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Newsletter of the Health Psychology Section
of the Canadian Psychological Association
Bulletin de la Section de psychologie de la santé
de la Société canadienne de psychologie

Some recent events offer new opportunities for health psychologists. I refer, in particular, to the decision of the Medical Research Council to accept the report of their Health Research Task Force. This Task Force was established in 1993 to make recommendations on how the MRC could best fulfil its legislative role in promoting applied health research. The acceptance of this report means that from now on applied health researchers can seek support from the MRC. Health psychology researchers should now be considering the opportunities this offers.

However, we should also be aware of the obstacles involved in obtaining funding and consider how best to overcome these. In a recent commentary published in the *Canadian Medical Association Journal* Nicholas Burkitt, an epidemiologist from the University of Ottawa, raised some concerns about the current review process for applied health research. He estimated that 70% to 95% of all applications to agencies that provide funding for applied health research are rejected. This is a rather demoralising figure for new researchers. Burkitt suggests a variety of factors contribute to this high rate of rejection including the 'guilty until proven innocent' stance of the review committees, and the dynamics of review committees in which members, especially new ones, compete with each other to find flaws.

In a new field such as health psychology where there is an urgent need for researchers to gain access to research funding there is an additional problem. There is a danger of health psychologists in applying to a new agency of being squeezed between the competing demands of more influential disciplines such as epidemiology and nursing. In this situation there is an urgent need for health psychologists to support one another, not to view each other as competitors but as colleagues.

This issue of the newsletter includes our annual listing of published research and a supplement on psycho-oncology. Both of these demonstrate the growing influence of health psychology. The task now is to build upon this base and to strengthen the discipline as a whole. Members are urged to attend the Annual Meeting at this year's CPA conference to discuss the opportunities. If they cannot attend they should write me with their ideas. In the meantime, have a good summer. The next issue should be distributed in the fall.

Quelques événements récents offrent de nouvelles occasions pour les psychologues de la santé au Canada. Je réfère, en particulier, à la décision du Conseil de recherches médicales d'accepter le rapport de leur groupe de travail, sur la recherche en santé. Ce groupe, établi en 1993, est chargé de recommander au CRM, des orientations pour la recherche en santé ainsi qu'à conseiller sur la façon, dont la loi lui est conféré. Le fait que ce rapport soit accepté, signifie que les chercheurs en santé peuvent dépendre du soutien du CRM. Ceci ouvre de nouvelles portes pour les chercheurs en psychologie de la santé.

Cependant, il faut être conscient des obstacles à surmonter pour obtenir ces ressources. Dans un commentaire récemment publié dans le *Canadian Medical Association Journal*, Nicholas Burkitt, un épidémiologue de l'Université d'Ottawa, a soulevé quelques points sur la méthode d'évaluation de la recherche en santé. Il soutient que 70% à 95% des applications soumises aux sources des fonds pour recherches en santé, sont rejetées. Ceci peut être démoralisant pour les néo-rechercheurs. Burkitt suggère que ces hauts taux de réjection sont probablement dus à une attitude négative présente par les comités qui promouvent une "compétition" pour trouver les fautes, en particulier chez les nouveaux membres.

Dans un nouveau domaine comme la psychologie de la santé, souvent il est difficile d'accéder aux ressources financières pour la recherche. Un danger existe que ce domaine soit soumis à de forte compétition au près de tel disciplines avec plus d'influence comme l'épidémiologie ou la médecine. Dans une situation comme tel, il est primordial que les psychologues de la santé se soutiennent entre eux, se voient non comme compétiteurs mais comme collègues.

Inclut dans ce numéro de bulletin sont les listes des recherches publiées ainsi qu'une section spéciale sur la psycho-oncologie. Ceux-ci démontrent l'influence émergente de la psychologie de la santé. La tâche qui suit consiste maintenant à bâtir de cette base et de renforcer la discipline. Les membres sont conseillés d'assister à l'assemblée générale suite au congrès de la SCP, pour discuter les opportunités ou m'écrire avec leurs idées, s'il y est impossible de s'y rendre. Pour conclure, je vous informe que le prochain numéro sera disponible à l'automne et je vous souhaite un bel et bon été.

Treatment for Irritable Bowel Syndrome: A Case Study Using Multi-Component Treatment Approach

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and

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Abstract: *The effect of a multi-component behavioral treatment was investigated in a patient with chronic irritable-bowel syndrome (IBS). A single subject experimental design was used. A t-test comparing pre and post repeated measures on self-report, behavioral and physiological measures indicated a clinically and statistically significant improvement. One year follow-up (post treatment) showed a maintained improvement. This suggests that a multifaceted behavioral programme may be necessary to obtain total treatment success with IBS.*

Résumé: *L'effet à multiples composantes d'un comportement fut examiné dans une patiente avec le syndrome d'intestines irritable. Un teste de t fut utilisé pour comparer les mesures avant et après le traitement. Les résultats ont démontré une amélioration considérable au point de vue statistique et clinique. Les résultats semblent donc indiquer qu'un programme de comportement à facteurs multiples est probablement nécessaire pour obtenir une rémission totale chez les personnes affectées par le syndrome des intestines irritable.*

Irritable bowel syndrome (IBS) is a prevalent functional gastrointestinal disorder which is estimated to affect 8 to 14% of healthy adults in a given year. The disorder is typically defined as a disturbed state of intestinal motility, accompanied by bowel disturbance (diarrhoea/or constipation) and abdominal pain for which no organic cause can be found (Blanchard, Schwartz, Radnitz, 1987). The symptoms are typically reported to be chronic and it is rare to find individuals

reporting remission of symptoms.

Latimer, Sarna, Campbell, Waterfall & Daniel (1981) found no differences between IBS sufferers and a psychoneurotic control group without gastrointestinal complaint on measures of colonic motility. Thus it appears that the symptoms observed in IBS may not be attributable solely to colonic disturbance. Latimer et al. (1981) suggested that when compared to normal controls IBS sufferers showed quantitative changes in abdominal pain, change in bowel habits, medication taking, restricted activity, and colonic motility.

Until recently treatment of this disorder has been primarily medical with drugs and diet therapy, both of which provide minimal relief from gastrointestinal symptoms. In recent years behavioral treatment strategies have increased with promising results (Garrick, 1981; Svedlund, Sjodin, Ottosson & Dotevall, 1983; Bennett & Wilkinson, 1985). Treatment incorporating psychological and physical components appear to have been most effective.

The present case study demonstrates the use of a multi-component treatment approach.

Case study

AB was a 27 year old married female with a diagnosis of Irritable Bowel Syndrome. This was a chronic condition and the frequency of her bowel movement increased whenever she had to travel in a car with another person or a relative. AB's initial symptoms were marked by frequent bowel movement six to seven times in two hours during periods of stress. These have been recurrent for the previous six years. On several occasions while driving on the busy highway, she has had to go through embarrassing situation of stopping her car on the roadside to "visit a bush".

She had several years of unsuccessful medical treatment with various anti-anxiety medication. At the time of assessment she was dependent on Alprazolam 0.25mg.

Behavioural analysis

Her problem was conceptualized as involving psychosomatic symptoms resulting from general anxiety. Treatment was geared towards reducing anxiety through educational information and relaxation skills training as well as helping her to cope with stress and improve her sense of control.

The ABA design was employed. The target behaviour was assessed regularly on a daily basis through self-monitoring. A one year post treatment follow-up was also carried out.

Treatment Outline

The treatment program comprised of progressive relaxation, thermal biofeedback, training in cognitive coping strategies, and the provision of educational information. Treatment consisted of ten one-hour sessions spread over seven weeks. The patient was given information regarding

normal gastrointestinal functioning and the disturbance of irritable bowel syndrome. This was provided in order to correct any misconceptions about gastrointestinal functioning and to help define what was reasonable to expect following therapy.

Progressive relaxation therapy (PRT) was introduced. During therapy, the patient was taught to reduce gradually the number of muscle groups used in PRT, from sixteen to four. Concurrently, she was taught to relax by recalling sensations of relaxation or release she felt when practised using tension-release cycles.

After relaxation therapy, thermal biofeedback was used as a strategy to help her achieve self-control of autonomic responses and to enhance her sense of being in control. Hand temperature was recorded with a 409A thermister. She was provided with a small thermometer to allow her to practice at home. AB was taught to use her newly acquired skills of relaxation induction and self-control to cope with stress. She learned to intervene before she lost control.

In collaboration with the patient's physician, a final aspect of treatment involved gradually weaning her from anti-anxiety medication.

Outcome Measures and Results

A daily gastrointestinal symptom diary was devised. She monitored her symptoms for a two week baseline evaluation period. The sum of the rating scores for each symptom was recorded. A Composite Primary Symptom Reduction Score was created from the daily recordings. For each primary symptom (abdominal pain, diarrhoea, and constipation), the mean percentage reduction during treatment and post-treatment was calculated using the following formula:

$$\text{Percent Symptom} = 100 \times \frac{(\text{BSS}) - (\text{ETS})}{\text{BSS}}$$

The average Composite Primary Symptom Reduction Score showed a high reduction ($x=74.2$). A *t*-test comparing pre and post treatment ratings of each symptom revealed that the mean post-treatment (Kazdin, 1984) ratings were significantly lower than the pre-treatment ratings ($p<.001$).

At the end of the seven week treatment period the patient had also been weaned completely from anti-anxiety medication. She reported being able to ride in a car with others and was actively looking for a job.

