results of this analysis. After controlling for time spent in the support group, at Step 2, R (.23) reached statistical significance. The greater the member perceptions of the group's norms matched those of the leaders, the better were their outcomes. When the five normative dimensions were added to the equation, R (.33) reached statistical significance. One dimension, aggression, was significant: Participants who saw their groups as approving of aggressive–competitive behaviors were less likely to show positive outcomes. Normative Expectations We hypothesized that participants entering TWC groups with recent experiences of support groups or other types of psychotherapeutic help for their cancer had developed expectations that would influence how they perceived TWC-led support groups. Specifically, they would more closely match the norms of the leaders. Those who had participated in any kind of professional psychosocial intervention associated with their cancer were compared with those who had not. This sample was high in using a variety of professional psychological resources in addition to TWC groups. Overall, 53.5% had turned to professional help settings other than TWC when faced with their cancer. Table 3 shows the findings based on the multivariate analysis.

Table 3

The overall F was significant, F(7, 123) . 1.84, p . .05. The univariate analysis shows that a number of the norm dimensions, as well as participant-perceived norms that match the leaders', contributed to the overall findings. Those who had had recent psychotherapeutic experiences perceived norms more approving of intense emotional expression, and a trend emerged toward more firm boundaries, higher tolerance for aggression, more expression of counterdependence–dependence, and increased peer control.

These participants were more likely to perceive the group-approved norms similar to the leaders (see Table 4).

Table 4

DISCUSSION

We undertook this investigation with the hope of uncovering the relationship between the normative regulation of cancer support groups and participant outcomes. We tested the hypothesis that leader-defined norms set the standard and that participants whose normative perceptions more closely match those of the facilitator will have better outcomes. In addition, we asked whether, above and beyond the match, the content of the norms, based on scores of five normative dimensions, would affect outcomes. This study defined a framework for assessing normative regulations on the basis of consensual agreement of approved and disapproved This strategy was based on our assumption that these highly experienced facilitators' view of TWC groups would reflect well-functioning group norms, which could provide a positive learning environment. This approach to indexing participants' perceptions of normative regulations proved to be a successful strategy. The more that participants' views match those of the facilitator, the greater is the likelihood they will benefit from the group. The results indicate that

the content dimensions did add to the regression equation. Those who perceived their group as encouraging aggressive behaviors showed lower change scores. The facilitators' model of norms that lead to productive groups can be seen in reference to Table 2. One dimension stands out as being encouraged by facilitators, emotional intensity, with the strong expression of sad, affectionate, and humorous feelings being encouraged. In contrast, behaviors in two normative dimensions are discouraged: hostile–judgmental and counterdependence–dependence. The expression of high-intensity anger and competition are also discouraged, as are going against the leader's suggestions as well as almost any type of counterleadership behaviors. Two normative areas were unregulated, showing little consensus. Boundary norms, which ordinarily set rules for membership and appropriate topics of conversation in the group, were not a shared view among the facilitators. Also, behaviors associated with peer control were not consensual among the facilitators. Given the paucity of empirical studies on normative regulation and groups directed toward repair, growth, or change, it is well neigh impossible to determine whether this model of support groups fits a more general setting beyond the current study. In addition to testing the hypothesis, we explored several factors that can influence the specific normative characteristics of a group. We did find that there was a very modest relationship between facilitator behaviors and participant perceived norms. We also found, using an indirect measure of ascribed expectations, that participants differed in their perception of normative regulation on the basis of their prior recent experiences with various forms of psychotherapy.

 A number of cautions must be acknowledged. We are reporting on a cross-sectional study that relied on amount of time in treatment as an experimental variable. The study does not have the power of a follow-up design or, of course, the force of a randomization design. Furthermore, we have chosen to use the consensus of all leaders, rather than each of the groups, as the unit of analysis. This strategy was used to permit sufficient numbers of participants within each analytic unit and to avoid the small numbers that would have resulted if each group had been used. The fact that each facility has a common training and supervision model, as well as the same supervisor, makes this strategy reasonable. Empirically, the degree of consensus is very high among the facilitators. The results of this study generate more unanswered questions than those answered. Foremost is this issue: Are there a basic set of normative regulations that are critical to the successful working of groups directed toward change, repair, or growth? In a very general way, the limited number of studies linking normative dimensions to outcomes do address some fundamental area, even though details of these studies make it difficult to compare one with another. Positive findings were reported by several investigators reviewed at the onset of this article (Bond, 1976, 1984; Bond & Lieberman, 1981; Lieberman, 1990; Lieberman et al., 1973; MacKenzie, 1999). Clearly, on the basis of these studies, which used similar although not identical behavioral items, there is some general overlap in dimensions. However, considerable differences among the normative dimension were found in the three studies, which examined three types of groups. For more detailed analyses of methodological issues, see Bond (1984). There is, unfortunately, no theoretical consensus and even less empirical evidence about the specific areas of normative proscription and prescription. At the extremes of behaviors, agreement could be found among the diverse therapists about antitherapeutic norms.

