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REVIEW

Psycho-Oncological Support Group Meetings for Patients and Caregivers During Radiotherapy in Head and Neck Cancer: A Narrative Review

Anushiya K[1], Gautam Vydia Vedagiri[1], Mukesh B[1], Surendran Veeraiah[2]

[1]Department of Radiation Oncology, Cancer Institute (WIA), Adyar, Chennai, India. [2]Department of Pyscho-oncology, Cancer Institute(WIA), Adyar, Chennai, India.

Abstract

Head and neck cancer (HNC) is one of the most psychologically disruptive cancer diagnoses because both the disease and its treatment directly affect speech, swallowing, eating, breathing, appearance, and social identity. Radiotherapy, often delivered daily over 6 to 7 weeks with or without concurrent chemotherapy, is accompanied by cumulative toxicities such as mucositis, odynophagia, xerostomia, dysphagia, weight loss, fatigue, and mask-related anxiety. These stressors amplify distress, depressive symptoms, caregiver burden, and social withdrawal, particularly in patients treated in high-volume radiotherapy units. This narrative review examines why psycho-oncological support group meetings are relevant during radiotherapy for HNC, with special emphasis on Indian institutional practice. The available literature shows strong evidence for high psychosocial burden during radiotherapy and growing evidence that structured psychosocial interventions, multidisciplinary supportive care, and repeated educational-contact models improve selected outcomes. Direct evidence for formal support groups during active radiotherapy remains smaller than the broader psycho-oncology literature, but patient-preference studies, implementation work, and supportive-care trials all suggest that group meetings can be a practical, low-cost, and scalable intervention. In Indian radiotherapy departments, where patient volumes are high and dedicated psycho-oncology staffing may be limited, a weekly support-group model aligned with on-treatment review visits may improve emotional support, symptom coping, caregiver engagement, and treatment continuity. The evidence supports integrating such meetings into multidisciplinary head and neck radiotherapy pathways rather than viewing them as optional add-ons.

Keywords: head and neck cancer- radiotherapy- psycho-oncology- distress- support groups- caregiver burden

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Introduction

Head and neck cancers impose a major clinical and social burden in India, where tobacco smoking, smokeless tobacco use, areca nut exposure, poor oral health, delayed presentation, and financial constraints continue to shape the treatment pathway [1, 2].

From a psycho-oncology perspective, HNC differs from many other solid tumours because the disease itself and the treatments used to control it threaten functions that patients use every day to define normal life: speech, swallowing, taste, breathing, facial expression, and participation in family and work roles [3-6]. The radiotherapy phase is especially demanding. Patients attend daily for several weeks, often travel long distances, frequently require caregiver accompaniment, and accumulate toxicities that worsen over time rather than immediately improving. During this phase, emotional distress is not a vague background symptom; it is tightly linked to pain, sleep disturbance, nutritional decline, fear of treatment, shame related to appearance or feeding difficulties, and anxiety about completing therapy [7-12].

International supportive-care guidance now treats distress as a core oncologic problem rather than a

Corresponding Author:
Dr. Gautam Vydia Vedagiri
Department of Radiation Oncology, Cancer Institute (WIA), Adyar, Chennai, India.
Email: gautam.gv71@gmail.com

peripheral issue. NCCN guidance recommends systematic distress screening across the cancer journey, and head-and-neck-specific guidance from Europe and the United Kingdom explicitly includes counseling, emotional support, psycho-oncology referral, and support-group access within good multidisciplinary care [3-5, 13]. Yet in daily practice, especially in resource-constrained or high-volume units, psychosocial intervention may still be reactive. Support often begins only when a patient has already stopped eating properly, started missing appointments, or become visibly withdrawn.

This review argues that psycho-oncological support group meetings deserve greater attention during radiotherapy for HNC. The concept is simple: regular, structured group sessions facilitated by a trained clinician or allied health professional, timed to treatment weeks, and focused on emotional normalization, practical symptom coping, rehabilitation messages, and caregiver engagement. The goal is not to replace individual psycho-oncology services or psychiatric care. Instead, support-group meetings can serve as a scalable layer of psychosocial care that fits naturally within multidisciplinary radiation oncology practice, especially in Indian institutions where staffing and time are limited but need is high.