At six weeks follow-up, AB had maintained her improvement. She reported experiencing diarrhoea no more than once in two weeks, cramping rarely and taking no medication for gastrointestinal symptoms. At one year followup she had maintained her improvement and had a regular job.

Discussion

The multi-component behavioral treatment program (educational information, progressive muscle relaxation, thermal biofeedback training, and coping skills training) was clinically effective in reducing gastrointestinal

symptoms and subjective anxiety. The treatment effect is consistent with results from other behavioral interventions (Garrick, 1981; Latimer, et al. 1981; Bennett & Wilkinson, 1985).

There are undoubtedly limitation to single case designs. Further, we did not establish the efficacy of each approach. We would however, argue that such clinical disorders are typically determined by multiple factors rather than a single maintaining variable. Thus a multifaceted therapy program is necessary to change behaviour. In clinical practice one should emphasize a problem-oriented approach in which several treatment methods are tailored to the individual patient's particular IBS problem.

This study demonstrates that IBS treatment programs may include as many component procedures as necessary to obtain, a total treatment success. Further research is needed to support both the immediate and long-term effect of Multi-component treatment program in IBS.

Acknowledgement

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**Canadian Health Psychology
1992-1993**

Following the very positive response to last year's listing of publications I am pleased to include a list of health psychology articles published by section members in the past year. This list was developed from details submitted by section members supplemented with a computer search of Current Contents.

Once again it is useful to emphasise that not all research in health psychology in Canada is published by section members and that section members have published many articles in journals which I was not able to trace. Further, section members publish articles about subjects other than health psychology. Indeed, I have omitted some articles by section members which I did not consider are usually classed as health psychology.

If you want your articles included in future listings please send details of them to me. In particular, I am keen to receive details of books and chapters published by section members.

Résumé: Après la réaction positive reçue l'ans dernier, je suis fière encore une fois, d'inclure une liste des publications en psychologie de la santé, par les membres de section. Cette liste a été générée par les renseignements fournis par les membres et complétée avec une recherche informatique.

J'aimerais cependant souligner que les membres de section ne publisent pas exclusivement tout recherche en psychologie de la santé et plusieurs d'entre eux ont publié dans d'autre périodiques dont je n'ai pas pu tracer. En outre, certains membres publisent sur d'autres sujets que j'ai omis s'ils n'étaient pas considéré comme des sujets en psychologie de la santé.

Si vous désirez que vos publications soient incluses dans la future, je vous prie de m'envoyer les renseignements nécessaires. En particulier, j'aimerais recevoir de l'information sur les livres et chapitres de livres publiés par les membres.

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Introduction to special section on Psycho-oncology

One area of health psychology that currently has enormous potential for growth is that of psycho-oncology. Over the past fifty years governments in most industrialized societies have poured enormous amounts of funding into biomedical cancer research. While there have been some notable advances in the treatment of the disease the basic risk of developing and dying from cancer has changed little. This has led to increasing disquiet among the public and a demand for new approaches to the prevention and treatment of the disease. Health psychology offers promise in both these areas.

In view of the recent organizational changes in the National Cancer Institute of Canada (NCIC) with its commitment to promoting behavioural research *The Canadian Health Psychologist* thought it would be useful to devote this first special section to highlighting current work being conducted by psychologists in this area. For this reason I invited a number of health psychologists from across Canada to write a short article about their work. They range from those who are exploring various research opportunities in this area through to clinicians who are providing assistance to cancer patients. In addition, I am pleased to include an article by Don Iverson who has recently taken up the position as Director of Behavioural Research with the NCIC.

I would like to thank all the authors for their contributions to this special section and hope that it provokes increased interest in the subject among section members. In particular, I would encourage members to develop research in this area and to seek funding from the NCIC. I am sure that the authors of the papers in this issue would be only too willing to provide advice and possible collaborative opportunities to fellow section members who would be interested in initiating a new research project.

L'introduction d'une section spéciale en Psycho-oncologie

Un champ de psychologie de la santé qui a un énorme potentiel de grandir est le psycho-oncologie. Au cours des cinquantes dernières années, les gouvernements dans la plupart des sociétés industrialisées ont versé beaucoup de fonds pour la recherche biomédicale du cancer. Malgré les progrès en tant que traitement, les risques pour développer ou mourir du cancer ont peu changé. Ceci continue à élever l'inquiétude chez le public ainsi qu'une exigence pour de nouvelles méthodes de prévention et de traitements. La psychologie de la santé promet dans ces deux domaines.

En tenant compte de la re-organisation à l'Institut national du cancer du Canada (INCC), qui propose promouvoir la recherche du comportement, *Le Psychologue canadien de la santé* a décidé de dévouer sa première section spéciale pour souligner les travaux présentement étudiés par les psychologues dans ce domaine. C'est pour cette raison que j'ai invité plusieurs psychologues de la santé à travers le Canada, à me donner un court récit sur leurs travaux. Certains explorent les opportunités de recherche dans le domaine, d'autres sont en milieu clinique. De plus, je suis fier d'inclure un article par Don Iverson qui tout récemment, a été nommé directeur du département de recherche au compartement avec l'INCC.

J'aimerais remercier tous les auteurs qui ont contribué à cette section spéciale et j'espère qu'il provoquera de l'intérêt chez les membres. Mais en particulier, j'aimerais encourager les membres à poursuivre la recherche dans ce domaine ainsi que l'assistance financière de l'INCC. Je suis convaincu que les auteurs des récits seraient prêts à partager leurs idées pour des opportunités collaboratives et aussi offrir leurs conseils aux membres intéressés à initier de nouveaux projets.

Michael Murray.

Psychosocial oncology: a brief overview and one research direction

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and

Zeev Rosberger

Sir Mortimer B. Davis-Jewish General Hospital
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Abstract: This paper sketches the rapid growth in interest in psychosocial oncology and details the NUCARE research project designed to enhance the coping skills of cancer patients.

Résumé: Cet article souligne l'intérêt en oncologie psycho-sociale qui grandit rapidement et démontre en particulier le projet de recherche chez NUCARE qui tente d'améliorer les moyens d'adaptation chez les personnes atteintes du cancer.

Over the past fifteen years there has been an exponential increase in interest and research in the field of psychosocial oncology. Cancer patients and their families often feel that they are traveling into seemingly uncharted territory. The picture is often, but not always, grim. Cancer will affect two out of three families. One of every nine women is diagnosed with breast cancer - increasing by one in seven by the year 2000! This is an epidemic that far outweighs the current impact of AIDS. The picture becomes even more frightening when it is considered that the mortality rate for women with lung cancer will exceed those with breast cancer this year.

Recently, the National Forum on Breast Cancer was held in Montreal with the goal of bringing together over 600 clinicians, researchers, policy makers, patients, and community volunteers for a three day think-in and strategy session. Patients with breast cancer have become vocal advocates who realize that policy decisions are only made when their concerns are heard in the public domain.

The implications of the Breast Cancer Forum are likely to be felt for some time to come, and as the President of the National Cancer Institute of Canada, Dr. Michael Baker, said, "...the fight against breast cancer has changed forever as a result of the Forum." What this means for health care

researchers can be best summed up by a review of the main recommendations that emerged from the forum. From a research perspective, the research agenda must be decided upon by all the stakeholders involved. Patient input was referred to time and time again; in fact, the patient appears as the central member of the team. A strong and vigorous call was made for research and clinical support to be available for the patient throughout his or her treatment, and to have access to all needed forms of treatment information at all times. There was a strong and clear demand for the patient to take his or her rightful place in the forefront of any activity relating to his or her care. The conviction and leadership shown by the women patients at the forum will ensure that these initiatives are followed.

What does this mean for researchers interested in the field of psychosocial oncology? Chiefly, it means that the research agenda has never been fuller, nor has it held such a variety of possibilities. The study of how behavior influences the cancer experience from primary prevention to tertiary palliation involves the entire range of human experience and requires the skills of researchers from many disciplines. The NCIC's Advisory Committee on Cancer Control recently released a framework of research categories which includes: studies of hypothesis-generation, methods of development, efficacy, effectiveness, implementation, and dissemination/adoption.

The targets of this behavioral and epidemiological research include five different populations: school districts, small communities, family physicians, patients in treatment and persons living with cancer. Other groups could also be involved: oncologists and physicians in other specialties, families of those with cancer, long term survivors, and volunteer agencies, among others. Each stage in the cancer trajectory provides fertile ground for psychosocial research. These stages include: detection of a physical change, diagnosis, hospitalization, treatment, convalescent and follow-up care, rehabilitation and reintegration, remission, cure, relapse or metastasis, palliative care, terminal stage, death and bereavement, and long term survivorship.

NUCARE

Our own prime area of interest in psychosocial oncology grew out of a clinical observation that regardless of the particular cancer patient's experience or where he or she was situated along the cancer trajectory, the patient was engaged in a dynamic attempt to cope effectively and to return a sense of personal control to a life course that has been irrevocably altered.

We have focused primarily on studying means of enhancing coping - the development and implementation of a cognitively-based, coping skills training intervention for people with cancer. Our cognitive-behavioral approach is based on Lazarus and Folkman's (1984) conceptualization of coping as constantly changing cognitive and behavioral efforts to manage external and/or internal demands that are appraised as taxing or exceeding the resources of the person. We operationalized coping for our research by choosing Weisman, Worden and Sobel's (1980) definition of coping as active problem solving which is flexible, resourceful, optimistic and practical. Thus, our point of view appears to us to be somewhat eclectic because we focus on the

personal resourcefulness and strengths of the patient and build on these attributes during the intervention. The intervention has come to be known as NUCARE - an acronym resulting from the words Nursing (or new), Cancer, and Research (Edgar, Rosberger, and Nowlis, 1992). It was originally designed for clinical oncology nurses to provide within the framework of their clinical work with patients. In subsequent funded research studies however, the intervention has been administered by counsellors with social work or psychology backgrounds, in addition to nurses with a variety of educational preparation.

