

How Do You Feel About Cancer Now? —Survival and Psychosocial Support

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This study by Evans and Connis (*Comparison of Brief Group Therapies for Depressed Cancer Patients*, page 306) compares two types of group psychotherapy for depressed cancer patients who are also receiving radiation therapy. It contributes to a growing literature indicating that group psychotherapy is effective in helping cancer patients better cope with their disease. As the authors note, a number of studies have shown that group psychotherapy can help reduce anxiety and depression, decrease pain, and may even influence survival time (1).

The Evans and Connis study is a second generation study in that it does not really address the question, "Does group psychotherapy work?" Rather, it provides a randomized comparison of two types of group therapy—one focusing on cognition and the other on social support and affective expression. This kind of systematic exploration of the types of intervention that are most effective is much needed in the field now. There is sufficient evidence that such treatments work. By itself that is no longer an interesting question. How they work is the next question. The authors call for process analysis, which would be helpful as well, but systematic comparison of different types of intervention is a useful contribution.

The authors found that the support group method was more effective than cognitive behavioral treatment, although both were superior to the findings in the control group. In particular, it was only the social support group participants who showed significantly improved scores on somatization and depression, as well as global severity of distress, on the SCL-90-R. The authors speculate that the reason for this differential effectiveness was some possible stress induced by the cognitive behavioral method. Although this is possible, it may well be that emotional expression, a major component of the social support intervention employed by the authors, has a powerful and positive therapeutic effect.

There is a literature suggesting that cancer patients are, if anything, rather emotionally suppressive (2–3) and that cancer patients who give vent to feelings do better medically (4). Whether or not cancer patients differ from others in this regard, there is reason to believe that the ability to express strong feelings in a supportive group setting would have positive therapeutic benefit. Expression of emotion has the potential to facilitate a shift from emotion-focused coping, in which the patient is simply trying to manage intense and unpleasant affect, to problem-focused coping, in which the discomfort is acknowledged but can lead to various means of addressing or even resolving some of the causes of the negative emotion.

In our psychosocial treatment laboratory, we have obtained recent evidence that attempts to suppress emotion are counterproductive. Metastatic breast cancer patients who rated themselves as high in emotional suppression on the Courtauld Emotional Control Scale (5) turned out to have higher total mood disturbance scores on the Profile of Mood States (6) than those who were low in affect suppression. In other words, suppression of adverse affect does not work. It seems to increase, rather than reduce, dysphoria. The patient who suffers constant intrusion of her fear of death may be relieved by the opportunity to discuss that fear with others in a similar situation. As one support group member commented, "The world hasn't changed, but I feel less alone with my feelings about it."

It is indeed interesting that similar results were obtained in a study of cognitive behavioral versus supportive expressive group therapy for HIV infected individuals (7). In that study also, both interventions were helpful, but there was advantage for the supportive intervention. The fact that similar results are found in the treatment of two different groups of medically ill people suggests that the finding is a valid and robust one.

Indeed, a sense of isolation, especially with uncomfortable affect, may compound disease-related anxiety and depression. Any cancer patient naturally fears death, even though many are cured of the disease. But, one way in which we conceptualize death is isolation (8). Death is the ultimate aloneness: removal from loved ones. Anything that makes

people feel alone, removed from the flow of life, is bound to exacerbate death anxiety. Therefore, having a setting in which one can express strong emotion and feel understood and supported will have the natural tendency to reduce the sense of isolation and the associated death anxiety.

There is evidence that married cancer patients live longer than unmarried cancer patients (9), suggesting an important role for social support in the medical management of cancer. Indeed social isolation increases the risk of all-cause mortality to a similar degree that smoking and high serum cholesterol elevate mortality risk (10).

Loss of control is another theme intertwined with fears about dying and death. As the authors note correctly, perceived loss of control is a critical issue for cancer patients. There is indeed evidence that patients who participate in decision making about their treatment are better adjusted, subsequently, regardless of the treatment decision. For example, Fallowfield and colleagues (11) found that, if anything, lumpectomy patients did somewhat worse emotionally than mastectomy patients, rather a surprising finding. This may have been due to the observation that lumpectomy patients got somewhat less emotional support from their husbands than those who had received a mastectomy. However, patients who felt they had participated in the decision about which treatment to receive did better, regardless of the treatment choice. Thus, active patient participation in treatment decisions is a good way to improve emotional outcome.