Why Head and Neck Radiotherapy Generates Exceptional Psychosocial Strain

The psychosocial experience of HNC is qualitatively different from that of many cancers because functional impairment is visible, socially consequential, and often immediate. A person with oral cavity, oropharyngeal, hypopharyngeal, laryngeal, or nasopharyngeal cancer may lose ease of speech, struggle to swallow in public, rely on texture-modified foods or tube feeding, develop halitosis, or perceive marked changes in facial image. These are not merely symptom scores; they alter how patients interact with relatives, strangers, coworkers, and caregivers [4-6, 11, 12]. Radiotherapy intensifies these burdens. Rose and Yates showed that quality of life falls during radiation treatment for head and neck malignancies, and Kelly and colleagues demonstrated worsening quality of life and increasing depressive symptoms as treatment progressed [11, 12].

Prospective work has repeatedly linked treatment-week symptom escalation to distress. Pain, ulcers, odynophagia, thick secretions, taste loss, sleep disruption, and fatigue do not occur in isolation; they cluster and create a sense of progressive loss of control [7-9, 12, 14, 15]. This matters because psychological distress during RT is not just an emotional state. It can influence adherence to swallowing exercises, oral care, clinic attendance, nutritional intake, and willingness to disclose symptoms promptly. Another important contributor is the immobilization experience. Thermoplastic mask fixation is routine and technically essential, but for a subset of patients it becomes a distinct source of anxiety or claustrophobic distress. Adeberg and colleagues found both feasibility and need for pre-radiotherapy psycho-oncological screening and support in patients facing mask fixation for head-and-neck or brain malignancies [16].

In practical terms, even patients who complete treatment may carry anticipatory dread into each session. Group discussion can be useful here because peers often articulate coping strategies in plain, credible language: how to signal discomfort, how to pace breathing, what to expect from staff, and how anxiety changes after the first week.

Long-term studies show that the psychological imprint of HNC can persist far beyond acute treatment. Bjordal and Kaasa described enduring distress years after curative treatment, while Katz and colleagues highlighted the roles of disfigurement, gender, and social support in psychosocial adjustment [17, 18]. These findings reinforce a key point: radiotherapy is not just a technical episode within a cancer journey; it is a psychologically formative phase that may shape adjustment long after the last fraction. Early group support during RT therefore has a preventive as well as a supportive rationale.

Distress, Anxiety, Depression, and Caregiver Burden During Treatment

The prevalence of distress in patients receiving head-and-neck radiotherapy is high enough that selective referral based only on clinical intuition is inadequate. The systematic review by Nayak and colleagues concluded that HNC patients are psychosocially distressed during radiotherapy and that distress rises steadily through treatment [7].

Older Indian work similarly demonstrated overlap between distress, anxiety, and depression in head-and-neck cancer, and later distress-thermometer studies in patients undergoing RT confirmed that symptom burden and emotional morbidity move together [8, 19]. More recent observational evidence continues the same message. Tang and colleagues reported anxiety in more than half of patients undergoing radiotherapy and depression in roughly one-third, while simultaneously showing major psychological impact on family caregivers [9]. This caregiver dimension is crucial and especially relevant in India. Family members usually do far more than offer emotional companionship. They organize travel, lodging, food preparation, finances, communication with clinicians, and at times basic treatment adherence. Badr and colleagues tracked patient-caregiver dyads during radiotherapy and found that distress increased over the course of treatment, peaking around later treatment weeks; patient and caregiver distress influenced one another [8]. Kudrick and colleagues later demonstrated that caregiver burden in HNC survivorship is common and shaped by both patient- and caregiver-level factors [10]. Ross and colleagues showed that caregivers themselves have significant adjustment and informational needs [20]. In everyday departmental practice, when the caregiver is exhausted or frightened, the patient's treatment experience becomes harder. The emotional burden also begins before the first fraction. Al-Salool and colleagues found that more than 60% of patients scheduled for radiotherapy or chemoradiation for HNC reported emotional distress even before treatment started [21]. That pretreatment burden

has practical implications. If support is delayed until severe mucositis or weight loss has already occurred, intervention misses the chance to establish trust, coping routines, and realistic expectation-setting early. This is one of the strongest arguments for beginning a support-group program in week 1 rather than waiting until a crisis appears.