The Nucaire intervention is derived from work in the area of patient education, strategies known to increase a sense of personal control, and knowledge about emotional and instrumental coping responses. Nucaire is a five-session, multi-component, fairly didactic intervention based on the acquisition of behavioral skills, cognitive strategies, and specific information about the resources in the health care system. The individual components consist of the following six areas:

- 1. Cognitive strategies** (reframing and reappraisal). The orientation is towards a cognitive view of the relationship between thought patterns and negative mood. Patients are taught to recognize the differences between facts, thoughts and feelings. The emphasis is placed on the relationship between cognitive reappraisal and an enhanced sense of personal control.
- 2. Relaxation training.** Training in progressive muscle relaxation or a modified version based on autogenics or visualization is provided over parts of three sessions to permit practice and a familiarity with the technique. We provide an audiotape of relaxation instructions for home use.
- 3. Problem solving.** Each patient is taught skills in problem solving, beginning with a number of neutral examples and then progressing to issues related to the specific concerns of the patient.
- 4. Goal setting.** We adapted goal setting from previous work in counselling services, the area of time management, and from behavioral medicine studies of pain control. Setting graduated and attainable goals constitutes a realistic means of accomplishing tasks that are timely and relevant to the patient and provides a sense of increased personal control.
- 5. The effective use of resources.** The focus of this training is to provide information about the resources within the health care system and how they may be accessed.
- 6. Social support.** Instruction is given about the types and sources of social support that might be available to the patient; how to identify and assess satisfaction with the current level of support; and strategies to enhance the expression of need for support.

The intervention has been and is presently the focus of several funded research studies and funding is currently being sought to expand our work into other directions. We have demonstrated that the intervention was effective in

improving quality of life through reducing distress and increasing a sense of personal control in two distinct groups of patients; persons with HIV disease, and persons newly diagnosed with cancer who were followed for a year. Presently, we are studying the timing and the mechanics of delivering the intervention in a study funded by the National Cancer Institute of Canada with the support of the Canadian Cancer Society. Our work on Nucaire has become a research program:

We are attempting to determine which aspect or component of the intervention is most effective. We are continuing to learn more about who benefits most from the intervention and when in the cancer trajectory it is most useful. We have learned more about what constitutes good coping, and the nature of those patients who demonstrate it so well. We are hopeful that in the near future we will have the opportunity to test the intervention in Europe, with HIV+ patients, and with palliative care cancer patients.

Santos and Greer (1991) coined the term "adjuvant psychological therapy" to encourage the addition of psychosocial interventions to conventional cancer treatment. We plan to continue our research program in the hope that one day conventional cancer care will be just that - care that places the patient at the heart of the team and provides all the information desired and needed for sound, individualized decision making, enhancing the sense of personal control and contributing to an enhanced quality of life for both the patient and the family.

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Psychological distress associated with breast cancer screening

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Abstract: Regular breast screening with the use of mammography for asymptomatic women is the most effective method for early detection of breast cancer. The health and economic implications of breast screening have received significant attention, however, the psychological consequences of attending a breast screening program which includes a mammogram have been largely ignored. This article briefly reviews the few studies which have examined the psychological distress experienced by women participating in breast cancer screening.

Résumé: Les examens périodiques de dépistage faisant appel à la mammographie constituent la méthode la plus efficace le dépistage précoce du cancer du sein chez les femmes asymptomatiques. Les implications économiques et au plan de la santé du dépistage du cancer du sein ont été étudiées de façon approfondie, tandis que les effets psychologiques chez les femmes qui participent dans un programme de dépistage comportant une mammographie n'ont pas reçu beaucoup d'attention. Cet article passe brièvement en revue quelques études portant sur les conséquences psychologiques du dépistage du cancer du sein.

Breast cancer is the most frequently occurring cancer and the leading cause of death from cancer among Canadian women. It is also the cancer in women most amenable to early detection at a curable stage of disease. Long-term survival or cure for breast cancer is only attainable if methods for the earliest possible detection are employed on a regular basis. The techniques of early detection are (1) breast self-examination (BSE), (2) physician/nurse examination, and (3) screening mammography. Mammography is the most sensitive and specific method of early breast cancer detection in women aged 50 years and older. Consequently, annual screening

with mammography has been recommended for all women aged 50 years and older, in many countries.

Although a number of investigations have examined such issues as health and economic implications of breast screening, the psychological consequences of attending a breast screening program which includes a mammogram have received little attention. A number of authors (e.g., Bull & Campbell, 1991; Dean, Roberts, French & Robinson, 1986; Lerman, Rimer & Engstrom, 1991; Lerman, Trock, Rimer, Boyce, Jepson & Engstrom, 1991) have expressed concerns that screening for breast cancer may create psychological distress (e.g., anxiety, depression) in participants. Also noted by several authors is that the adverse psychological distress of those women who receive false-positive breast screening results (no evidence of cancer on follow-up) could be of particular significance. When one considers that the proportion of mammograms interpreted as inconclusive or abnormal in large-scale screening programs are as high as 20% this represents a potentially major problem for participants. Many of these same authors recommend that breast screening programs should try to determine the nature of these associated negative and/or positive psychological consequences for both those who screen normal and false-positive and whether these psychological consequences can deter subsequent attendance at breast screening programs.

Studies in Europe

The first systematic study to examine the psychological impact of breast screening was conducted by Dean and colleagues (Dean, Roberts, French & Robinson, 1986) at the Edinburgh Breast Screening Clinic in Scotland. One hundred and thirty two women with normal breast screening results were interviewed six months after their attendance at this clinic. Eight percent of women said screening had made them more anxious about developing breast cancer. Thirty eight percent said they were more aware of the disease since screening but they regarded this as advantageous. There was no difference in the psychiatric morbidity of the screened sample as assessed by the General Health Questionnaire (GHQ) when compared with a matched random sample community control group. The GHQ is a self rated screening questionnaire which is used to screen for psychiatric morbidity in a population. The psychological impact on those who screened false-positive was not assessed. The behavioral intention to return for future breast cancer screening was not assessed.

Ellman and colleagues (Ellman, Christians, Moss, Chamberlain & Maguire, 1989) used the GHQ to assess psychiatric morbidity in 302 women attending routine mammographic screening, 300 women undergoing further investigation of a positive mammographic screening result, and 150 women referred for investigation of breast symptoms. Women with false-positive mammographic results and those with symptomatic but benign conditions exhibited significantly greater distress and dysfunction than asymptomatic women with normal results. After 3 months, impairment persisted among women with benign, but symptomatic conditions; anxiety returned to baseline among women with false-positive results. No efforts were made to assess behavioral intention to return for future

mammograms for any of the groups.

In Norway, Gram, Lund and Slenker (1990) evaluated 126 women with false-positive mammograms and 152 women with normal screening results. Six months following screening, these women completed self-report questionnaires of their psychological responses to the screening process including attitudes toward mammography. A substantially larger proportion of women with false positive results reported moderate anxiety, compared with the women with normal screening results. Anxiety levels decreased in both groups after 1 year, and there were no long-term effects on sleep patterns or general well-being. The vast majority of women reported that they would return for another screening.

Bull and Campbell (1991) in England examined the psychological effects of attending a breast screening clinic utilizing questions from the Hospital Anxiety and Depression Scale. Questionnaires were sent to 750 women at invitation to screening and 6 weeks after screening, to 420 women normal after the first mammograph, to 240 women normal after special assessment and to 68 women after open biopsy. Psychometric scores revealed no increase in general anxiety or depression levels in the screened groups. No assessment was conducted to determine participants willingness to return for future mammograms.

Studies in North America

In the United States, Lerman and colleagues (Lerman, Trock, Rimer, Boyce, Jepson & Engstrom, 1991) reported levels of psychological distress and impairment in these women increased significantly with the degree of mammographic abnormality. Three months after screening, a substantial proportion of women who had abnormal mammograms reported mammography-related anxiety (47%) and worries about breast cancer (41%). Such worries affected the moods (26%) and daily functioning (17%) of these women, despite diagnostic evaluation which eventually ruled out breast cancer. This study did not find any evidence to indicate that psychological distress deterred intention to return for future breast cancer screening.

In Canada, Lightfoot and colleagues (1994) investigated the short-term psychological impact of breast screening. At the Sudbury Centre of the Ontario Breast Screening Program, 315 women were interviewed, before and immediately after screening. Two pre-validated scales were employed to evaluate psychological distress. The Profile of Mood States was used to assess six transient mood or affective states: tension-anxiety, depression-dejection, anger-hostility, fatigue-inertia, confusion-bewilderment, and vigour-activity. The Psychological Consequences Questionnaire was used to assess the breast cancer screening experience overall, and in emotional, social and physical life domains. Based upon mean scores for the entire group, there was little evidence of adverse psychological effect of screening on either of the pre-validated scales. In terms of assessment of behavioral intention to return for future screening 88.6% of the women felt strongly and 9.2% of the women probably felt they would return somewhere for screening in the future.