The extent of distress experienced by many cancer patients is illustrated by the fact that 78 of 95 stage-two cancer patients screened for involvement in this study met cutoff criteria for clinically significant depression on the CES-D. This is quite a high proportion, indicating that depression is the rule and not the exception with such patients. Depression is frequently under diagnosed in cancer patients (12) because of misattribution of depressive symptoms to the disease itself (13). Sadness is attributed to poor prognosis, anxiety to fears about disease progression, sleep disturbance to physical discomfort, poor appetite to chemotherapy side effects. Yet, depression is a common and treatable problem among the medically ill (14), and overlooking it or misattributing it deprives us of opportunities for substantially improving cancer patients' quality of life.

One other area of interest in this study is the fact that the majority of the sample were men. Many of the psychotherapy intervention studies have been conducted with women who have breast cancer, leaving the question of whether or not men would

respond as well. The positive results in this study seem to provide a clear answer to that question—they do. Although men initially may be somewhat more reticent to enter support groups, they may benefit even more than women from them because they have fewer other opportunities for the kind of supportive and emotionally expressive interaction that occurs in these groups.

The kind of positive result reported in this and a number of other studies raises an important policy question as well. Since such treatments are so effective, why are they not more widely employed? Modern medicine has become so focused on cure that it seems to minimize the importance of care. Certainly cure is a high priority when it is possible, but it is the responsibility of the health care system to help people cope with progressive illness even when it is not curable. The stress of such disease is substantial, as the high proportion of patients with depression in this study and others (15) indicates. The oldest adage of medicine is that our task is to 'cure rarely, to relieve suffering often, and to comfort always.' In this century we seem to have inverted this job description, acting as though our job were to 'cure always, relieve suffering if there is time, and let someone else do the comforting.' In the structure of the current health care system, procedures are overvalued and sometimes overapplied, and supportive interventions are undervalued and underutilized.

This not only deprives patients of help from which they can benefit substantially but may actually make the health care system less efficient. A study by Browne and colleagues (16) in Canada showed that the most poorly adjusted patients cost the health care system (a far more fiscally efficient one than ours) 75 percent more to care for than well-adjusted patients with the same illnesses, largely through more visits to specialists, laboratory tests, and days spent in the hospital. Indeed, a meta analysis of 68 studies demonstrated an average reduction of a day and a half of hospitalization when medically ill patients received psychiatric consultation (17). This finding has recently been confirmed in a randomized study of psychiatric consultation for elderly hip fracture patients (18).

There is no doubt that physicians, nurses, social workers, and other health care providers are themselves burdened by myriad responsibilities, not the least of which is the growing burden of paper work that, along with insurance and management costs, soaks up 31 percent of the health care dollar in the United States. But, techniques like the ones demonstrated in this study can help health care providers do their jobs better. There is no reason why we cannot

develop methodology for psychosocial support with the same precision that we develop and test methods for radiotherapy, chemotherapy, hormonal treatments, and surgery.

Systematic assessment of outcome and methods is an appropriate standard for the development of medical practice, and it should apply equally to psychosocial as well as biotechnological intervention. Data like that seen in this paper can serve as basis for the rational development of our concept of medical treatment to include systematic intervention for the psychosocial as well as biomedical aspects of illness. Much more research needs to be done, but there is sufficient evidence of efficacy to suggest that we should devote resources to the application of this new knowledge and the routine treatment of cancer patients and others with life-threatening illness.

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Residency Training in Community Health Centers —An Unfulfilled Opportunity

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In 1969, I was invited by Dr. Harold Wise to become the first Social Medicine Resident at the

Martin Luther King, Jr. Neighborhood Health Center in the South Bronx, NY, affiliated with Montefiore Hospital and Medical Center. The purpose was to train community-responsive physicians as members of health care teams that already included nurse practitioners and family health workers from the local neighborhood.

The Residency Program in Social Medicine has continued since that time, producing substantial numbers of residents, including significant numbers of minorities, who are now in inner city generalist practices. There are similar examples in other organizations and settings, both rural and urban, State and