What Does the Intervention Literature Actually Show

The intervention evidence in HNC is heterogeneous, but it is not empty. The 2013 Cochrane review by Semple and colleagues found no convincing evidence that psychosocial interventions improved global quality of life at the end of intervention, reflecting small trials and methodological heterogeneity rather than irrelevance of psychosocial care [22]. That review remains important because it reminds us to be precise: the evidence base is broader for distress reduction, coping, selected functional or emotional domains, and service feasibility than for a single universal outcome such as global HRQoL. Several controlled studies have shown more encouraging signals. Van der Meulen and colleagues reported that a nurse-led psychosocial intervention reduced depressive symptoms at one year, and later demonstrated longer-term health-related quality-of-life benefits in a randomized trial [23, 24]. These findings matter for support-group design because they suggest that repeated, relational, nonpharmacologic contact delivered by trained oncology staff can improve outcomes even without highly specialized psychotherapy at every encounter. Humphris and Ozakinci's AFTER intervention, designed to address fear of recurrence, is another example showing that structured psychological content can be tailored to a head-and-neck population [25]. More recent work moves closer to the radiotherapy period itself. Adeberg and colleagues showed feasibility for psycho-oncologic screening and support before radiotherapy with mask fixation [16]. Sinha and colleagues, in an Indian randomized controlled trial, evaluated psycho-oncology/supportive-care referral in head-and-neck cancer patients undergoing radiation therapy. The study is particularly relevant because it was performed in the same broad clinical environment in which many Indian departments function. It underscores both the need for psychosocial support and the challenge of obtaining large, durable differences through referral pathways alone [14]. By contrast, Nayak and colleagues reported that a comprehensive intervention programme improved quality of life, fatigue, self-efficacy, and psychosocial distress among HNC patients receiving radiotherapy [15]. The programme was multicomponent and repeated, which is instructive: interventions that are sustained, practical, and woven into care seem more promising than isolated one-time contacts. The strongest recent supportive-care signal comes from the multidisciplinary team trial by Pei and colleagues, which showed that comprehensive nutritional, psychological, and rehabilitation support during radiotherapy reduced treatment interruptions and improved patient-centered outcomes [26]. Although not a pure support-group trial, it provides high-value evidence for the central premise of this review: psychosocial and supportive care during RT can change clinically important outcomes, including treatment continuity. For radiation oncologists, that is a compelling justification for building psychosocial structures into departmental workflow (Table 1).

Where Support Groups Fit Within Psycho-Oncologic Care

The term "support group" can mean very different things, from informal peer meetings to professionally facilitated psychoeducational sessions. For HNC radiotherapy, the most useful model is neither purely social nor purely psychotherapeutic. It is a structured, clinically connected, facilitated group that addresses both emotional and practical challenges of treatment [3-5, 27, 28]. Such groups can do at least five things that standard one-to-one consultations often struggle

Table 1. Selected Studies Informing Psycho-oncological Support During Head and Neck Radiotherapy

Study	Design / setting	Intervention or focus	Main relevance to this review
Badr et al [8]	Prospective dyadic study during RT	Weekly distress tracking in patients and caregivers	Distress rose over treatment and patient-caregiver distress was i nterlinked.
van der Meulen et al [13, 14]	Randomized controlled trials	Nurse-led psychosocial intervention	Repeated psychosocial contact improved depressive symptoms and later HRQoL domains.
Adeberg et al [16]	Feasibility study before RT	Screening and psycho-oncologic support for mask fixation	Shows need for proactive support before and during RT setup.
Sinha et al [18]	Indian randomized trial	Psycho-oncology/supportive-care referral during RT	Directly relevant to Indian RT workflow and distress management.
Nayak et al [19]	Single-centre interventional study	Comprehensive intervention programme during RT	Improved QOL, fatigue, self-efficacy, and psychosocial distress.
Pei et al [20]	Randomized clinical trial	Multidisciplinary supportive care during RT	Reduced interruptions and improved patient-centered outcomes.
Charters et al [21]	Cross-sectional survey	Support-group preferences in HNC survivors/caregivers	Most interested patients preferred face-to-face groups; desired topics included nutrition, emotional wellbeing, and swallowing.