Conclusion

The nature of this newsletter article prevents an exploration of the methodological weaknesses of these studies. Notwithstanding this the limited number of studies examining the psychological distress associated with breast cancer screening have been reviewed briefly. Based upon these studies a definitive statement on the psychological distress associated with breast cancer screening is presently not available. The need for future studies to explore this issue is underscored by the current trend for continued expansion of breast cancer screening services within most countries including Canada.

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Working towards a scientific study of the effects of mind on chronic disease (cancer)

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Abstract: This brief article will offer some ideas on how we might investigate a possible influence of mind on the progress of cancer. The account is somewhat personal or biographical and will focus on the evolution of my own ideas over the past 15 years or so.

Résumé: Cet article bref offre quelque idées sur les façons d'investiguer les influences du psychisme sur la rémission du cancer. Le récit est à la fois biographie et personnel, et démontre un évolution de mes propres idées au cours des 15 dernières années.

After an initial 15 years as a research immunologist, I began, in the late 70s, to feel the need to do something more directly helpful to other people, and therefore trained and became certified in psychology. Supportive superiors allowed me to retain my job as a scientist at a large cancer research centre while gradually making the shift towards research on adjunctive psychological therapy for cancer. I began reading widely in fields like psychosomatic research, hypnosis, behavioural medicine (then just coalescing into a separate discipline), as well as more popular accounts. It quickly became evident to me that scientific evidence lagged well behind many of the popular anecdotal claims for the potential of mind to affect body. Some of the ideas of psychosomatic medicine in the 50s were fascinating, but by this time were no longer taken seriously, for lack of evidence based on standardised experimental designs.

Little rigorous research on the influence of mental therapy on serious physical illness seemed to have been done. In the cancer field, there was satisfactory evidence (by the early 80s) that mental state could affect cancer growth rate in experimental animals, but work in humans was mainly confined to attempts to relate personality to

cancer incidence, which were (and still are) inconclusive. Perhaps most serious was the lack of any plausible overarching theory about how the mind might affect bodily health; it was even unclear in what terms such a theory might be cast.

Clearly the first thing to do was to get some first-hand experience with people coping with cancer, and to see what they could do with their own minds that might help them. So I began, in 1982, conducting some short-term groups offering support and training in coping skills to cancer patients at the Princess Margaret Hospital, and have done so continuously since then. Our program grew quite quickly to about 120 new outpatients per year, and has remained quite stable at this level. We also provide groups for family members, and since 1986 have conducted a variety of more advanced groups for graduates of the initial program (described in Cunningham et al, 1991). These groups all had a research focus: our basic finding, in agreement with the small body of similar research from elsewhere, is that this simple form of therapy produces a lasting improvement in affective state and quality of life generally. A workbook and tapes based on this approach has been published and is distributed by the Canadian Cancer Society (Cunningham, 1989), and a book for lay people is available (Cunningham, 1992).

I have learned from this experience just how difficult change is for most people, even when life is threatened and even if those attending programs like ours believe that psychological change can slow the progress of their disease. Nevertheless, some individuals do make substantial changes, and some of these people show unexpected remissions of disease, although it is impossible to infer causality from unsystematic observations. This is exciting, at least to me, and points to a phenomenon well worth investigating.

Search for theory

To shape therapy towards possible effects on physical disease, and to design useful research (at least, of the hypothesis-testing kind), we need theory. I joined the American Psychosomatic Association, only to find that the age of global theorising about mind-body effects was over, and that mechanistic studies were the order of the day. I investigated a number of schools purporting to have some understanding of mind-body relationships (bioenergetics, yoga, tai chi, hypnosis, meditation, to name a few), and found a good deal of intuitive wisdom, a lot of uncritical thinking, and no useful conceptualisations. It appeared to me (and still does) that a general theory of mind-body interactions would have to be couched in "informational" (pattern) terms, rather than in the language of material interactions, since the "mind" is clearly an informational construct, not a "thing". So I attempted to develop my own view (Cunningham, 1986), which is, in essence, that health is promoted by optimal connectedness (information flow) between all levels of a person, and disease by disconnectedness. A more detailed account reaching similar conclusions has been published by Foss and Rothenberg (1987). This point of view at least provides some guidance for improving therapy, although it needs a great deal of refining.

In considering the mind-body pathway from cognitive appraisal to subcortical events, physiological reactions, effects on cancer-regulating systems like the immune system, and eventual influence on cancer, it seems to me that the most useful level to study will be cognition, an informational construct. That is, my prediction is that the most helpful kind of analysis of individuals demonstrating some influence of their mind on cancer will come from a study of what they think, and not from neurophysiological or endocrine or immune measurements: the relevant changes at these finer levels will be simply too complex to identify, and will probably not point to therapeutic interventions.

Back to the research: by the mid to late 80s we had completed a number of studies on the quality of life benefits of brief group therapy: a randomised trial showing that adding cognitive behavioural training to support approximately doubled the improvement in QL (Cunningham and Tocco, 1989); a demonstration that, not surprisingly, quality of life was strongly correlated with perceived self efficacy (Cunningham et al, 1991); an analysis of which patients are most helped by the groups (Cunningham et al, 1994), and, more recently, a randomised comparison of different modes of delivering the basic group program, and some results from the more advanced groups (in preparation).

Then in 1987 I had some even more direct experience: a serious colon cancer. (A former friend said that "some people will do anything to be authentic")! I had surgery and some chemotherapy, intensified my practice of the techniques I had been teaching others (relaxation, mental imaging, meditation and the like), took myself off for 3 months to an Ashram for some intensive psychological reflection and spiritual work, and started a (5 year) course of individual therapy with a psychoanalyst. The cumulative experience taught me many things; I now know, in my bones and not just intellectually, that I will die one day, possibly before long. And while it may seem "unprofessional" to admit it, I had a number of very wonderful "spiritual" experiences during that difficult time which dispelled any doubt that there is a benevolent higher order, however conceptualised, which we can learn to contact with techniques like meditation, reading scriptures from many traditions, reflection, and in general being open to it.

Evidence on social support

By the late 80s, fortified by close observation of several hundred cancer patients, and by my own episode with the disease, it was clearly time to start trying to address the possible impact of adjunctive psychological therapy on progress of the disease. My research assistant, Claire Edmonds, and I began conducting longer term groups (6 months or more) for women with metastatic breast cancer, in order to gain experience for a trial using such therapy. Then in 1989 came a report which greatly helped this embryonic research, and provide a "window of opportunity" for seeking funding: David Spiegel and colleagues (1989) published a 10-year analysis of survival of women with metastatic cancer who had been in a randomised controlled trial testing the impact on survival of a year of weekly group support. The startling result: support groups prolonged life

by an average of 18 months! Soon after this we were funded by MRC to carry out a similar trial, now in progress, with a larger N (180, as compared to Spiegel's 86), and incorporating cognitive behavioural training into the intervention. Several other groups in North America, including a second one in Toronto, are doing similar research. Furthermore, there has been a recent report by Fawzy et al (1993), demonstrating in a randomised trial that a brief (6 week) support and educational course significantly promotes the survival of people with early stage malignant melanoma. It now seems fair to claim that a *prima facie* case can be made from the experimental evidence for an effect of psychotherapy on cancer progression.

More of these experiments need to be done, to confirm or disconfirm the phenomenon, and to define the conditions under which it occurs. However, if we attempt to peer into the future, 2 predictions are possible. First, that there will be some negative results, as well as further positives, allowing skeptics to claim that there is no true effect, and that support groups should therefore not become a regular adjunct to medical therapy for cancer. Second, that this kind of experiment, based on comparison of group means, will not put us much further ahead in defining the kind of mental change that promotes longevity.

In my view we also need a different kind of experiment, case-by-case prospective studies of patients who survive much longer than expected, correlating their psychological changes with physical events, such as tumour regression. An ideal design would be to do intensive therapy with patients who have measurable tumours (or tumour markers), but are not receiving any medical anti-cancer treatment. This is obviously a difficult kind of experiment to do (or to get funding for!): suitable patients are hard to find, and many subsequently receive confounding palliative medical treatment; tumour regression is likely to be quite rare (although we do not really know what the incidence might be in patients getting intensive psychotherapy, and even 2 or 3 well-documented cases could be significant). Also, as a correlative design, it does not provide an immediate definitive answer. We can begin, however, to build up a series of documented cases.

I have therefore been conducting (for the last 2 years) long term therapy groups for small numbers of motivated patients who have advanced cancer, and hope, if eventually funded, to expand the work to recruit people who meet the medical criteria more exactly. In order to describe their psychological change in a meaningful way (since self-report instruments largely fail to capture relevant change), I am attempting to develop an observer-rating scale based on the model of health mentioned above; it is a "developmental map", showing where the patient is at "body", "conscious mind", "deeper mind", "social" and "spiritual" levels. Participants are rated at intervals by collaborative discussion with the therapist. In addition to attending weekly groups, many of them to extensive homework, and may devote much of their lives to trying to overcome the disease (it is, of course, emphasised that there is no assurance that this is possible, and no cause for guilt if one tries and "fails"). In the present group, for what its worth, 3 of the 6 members have advanced cancer which is in remission are stabilised; all have had some recent medical treatment however,

although this was not expected to have much influence on their disease. One further member had a recent decline in a tumour marker, one did not have detectable disease on study entry, and still does not (although she is at high risk), and the sixth person, who is the one making least progress psychologically, has a progressing disease.