There appears to be less agreement on prescriptive (valued) norms. In summary, the types of normative regulations, as well as the content of norms, were found to be a factor in how much benefit a participant derived from his or her participation in TWC groups.

Table 1
Sample Demographics N = 289

Age in years (mean, SD)	55.6 (14.2)
Gender: Female %	70%
Employed %	43%
Education: Bachelors Degree %	65%
Marital Status: Married %	56.8%
Professional Support For Cancer: individual psychotherapy couples therapy group therapy support group	30% 5.2% 25.2% 17.4%
Cancer Type % breast prostrate ovarian lung colon mixed	42% 5% 8% 6% 6% 35%

TABLE 2

LEADERS' NORM CONSENSUS

LEADER APPROVED NORN ITEMS

Cried
Said to another member "I like you"
Pleaded for help
Told another member how much they cared for him/her
Hugged another member
Giggled
Warmly touched another member
Frequently joked
Brought up problems he/she had with others who weren't in the group

Argued with another member
Competed for the attention of an attractive man or woman
Persuaded another member to look at things differently
Probed another member who was silent
Said he was not getting anything from being in the group
Suggested that an individual leave the group
Told another member exactly what he thought of him/her
Challenged the facilitator's remarks
Resisted the facilitator's suggestions on procedures
Commented on a conflict between members
Sat alone
Continually showed up late/left early
Met with other members between meetings
Said he/she thought the group should take more responsibility for deciding what activities
Tried to manipulate the group to get her/his own way

LEADER DISAPPROVED NORM ITEMS

Made threatening remarks to other group members
Frankly showed sexual attraction to another person in the group   XXX
Focused his/her comments on what was going on in the group
Flirted
Disclosed information about the group on the outside
Refused to be bound by a group decision
Talked about the details of his/her sex life
Was often absent

Confronted a member who was avoiding problems
Discouraged someone from talking about their cancer
Kept on probing or pushing another member who had said, "I've had enough"
Put down another member who had just "opened up" with own personal feelings
Said another member's behavior was wrong and should be changed
Said that the group wasn't helping him/her
Told the group off, saying that the whole experience was silly and worthless
Wrote another member off, saying he didn't matter
Directed all comments to the facilitator
Interrupted a dialogue going on between two people
Showed he had no intention of changing his behavior
Stated that their problem was worse than anyone else's
Tried to convince people of the rightness of a certain point of view
Started the meeting if the facilitator was late
Dominated the group's discussion for more than one session

NORM ITEMS UNREGULATED; NO LEADER CONSENSUS

Talked a lot without showing his/her real feelings
Kissed another member
Described his/her dreams or private fantasies
Brought a relative to the meeting
Attended one or two meetings and didn't return
Kept bringing in topics from outside the group
Acted indifferently to other members
Asked a question that upset someone
Did not listen to other's suggestions
Shouted with anger at another member
Talked about committing suicide
Told another member he/she was unlikable
Appealed to the facilitator to back him/her up
Tried to take over the leadership of the group
Said little or nothing in most sessions

TABLE 3		
LINEAR REGRESSION; NORMS AND POSITIVE OUTCOMES		
	R	**Change Statistics**

Model	Square	R Square Change	F Change	df1	df2	Sig. F Change
1. TIME IN TWC SUPPORT	0.001	0	0.08	1	266	0.8
2. MATCH LEADER NORMS	0.05	0.05	14.2	1	265	> 0.01
3. NORM DIMENSIONS	0.08	0.07	3.2	5	260	0.01

	B	SE B	Stand. Beta	t	Sig
STEP 1					
TIME IN TWC	0	.004	-0.02	-0.28	NS
STEP 2					
TIME IN TWC	0	.038	-0.038	-0.637	NS
MATCH LEADER NORMS	.319	.085	0.226	3.761	> 0.01
STEP 3					
TIME TWC	0	.004	-0.02	-0.37	NS
MATCH LEADER NORMS	.783	.162	0.55	4.82	> 0.01
INTENSITY	-.44	.211	-0.19	-2.08	0.04
BOUNDARY	0	.199	0.001	0.01	NS
AGGRESSION	-.81	.329	-0.26	-2.46	0.02
DEPENDENCY/COUNTER DEPENDENCY	.304	.227	0.13	1.34	NS
PEER CONTROL	-.334	.241	-0.13	-1.39	NS

Table 4

Analysis of Variance of Norm Dimensions on Expectations based on previous Professional Psychotherapy

	df = 7,123			
Norm Dimension	Professional Therapy		F	P
	Yes	No		
Intensity				
Mn.	2.6	2.5	8.5	> .001
SD	.40	.43		
Boundary				
Mn.	2.0	1.9	3.6	> .05
SD	.39	.39		
Aggression				
Mn.	1.9	1.9	3.5	NS
SE	.32	.32		
Dependency/Counter				
Mn.	2.2	2.1	3.7	> .05
SD	.43	.43		
Peer Control				
Mn.	1.9	1.8	3.3	>.01
SD	.36	.41		
Agreement with Leader				
Mn.	2.1	1.9	4.2	> .05
SD	2.6	2.4		

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