Table 2. Practical Weekly Support-group Schedule for Indian Radiotherapy Departments

Treatment week	Suggested theme	Key outputs
Week 1	Orientation, distress screening, mask anxiety	Normalize fears, explain RT process, identify high-risk patients early.
Week 2	Mucositis, oral care, hydration, pain	Prevent avoidable suffering, reinforce symptom reporting.
Week 3	Nutrition, weight monitoring, swallowing exercises	Support intake and rehabilitation; involve caregivers.
Week 4	Fatigue, sleep, mood, social withdrawal	Offer coping strategies and triage for escalating distress.
Week 5	Caregiver burden and adherence near treatment end	Address burnout, transport, feeding support, and missed-fraction risk.
Week 6 / completion	Recovery expectations and follow-up planning	Prepare patients for post-RT recovery and ongoing support needs.

to achieve on their own. First, they normalize distress. Patients who are frightened by weight loss, thick saliva, feeding tubes, inability to eat socially, or fear of the mask often feel less isolated when they hear that others on treatment are experiencing the same problems. Second, they promote realistic coping by allowing peer exchange of what actually helps from one treatment week to the next. Third, they reinforce rehabilitation messages from nutrition, speech-and-swallow, and nursing teams. Fourth, they create a low-threshold route for caregivers to ask questions they may hesitate to raise during brief physician encounters. Fifth, they offer a system for early identification of patients who need escalation to individual psycho-oncology, psychiatry, pain, palliative care, or social work services [4-5, 16, 20, 26, 27].

Interest in this model is not hypothetical. Charters and colleagues found that 51.5% of surveyed HNC respondents wanted to be involved in a support group and another 25.2% were unsure; most preferred a face-to-face format, and the most desired topics included nutrition, emotional wellbeing, and swallowing. Awareness of available groups was poor [27]. Sharman and colleagues later showed that the availability of HNC support groups remains uneven and that rural or non-metropolitan access is particularly limited [29] Zhou and colleagues, examining current support-group practice in Australia, identified practical gaps in facilitator training, resources, and implementation [30]. These studies do not directly prove that support groups improve survival or distress scores during RT, but they strongly support feasibility, patient interest, and the need for more structured implementation.

The wider psycho-oncology literature also suggests why group-based formats may be efficient in HNC. The burden is shared across recurring themes: nutrition, social eating, communication, fatigue, body image, return to work, and uncertainty. Group meetings allow these common concerns to be addressed once but heard by many, while still preserving opportunities to triage specific needs. In a setting with limited psychology staff, this is an advantage rather than a compromise.

Why this Matters Especially in Indian Radiotherapy Departments

Indian radiotherapy units often function under constraints that make scalable supportive-care models especially valuable. Daily patient volumes are high, waiting areas are crowded, consultation time is limited, and many patients travel considerable distances or temporarily relocate for treatment. Dedicated psycho-oncology teams are not universally available, and when present they may already be stretched by referrals from multiple disease sites. At the same time, HNC case volumes are high, social vulnerability is common, and financial toxicity affects treatment resilience [1, 2, 14, 15]. These realities make a strong case for support-group meetings that are brief, structured, and synchronized with routine care. A weekly model linked to the on-treatment review clinic, nursing review area, speech-and-swallow visit, or dietetics consultation may be more practical than separate appointments requiring extra travel or time away from work. The group does not need elaborate infrastructure. A small room, a fixed weekly schedule, and a facilitator who follows a simple agenda can be enough to start. In many departments, caregivers accompany patients through most of the treatment course, assist with communication, and participate in decision-making about feeding support, symptom reporting, and even whether the patient continues daily attendance. Group meetings that welcome caregivers can therefore strengthen the entire treatment ecosystem. They can cover issues that are frequently misunderstood at home: why oral intake must be preserved if possible, how to monitor weight and hydration, what symptoms require urgent review, why swallowing practice matters even when tube feeding is used, how to support a patient with irritability or low mood, and when distress requires more than reassurance. [8-10, 15, 20, 26]