Conclusion

As a relative newcomer to health psychology, I am enthusiastic about my new discipline, and it has saddened me to see the strong, irrational resistance that exists to bringing the mind into medicine. The waters are unfortunately muddied by extremist claims, which promote an understandable medical backlash. However, it is already accepted that psychological events (unhealthy behaviours) are the major cause of morbidity in the West, and there is increasing research evidence for effects of more subtle psychological variables, like a perception of having little control over events.

It would therefore seem to follow logically that primary care professionals should have a training principally in psychology, with enough medical knowledge to refer "organic" cases to a specialist, the physician as currently defined! While such a system may be some way off, as health psychologists we have a responsibility to help our more biologically oriented colleagues understand that words, symbols, have dramatic effects on physiology. They are therapeutic tools, as surely as scalpels and drugs. For the present, many people can clearly be helped by short term psychological interventions, even in a climate basically hostile to these efforts: we hardly know yet what could be accomplished by longer, more intensive therapies which were endorsed by the whole health care system. Many voices are calling for reform of health care: we health psychologists, by reason of our training, are well placed to contribute to the evolution of a new paradigm.

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Women with cancer: two research topics

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Abstract: This article presents some of the findings from an ongoing research project which is concerned with women's reaction to breast cancer. The preferred research method is in-depth interviews with the women.

Résumé: Cet article résume quelques données d'un projet de recherche courant qui étudie la réaction des femmes suite à un diagnostic de cancer du sein. La méthode de recherche choisie, consiste d'entrevues rigoureuses avec les femmes.

Over the past five years, I have been conducting in-depth interviews with persons with cancer as part of my research interests. Within this time period, my earliest work of a qualitative nature afforded me a glimpse into discrepancies between how ill persons experience their illness and how health care professionals of all sorts examine and talk about the illness trajectory of patients. These discrepancies continue to surface in my interviewing to date, and seem to me to be accentuated at times by the gender of the ill person. In some respects, there have been large scale attempts to get closer to the way these discrepancies affect women.

Emphatic calls for members of the involved community to shape research foci have surfaced in the recent Breast Cancer forum in Montreal. The entire spring issue of *Canadian Woman Studies* is being devoted to women and health, although not specifically to cancer. In the Spring, there will be a national multidisciplinary conference held in Ontario on women's health, which will include a focus on women's illnesses. Within cancer research, there is considerable activity regarding screening for breast and cervical cancer, the role of women's clinics, the impact of social support, and dissemination of information to hard-to-reach, at risk women.

Women in my studies have consistently provided me with recurrent themes of concern. I can easily name two

themes: body changes and communication. In the midst of the above flurry of research activity, I find it interesting that research findings seem to reach a bottleneck where they may never find their way to the patient's general understanding. I do not think this problem springs from the ill person.

Women I interview have often developed elaborate, systematic, and/or sophisticated methods for finding information about their cancer. Rather, I suggest that health care professionals and patients seem to be speaking in a different voice, as it were, which encourages a gap in understanding. In medical interviews, Mishler (1984) refers to this gap as the voice of medicine versus the voice of the lifeworld (also see Silverman & Torode, 1980). The issue I wish to stress here as a researcher is that it is time to re-evaluate our theoretical frameworks for psychosocial oncology research. A place to start would be, for example, with the two concerns listed above. How can the voice of the lifeworld of ill women inform our research questions? If our theories are sound, they will reflect the authentic lived experience of the ill.

Body Changes

Research on the way a woman's body changes during cancer has produced a core of literature on "body image." In general, the bulk of the body image literature seems to concern breast cancer. Here we find the message that impaired body image can result from breast loss, body failure, and resulting psychological distress. In some studies there is the feeling that body image is like a personality trait which can be measured on some type of scaled continuum. I think it is worth pointing out that much of the cancer/body image studies concern women, which adds to the implicit idea that body image problems are largely women's problems. However, obviously all persons have bodies, men and women, healthy and ill, alike. Therefore, one challenge in the body image research appears to be our need to question and articulate this gender bias.

A more basic question involves asking what body image, or a body image score, actually means to women who are living with the ongoing physical and psychosocial demands of cancer. Living with this chronic illness is not just a matter of realigning one's body image with its pre-illness state. Things might be done to the body during treatment to try to control the disease, but body talk from patients is not central to this series of medical events. What I have come to believe is that body talk from women with cancer is an important way of negotiating one's altered identity. I am therefore suggesting a shift from the researcher's tendency to superimpose a measurement concept on this body talk to that of creating a space for articulating the meaning of body changes. This shift, although theoretical in nature, would also force us to evaluate our methodology.

Women's own stories bear little resemblance to the type of questions which are posed on body image questionnaires. Women speaking for themselves have repeatedly highlighted the psychosocial and cultural meaning of their body cues. Body changes are signals for a rite of passage into the world of the ill. Diagnosed with cancer, I found

women speaking of their bodies being damaged or broken, of feeling contaminated, or being treated like they had leprosy. This type of talk clearly places the world of illness in its social radius, where such things as loss of weight and/or loss of hair become occasions to stigmatize the individual. The concept of some abstract body image, to be viewed or measured, does not allow us to access the world of illness.

Communication

Despite recent calls for women to take charge of their health and to become equal partners in their cancer treatment, women continue to provide me with stories which highlight communication problems of all sorts. The most prominent seems to be concerns about being afraid to take up the physician's time with questions. I do not mean to single out physicians with this example. Women in my interviews have suggested that there are strong expectations placed on them by health providers in general to comply with treatment, to put on a happy face, and to understand the responses to questions the first time the answer is given.

Once again I think it is important to underscore a discrepancy between patient experience and that of the health care provider, or the researcher. Strauss and his colleagues (1985) use the term "illness trajectory" to refer to the physiological unfolding of a person's disease along with the institutional organization of work which accompanies this unfolding. While health care professionals may be well aware of the detail of this trajectory, it is very rare for a patient to understand this trajectory in all its complexity, at least until they live through it.

Health care providers with whom I conduct research are constantly amazed at so-called misconceptions held by patients about their illness. But I think we must remember that for the ill person, this illness trajectory includes a whole new set of social contingencies which continue after treatment and are not confined to on-site hospital care. Having to re-assess one's role among family and friends is such a contingency. More specifically, for example, women who are single parents face serious hurdles in caring for their children during chemotherapy episodes if they have no support systems, and for them, the responsibility of being sole caregiver cannot be passed off even with a life-threatening diagnosis. This situation is uniquely part of their illness.

It may be that communicating with medical patients is such a complicated phenomenon that we may never hope to empirically capture the whole picture, but must eventually rely on bits and pieces of research on smaller topics. In fact, communicating with women patients may hold its own challenges. However, above I spoke of the researcher's potential to create a space for patients to articulate their experience. I am not referring to amounts of interviewing time as much as I am to creating a moral space, as it were, to validate the individual's experience. At the very least, to me this means that we must consistently build into our research the opportunity for the ill person to speak for herself which is not guided by design issues or generic illness models. In my opinion, this approach could be a powerful tool for examining the social construction of

illness, especially as it relates to gender issues in the care of the chronically ill.

A Re-evaluation

For those of us who study the psychosocial effects of cancer, there must be one primary goal which guides our research. This is to enhance the quality of life of the person with cancer. I have highlighted two concerns which seem to affect this quality for the women in my interviews, body changes and communication with health care providers. Despite sizable amounts of empirical research on these two topics, these issues remain problematic for many women with cancer. We should ask ourselves why this is so. Over the course of my interviewing, had I stuck with standardized questionnaires only, I would have had body image scores which in no way address the meaning of the body changes of women with cancer. I would, probably, have had some type of "satisfaction with communication" score(s), most likely scaled in Likert fashion. I am not convinced numerically driven approaches would have allowed me to begin to understand the discrepancy between the patient and research experience of which I initially spoke.

I suppose that I am calling for a renewed interest on the part of psychosocial researchers in the validity of their endeavors. It is not validity in a psychometric sense, however. If we open that window which allows us to question the basic validity of adopting, wholesale, statistical and professional models into our research with women with cancer, we would not only enrich the ill person's life. We would enrich our research. And we would be forging a new role for health psychology researchers in psychosocial oncology.

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Psychothérapie et accompagnement des malades: théorie et clinique

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Résumé: La situation de consultation-liaison auprès des personnes hospitalisées atteintes de cancer nécessite une pratique de l'intervention psychologique qui recoupe le champ de la psychothérapie et de l'accompagnement. Le clinicien doit s'adapter à la fois à l'état du malade et au contexte d'une unité de soins. Nous proposons un référentiel théorique et l'acronyme ANCRAGE pour encadrer l'évaluation et l'intervention clinique.

Abstract: When working with patients suffering from cancer, the consultation-liaison clinician must refer to the concepts of psychotherapy and compassionate presence for psychological intervention. He must take into account both the patients condition and the realities of a hospital ward. To achieve this, we propose a theoretical framework drawing from cognitive and existential psychotherapy approaches and the French acronym "ANCRAGE" (anchor) to assess the patient and his significant others and to delimit clinical interventions. The clinician will thus have a model dealing with the psychological, spiritual and adaptive responses to a situation of severe illness and impending demise.

Notre cadre de référence puise à la psychothérapie existentielle (Yalom, 1980), et cognitive (Néron et Fortin, 1993) ; Rowe, 1983) ainsi qu'à l'existentialisme per se (Marcel, 1964). La psychothérapie existentielle s'adresse aux efforts conscients et inconscients du malade pour composer avec la réalité de la maladie et de la mort. Ces efforts consistent à nier l'inéluctabilité de la mort, à craindre la solitude fondamentale et à chercher un sens à l'existence, à considérer les limites de notre liberté et à maintenir notre capacité d'agir. Un deuxième apport théorique encadre notre travail. La maladie et l'éventualité de la mort sont considérées sous l'angle cognitif. La maladie bouleverse le registre individuel de significations du malade, aux plans temporel et relationnel. Se mobilise alors un processus défensif de

fausses croyances, d'illusions, pour atténuer cette menace radicale qui remet en question ce qui était pris pour acquis. Les efforts de trouver un sens ou une explication à cette épreuve constituent une tentative de rétablir la continuité du système de croyance que la maladie a interrompu.

Pour le clinicien, il s'agit donc à la fois de recourir à l'aspect recouvrant (soutien et adaptation) et découvrant (dynamique) dans la rencontre intersubjective et d'accompagner les fluctuations de l'expérience du malade. Ceci repose premièrement sur une évaluation du type de défenses et de l'efficacité à maintenir l'homéostasie face à l'angoisse de mort. Deuxièmement, le clinicien observera les schèmes cognitifs (Avants, Margolin, Signer, 1993; Néron et Fortin, 1993) inadaptés, excessivement rigides ou irréalistes du malade, c'est-à-dire la manière de voir et de comprendre l'univers qui l'entoure et comment cela l'affecte. L'intervention clinique devrait occasionner une modification de la perspective du malade sur sa maladie, pour ensuite lui permettre de retrouver une cohérence dans le flot des événements de sa vie. Enfin, le malade reprendra contact avec un sentiment de maîtrise et de compétence malgré l'épreuve qui est venu briser la continuité de sa vie.

La psychothérapie et l'accompagnement

Comme psychologue clinicien, nous connaissons mieux le champ de la psychothérapie. Point n'est besoin d'élaborer sur la notion de cadre et d'alliance thérapeutique, de conflit inter- et intra-subjectif, de symptômes et d'adaptation. Sur ces notions s'étayent la plupart des systèmes thérapeutiques propres à la psychologie clinique des individus et des groupes. En un lieu et un temps déterminé, une tâche explicite et implicite réunit psychologue et patient en une relation où s'élabore un processus de résolution du conflit, du symptôme ou de la crise.

L'accompagnement se distingue de la psychothérapie. Il n'est pas une offre de soins et ne vise donc pas le changement ou la résolution de ce qui fait souffrir. Au plan objectif, l'accompagnant sollicite en lui (Winnicott, 1969) cette capacité interne propre à mobiliser les caractéristiques de "holding" et de "handling" qui structurent la relation inter-psychique par association à la sécurité de base des premiers moments de la relation avec la mère. Au plan relationnel, la solidarité avec la souffrance, autant qu'avec les moyens d'y échapper, caractérisent l'accompagnement. Cette présence l'autre dépasse la simple consolation la douleur et ne porte pas la même exigence interne de "succès thérapeutique" que la psychothérapie; c'est plutôt la manifestation d'une vitalité et d'une connivence avec la souffrance caractéristique de la condition humaine. Le clinicien s'adresse ici aux notions existentielles d'effort, de lutte et de volonté qui constituent, avec leurs opposés, les repères de la conscience "d'exister" comme malade. Accompagner, c'est être le témoin des fluctuations de cette dynamique existentielle et s'en montrer solidaire.

Attitude recouvrante ou découvrante

La tâche du clinicien consiste d'une part à réduire la détresse un niveau supportable et permettre l'adaptation (Néron et Fortin, 1993) et d'autre part, à explorer, avec le

patient, les divers sens de l'angoisse existentielle (Néron, 1991; Yalom, 1980). C'est un choix souvent difficile pour le clinicien dont la décision constitue la pierre angulaire du geste clinique

Clinique de l'accompagnement et de psychothérapie des malades

Nous proposons une façon de *penser*, planifier et nuancer la clinique de l'accompagnement et de la psychothérapie des malades. Cette stratégie permet de prendre du recul, d'examiner la situation sous divers angles et de répondre de manière adaptée et efficace aux besoins du malade et de son entourage.

Nous souhaitons que le clinicien puisse, tout au cours de la maladie ou dans le contexte de la mort imminente, accompagner la personne malade sans se vider. Cette tâche complexe exige d'abord que l'on conserve son altérité. Il faut ensuite avoir accès à son savoir-être et son savoir-faire. Enfin, il faut pouvoir les communiquer au malade selon son état présent et sa perception de sa maladie, de sa détresse, de ses relations et de ses croyances. Nous préférons en fait parler d'une pluralité d'accompagnements selon l'état et le devenir du malade et de ses proches. C'est ce que nous appelons la stratégie **ANCRAGE**. Voyons ce que cet acronyme signifie.

• **A** représente l'**Ancrage**. Dans le paysage relationnel de l'accompagnement, le clinicien devra souvent jouer le rôle de coordonnateur, celui qui facilite le "travail" à réaliser par le malade et ses proches. Le malade peut aussi établir un lien privilégié avec le clinicien de telle sorte qu'il devienne le dépositaire privilégié de l'angoisse et des investissements affectifs du malade.

• **N** rappelle que **Nous sommes présents**. Le clinicien doit évaluer la capacité du malade en phase terminale à vivre l'expérience d'être seul en présence de quelqu'un d'autre (Winnicott, 1958).

• **C** symbolise le caractère **Concentré** de l'accompagnement. Il est primordial de s'adapter à la temporalité psychique du malade. (la finitude, la séparation et le détachement). La souplesse est de mise dans la l'organisation des rencontres avec le malade, son entourage ou le personnel soignant. Elles peuvent être planifiées ou imprévisibles.

• **R** évoque la nécessité de considérer le **Réseau d'aidants** et de soignants qui entourent le malade.

• **A** signifie notre présence à l'**Avant** ou à l'**Arrière-scène**. Le rôle de l'accompagnant s'exerce parfois directement auprès du malade (avant scène) tandis qu'à d'autres moments, il consiste à faciliter les liens avec l'entourage (arrière-scène).

• **G** introduit la notion de **Gestion** cognitive (Néron et Fortin, 1993) de nos pensées, images et de nos réactions de telle sorte que le clinicien demeure efficace, souple et nuancé.

• **E** représente le choix du clinicien d'**envelopper** en apaisant ou de faire découvrir l'angoisse **Existentielle**.

Conclusion

La psychothérapie et l'accompagnement des personnes atteintes de cancer dans un contexte de consultation-liaison exige du clinicien un cadre théorique nuancé auquel il se réfère sans dogmatisme et qui guide l'intervention de telle sorte qu'elle puisse convenir à la situation du malade. La maladie et la mort nous confrontent à l'aveuglante vérité de la fragilité de notre condition humaine. Elles mobilisent les dimensions psychiques et spirituelles, mais aussi toutes les forces précieuses nécessaires au sens et la continuité de notre vie.

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A new behavioural cancer research centre

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Abstract: In 1993 the NCIC established the Centre for Behavioural Research and Program Evaluation. This article describes the aims, structure and current activities of this centre.

Résumé: En 1993 l'INCC a établi le Centre de recherche du comportement et d'évaluation de programme. Cet article décrit les objectifs, la structure et les activités courantes du centre.

The immediate past director of the National Cancer Institute of Canada (NCIC), Dr. Peter Scholefield, championed the creation of a behavioral research program within the NCIC. The momentum created from his efforts was enhanced by the NCIC's current director, Dr. David Beatty, with the result being the establishment in September, 1993 of the Centre for Behavioural Research and Program Evaluation (CBRPE). I was appointed the Centre's first director; the other full-time staff of the Centre are Dr. Fred Ashbury (Associate Director) and Ms. Lori Lockyer (Research Coordinator). We are ably assisted by six graduate students, each of whom spends 12-15 hours per week at the Centre. This is likely to remain the staffing pattern of the Centre for the next few years with the possible exception of employing a part-time secretary.

With the staffing of the Centre now completed, we have initiated the process of developing and implementing strategies that will allow the Centre to achieve three objectives: to increase the number of funded, independent researchers conducting studies that address sociobehavioural aspects of cancer; to establish a network of research satellites across Canada to conduct studies on sociobehavioural aspects of cancer; and, to provide program development and evaluation consultation services to the national and divisional Canadian Cancer Society (CCS) offices with the intent of increasing the effectiveness of their patient and public education programs. The remainder of this paper is devoted to a description of our preliminary thoughts about how we plan to achieve these objectives.

The foundation of the research community in Canada is comprised of independent researchers, who working along or cooperatively with selected colleagues, pursue research topics of personal interest. The financial support for this research has traditionally come from federal and provincial government agencies, national not-for-profit health organizations and private foundations. While Canada has many social science researchers, too few of them have cancer research issues on their personal research projects supported by the NCIC. We plan to take actions to change this situation.

One immediate goal is to demonstrate to social science researchers the many opportunities for them to pursue their research interests within the field of cancer, and thereby recruit them into the cancer research community. Towards that end, Centre staff will make themselves available for presentations to university-based social science faculty, and at provincial and national conferences. The central message of these presentations will be that social science research has a crucial role to play in the overall effort to reduce the impact cancer has on individuals and society. The impact of social science research can be significant if our research agenda encompasses the continuum from prevention through post-treatment, and if research projects are conducted in all of the intervention research phases of the NCIC framework (see Figure 1).