Another major benefit is destigmatization. In some settings, referral to a psychologist or psychiatrist may still be perceived as meaning that the patient is “not mentally strong,” whereas attending a treatment-support group feels like a normal part of cancer care. Group meetings can therefore lower the threshold for engagement and create a bridge to formal psycho-oncologic referral when needed. This is especially important for men with tobacco-

related cancers, who may otherwise underreport emotional suffering despite visible functional decline.

A Practical Model for Weekly Support-Group Meetings During Radiotherapy

For support groups to be clinically useful during RT, they should be deliberate rather than ad hoc. A workable model for many Indian institutions is one brief session per week, 30 to 45 minutes, ideally scheduled before or after on-treatment review. A radiation oncologist need not lead every session; oncology nurses, speech-language pathologists, dietitians, palliative-care clinicians, psycho-oncology staff, or trained residents can rotate facilitation. The core principles are consistency, brevity, practical relevance, and clear escalation pathways. Week 1 should focus on orientation and expectation-setting: what the treatment course usually feels like, common emotional reactions, how the mask and machine experience changes after the first few sessions, and whom to contact for urgent issues. Week 2 can focus on oral care, pain, mucositis, and eating strategies. Week 3 can emphasize swallowing preservation, communication changes, and ways to prevent social withdrawal. Week 4 is well suited to fatigue, sleep, and low mood. Week 5 can address caregiver burden, feeding support, and maintaining adherence near the end of treatment when symptom burden is greatest. A final session near completion can focus on recovery expectations, common misconceptions about "getting better immediately," and the importance of continuing supportive follow-up (Table 2) [11, 12, 14-16, 22-24, 26-28].

The group should also incorporate a simple triage function. Patients who express marked hopelessness, inability to attend treatment, severe insomnia, panic related to mask fixation, unsafe weight loss, caregiver collapse, or suicidal ideation should be referred promptly for individualized review. In that sense, support groups are not a substitute for professional psycho-oncology; they are a structured front door to it. Because departments differ in resources, hybrid models may be useful. In centres where repeated face-to-face meetings are difficult, a core in-person session can be supplemented by printed checklists, tele-support for patients and caregivers who cannot remain on site. The intervention can remain simple and still be meaningful, provided it is predictable, clinically anchored, and repeated.

Limitations of the Evidence

Any recommendation for support-group meetings during active radiotherapy must acknowledge the limitations of the current evidence base. First, formal group-based interventions are fewer than broader psychosocial or multidisciplinary supportive-care studies, so the argument rests partly on indirect evidence. Second, the studies vary widely in timing, content, facilitator expertise, outcome measures, and follow-up duration. Third, not all patients will want group participation; some prefer one-to-one support, and some are too unwell or geographically constrained to attend. Fourth, support-group research is vulnerable to selection bias because patients who attend may be more motivated or more socially open than those who decline [14, 15, 22, 26, 27, 29, 30].

In Indian institutional radiotherapy settings, support-group meetings are especially relevant because they are practical, low-cost, and scalable. When linked to routine weekly reviews and integrated with nursing, nutrition, speech-and-swallow, palliative-care, and psycho-oncology pathways, they can transform psychosocial care from a reactive referral model into a visible and continuous part of treatment. The present evidence does not justify exaggerated claims, but it does justify action: well-designed support groups should be treated as a serious component of supportive radiotherapy practice in HNC, and future Indian studies should test them prospectively using outcomes such as distress, treatment completion, nutritional decline, caregiver burden, and patient-reported quality of life.

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Statement of Transparency and Principles

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• The study was approved by the Research Ethics Committee of the authors' affiliated institution.

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