Figure 1 NCIC Cancer Control Framework

NCIC Intervention Research Phases	Prevention	Early detection	Management	Post treatment
Hypothesis generation	1	2	3	4
Methods development	5	6	7	8
Efficacy studies	9	10	11	12
Effectiveness studies	13	14	15	16
Implementation studies	17	18	19	20
Dissemination/Adoption studies	21	22	23	24

Referring to Figure 1, the NCIC intervention research phases are defined as follows: hypothesis generating studies are descriptive and exploratory studies that lead to the development of testable hypotheses; methods development studies include studies to develop and test methods of measuring outcomes, and studies to develop and assess the viability of interventions; efficacy studies to develop and assess the effects of an intervention under ideal conditions, with particular emphasis being placed on the internal validity of the research design; effectiveness studies test an

intervention within a defined population; implementation studies test an intervention in multiple defined populations; and, dissemination/adoption studies test methods of encouraging persons or organizations to do something that has been shown to be effective. The phases are intended to be sequential, thus efficacy studies on a topic should be conducted before effectiveness studies on the topic are conducted. To simplify the matrix the cancer continuum includes only four categories. Prevention studies focus on issue related to reducing the incidence of a specific cancer; early detection studies focus on issues related to identifying cancer in its early stages; management studies focus on aspects of the treatment process including the provision of palliative care; and, post-treatment studies focus on issues that arise when the treatment has been completed. Each cell of the matrix represents a particular type of study e.g., increase patient adherence to a chemotherapeutic regimen. Within each cell there are numerous possibilities of studies involving different cancer sites (e.g. lung), populations (e.g. patients, providers, families) and interventions (e.g. behavioural, economic, social).

Thus, within this matrix the specific research opportunities are almost endless. For example, a cognitive psychologist interested in studying how patients make decisions among treatment options could conduct studies in cells 3 and 7, while a clinical psychologist interested in testing the effects of specific decision aids of treatment choices could conduct studies in cells 11 and 15. A medical anthropologist interested in understanding how cultural beliefs and practices impact on use of early detection methods could conduct studies in cell 1. A health educator interested in community-based cancer prevention and early detection projects could conduct studies in cells 19 and 23, and, clinical psychologists interested in the effects of different types of support groups on cancer morbidity and mortality rates could conduct studies in cells 12 and 16. The proposed presentations will provide Centre staff with opportunities to discuss specific research projects with social scientists and, hopefully, increase their interest in applying their research talents to the field of cancer.

To complement the recruitment effort we plan to offer research proposal development workshops in each province. The objectives of the workshops will be to describe the NCIC grant review process including a discussion of grant review criteria, and to offer suggestions regarding how to write research proposals. The workshops are likely to be most helpful to researchers who have relatively little experience writing research proposals. Centre staff will also make themselves available to discuss specific research ideas or study methods with researchers, both during and following the workshops. In addition to the above actions, we plan to work with NCIC Director to ensure that the grant proposals received appropriately reviewed. To do this we will attempt to broaden the membership of the review panel to include researchers from a number of the academic disciplines involved in research pertaining to sociobehavioural aspects of cancer, and prepare materials for panel members on the types of research studies that fit within the NCIC cancer control research framework. It is especially important, for example, that panel members realize that within the NCIC cancer control framework studies that use experimental and quasi-

experimental designs, qualitative and quantitative data collection and analysis techniques, or involve the analysis of administrative data sets are all appropriate. If we can accomplish the actions outlined above in the Centre's first year of operation, we will have made significant progress towards achievement of the Centre's first objective. In subsequent years we focus on different strategies related to this objective.

The Centre's second objective involves the establishment of a national research network devoted to studying issues related to the sociobehavioural aspects of cancer. We envision the research network as having the potential to conduct studies in five populations: patients in treatment; persons living with cancer; family physicians; school-aged children and youth; and, communities with populations between 10,000 and 50,000 persons. The network will be comprised of 12-14 research satellite centres (RSC), each of which will have demonstrated access to two or three of the study populations. This could result in a distribution of study populations as depicted in Table 1.

Table 1 Possible distribution of study populations in the NCIC Sociobehavioural Reserach Network

Population	Number of research satellites with access to the population
Patients in treatment	7
Persons living with cancer	8
Family physicians	6
School-aged children and youth	7
Communities: 10-50,000 persons	4

If a distribution of study populations as depicted in Table 1 was actually achieved, it would mean that a study involving family physicians would be conducted at six sites across Canada. By conducting a study at multiple sites simultaneously, as is done in clinical trials, the study can be conducted in a shorter time period and the results are likely to be considered to be more generalizable. Because formulation of a study's questions, hypotheses, and methods will involve discussion among all members of the network, the expectation is that the resulting products will be of a higher quality than if developed by only one of the network's members. This interactive process also illustrates another advantage of network research -- the opportunity to develop professional relationships and friendships with researchers across Canada who share similar interests.

In the past five years interest in developing research networks has increased dramatically, in part because the experiences of successful research networks have been described in the professional literature and at national and international meetings. Among the

characteristics shared by successful networks are: perceived ownership of the network by its members; selection of network studies by its members; pilot testing of study protocol before initiating full-scale studies; ongoing research activity within the network opportunities for network members to have their studies conducted in the network; regular communication among network members; and, opportunities to be involved in the publication of study results. We plan to incorporate those and other characteristics of successful networks into the proposed research network. How they are actually incorporated will be determined primarily by the network's Management Committee that will be comprised of the principal investigators from each of the research satellite centre and senior staff of CBRPE.

A request for applications (RFA) for establishment of the research network has just been released. Review of the applications will focus on two criteria: demonstrated access to the selected study populations, and composition and expertise of the proposed research team. Successful applicants will meet three times throughout the first year to establish operating principles and rules for the network, select study ideas, and develop study protocol. Funds to support pilot studies conducted in the network will come from CBRPE, with the network's Management Committee deciding on the amount of funding necessary for any one pilot study. If the pilot study is successful and the Management Committee votes to expand the scope of the study, a proposal will be written and submitted to the appropriate funding body, e.g. NCIC, MRC, etc. Thus, while support for the pilot studies will come from the CBRPE, support for full-scale studies is expected to come from governmental and non-governmental funding agencies. Clearly the establishment, growth and maintenance of the network represents a formidable challenge. However, if we are successful in achieving this objective the public, the NCIC and the social science research community should benefit in a variety of ways.

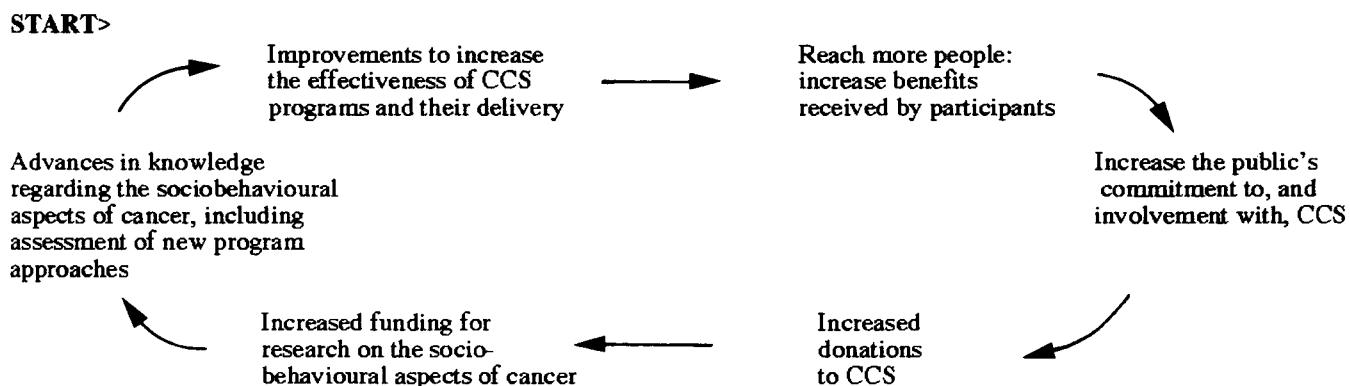
The Centre's third objective involves the provision of program development and evaluation consulting services to the national and divisional CCS offices. The expected outcome of this activity is improvements in the quality of

CCS patient and public programs and/or their delivery, thereby increasing the impact of the programs on the intended audiences. The importance of these activities should not be underestimated. If, for example, a CCS-sponsored program can be modified in its content or delivery such that its effectiveness in achieving participant outcomes is increased by 20%, thousands of program participants across Canada could be positively affected. The Centre's involvement in these activities is coordinated by one of the CCS's national committees in order to ensure that our efforts are directed at programs the CCS considers to be of regional or national importance. Examples of consultation services currently being provided by Centre staff include; the development of a plan to evaluate the Reach-to-recovery and CanSurvmount programs; the development of a protocol for formative and summative evaluations for telephone-based cancer information services; and analysis of the theoretical assumptions underlying empowerment-based patient education programs; and, a critical review of the published literature on the needs of cancer patients. We anticipate that improvements in the quality of CCS sponsored programs, in the process of delivering these programs, and in the number of people who are reached by these programs will benefit all parties, including the social science research community (see Figure 2).

Conclusion

The NCIC Board of Directors has made a 5 year commitment to the CBRPE. At the end of this time period the Centre needs to demonstrate to an independent scientific review committee and the NCIC Board that it has achieved, or made significant progress toward achievement of, its three primary objectives. Achievement of the objectives, especially the first two objectives, requires the active involvement of persons from the social science research community, who in turn should benefit from the Centre's success (Figure 2). However, if we are successful, the most important beneficiaries should be the people of Canada who hopefully will experience cancer less frequently, experience less morbidity related to the diagnostic and treatment processes should they develop cancer, experience a higher quality of life in the years following treatment, and at some distant time, see the cancer mortality rates decline.

Figure 2 Benefits related to CBRPE consulting activities



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Memories, dreams and refractions

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Abstract: This paper presents some details from a series of studies concerned with attitudes and beliefs about cancer.

Résumé: Cet article présente quelques détails de plusieurs études sur les attitudes et les croyances au cancer.

*"The past - qua past - only exists in the present,
in memory; it is not to be confused with
the 'past presents' we formerly lived"
(Freeman, 1993)*

The focus of my research into cancer over the past few years has been on public and private attitudes and beliefs about the disease. This research has used various methods ranging from traditional public attitude surveys, through interviews to content analysis of popular magazines and survivors' autobiographies. In this article I would like to comment on some of the findings from this unfolding research enterprise.

Patient autobiographies

But as the Mad Hatter might say when invited to tell a story, a story is no good without an ending so let's begin at the end. My most recent research has been concerned with exploring the autobiographies produced by survivors of cancer. This research has opened up for me a whole new literature which has often been ignored by psychologists but is now being enthusiastically pursued by historians, anthropologists, sociologists and other researchers interested in understanding the human psyche. This has led to the creation of a new interdisciplinary force known by such names as narrative social/human science/studies. Evidence of the rapid growth of interest in this approach can be found in such new ventures as the *Journal of Narrative and Life History*, *The Narrative Study of Lives*, special issues of *Sociology* and of the *Sociological Quarterly*, and a rash of symposia at recent social science conferences.

Within psychology, there is increasing interest in this "narrative turn" led by such people as Polkinghorne, Bruner,

and Howard. (Please note the planned workshop at this year's CPA congress). These researchers emphasize that, in the words of Miller Mair (1992), "we live in and through stories. They conjure worlds. We do not know the world other than as-a story world. Stories inform life. They hold us together and keep us a part". We exchange stories about ourselves and others in our everyday interaction. These stories have a certain structure, an understanding of which can give us an insight into the individuals who recount them and of the society in which they live.

The stories the cancer survivors tell about their lives make fascinating reading (see Murray, 1994). In them, they describe their experience of cancer from diagnosis, through treatment (usually surgery) to reassessment of their lives and how they should live them. In analysing these autobiographies you can consider these sequences in a factual manner. However, a more interpretive stance considers the perspective of the author - one who has survived/beaten cancer, one who has come through a crisis and now lives with death more real than imagined. Many of the writers emphasize the positive features of having cancer.

In a fascinating description of a series of autobiographies Mark Freeman (1993) emphasizes how the end shapes the beginning. St. Augustine writing about his salvation does so after he has seen the light. Looking back he sees a destitute creature: "I was tossed and spilled, floundering in the broiling sea of my fornication, and you said no word". Then he saw the light and was transformed. The cancer survivor often adopts a similar perspective. The very experience of having cancer transforms their lives. In analysing these autobiographies, and in understanding the importance of perspective, I now look back on my earlier work more self-consciously seeking a pattern, a sequence of development.

Interviews with the public

Although I have been involved in a series of quantitative studies there was always a feeling of dissatisfaction but one which was difficult to reconcile with the attitude of funding bodies. I recall applying in the early eighties to conduct a study based upon interviews. The reviewer's comments were quite amusing, in recollection. He wrote with bemusement (I recall from memory) "The applicant seems to want to talk to people. This isn't very scientific". Fortunately, other funding bodies were not so hostile to the interview as a means of data collection.

One study I conducted involved detailed interviews with a cross-section of the population about their views on cancer, its causes, its treatment, etc (Murray & McMillan, 1991). These interviews provided me with an initial insight into how the general public views cancer - to get behind the generalized picture of fear. The character of the fear varied across the participants from young men who dismissed it as something of little relevance to them, to young women who viewed it with foreboding, to older people who adopted a more accepting stance.

In considering the structure of these popular representations I turned to the historical literature (Murray, 1992). There the evidence suggested that in previous eras cancer was not such a fearful beast. Rather in the days of

the great infectious diseases cancer was just one of many threats to survival. Further, in an age when religion was more powerful, it was accepted that our period on earth was transitory and that death was the gateway to a new life. There was also the whole ceremonial which the Church established around death. As one medical historian put it "Death was a learnt procedure, part of the ceremonial of life" (Wear, 1985). In our era this is not the case. Death is something to be avoided at all costs and hidden from the eye if at all possible in hospitals and other institutions.

One particularly contemporary part of modern fear of cancer, and apparent in these interviews, is the fear of the treatment. Surgery, radiotherapy, and chemotherapy ("slash, burn and poison" in more popular terms) are all sources of fear. There is the long lingering pain associated with the disease but this is compounded by modern-day treatment which can not only cause nausea, loss of hair, and disfigurement, but, in the eyes of many, actually contribute to the cruelty of death. In our society a quick death, such as through a heart attack, is a 'good' death unlike the slow painful death associated in the eyes of many with cancer.

Another theme which was particularly strong among both the lay public and in the survivors' autobiographies was the theme of injustice. Unlike with other diseases cancer often seemed to strike the least deserving - the young mother, the hard-working father. Lerner's concept of Belief in a Just World was particularly apposite here. Indeed, Epstein (1991) has argued that it is the very disconfirmation of basic belief systems, such as belief in a just world, which lies at the base of the post traumatic stress syndrome.

Surveys

We also conducted a large community survey of public attitudes to cancer (see Murray & McMillan, 1993). This confirmed the widespread nature of the public fear of cancer, particularly among women. The most frequently cited reasons for this fear was the perceived incurability and the pain associated with the disease. There was also some other fears including the perceived randomness of the disease ("anyone could get it"), and its insidious nature ("it can be growing inside you while you have no idea and feel fine"). This perceived insidious nature of cancer was also suggested in the popularity of the term "an eating-away disease" as a descriptor. One additional insight from this survey was the reported popularity of magazines and newspapers as a source of information about the disease. This prompted another study.

Popular magazines

In considering the etiology of people's beliefs I turned to popular magazines. Last summer I reviewed all of the issues of twelve popular magazines published in Canada in the previous year (Murray, 1993). There was limited reference to cancer. The few that there were, were generally upbeat and emphasized the value of prevention - especially through breast examination, mammography, and pap smears. There was almost nothing on the treatment of the disease itself and what happens afterwards. It seemed that cancer was still a hidden disease, one not to be talked about in polite circles.

A new beginning

On looking back with a new perspective I realise that the story I have told has a certain sequence. Admittedly this has been constructed and loose ends have been ignored. But that is in the nature of a story. Howard (1993) has argued that the very essence of research is the construction of a good story - not one which is fabricated but one which can find support in the evidence available and which can provide a new insight into the issue under investigation. Narrative theory makes this underlying assumption more apparent. This theory not only offers a new approach for research but a whole new approach to therapy with cancer patients and survivors. But that is another story.

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- Contact Dr Michael Murray, Division of Community Medicine, Memorial University of Newfoundland, St. John's, Newfoundland A1B 3V6.

The psychologist within a cancer centre: the Calgary experience

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Abstract: This article describes some of the activities of a large psychosocial oncology department and makes some suggestions for the potential contribution of psychologists in a medical setting.

Résumé: Cet article décrit les activités d'un grand département d'oncologie psycho-sociale et donne des suggestions sur les rôles potentiel des psychologues dans un milieu médical comme tel.

The dynamic field of psychosocial oncology provides challenging clinical, research and training opportunities for psychologists in a medical setting. Psychologists and interns working at the Tom Baker Cancer Centre in Calgary, Alberta apply psychological principles to real life situations as they help cancer patients and their families cope with cancer and adapt to life.

Clinical Service

The Department of Psychosocial Resources was established in 1981 to meet the counselling needs of southern Alberta cancer patients. The unique combination of psychology and social work (as well as consultant psychiatrists) in one department was recognized by the Canadian Council on Health Facilities Accreditation in a 1992 Alberta Cancer Board report as a model for other Canadian medical facilities. This organizational structure deruces administrative expense and duplication of services and fosters interdisciplinary co-operation, enabling professionals to function as a team as they conduct counselling, university and community education and research.

Members of the department may work as a single unit (for example, when addressing policy issues at a staff

meeting) or may separate in smaller working groups to accomplish tasks such as selection of new personnel or the production of patient education materials. From a staff of two - one psychologist and one social worker - in 1981, the department has grown to a complement of six professionals, a post-doctoral fellow in psychology, as well as a number of internship and practicum students in 1994. When it was founded, the department received approximately ten referrals monthly, currently it receives approximately seventy referrals each month.

Working primarily within a medical population provides unique opportunities for psychologists at the Cancer Centre, opportunities which may be unavailable in a more traditional mental health setting. Psychosocial staff function as members of the medical team in a majority of the Centre's clinics, which are organized to serve patients with specific cancer diagnoses. Patients may also self-refer by contacting the department directly. Psychological services are offered to patients and their families.

As one can imagine, cancer can pose an overwhelming assault on those whose lives it touches. Initial diagnosis, onset of treatment, negative physical reactions to treatment, cancer recurrence or fear of recurrence, decisions to terminate active care, anniversary dates and re-entry into everyday life are all moments which may provoke a crisis in a patient. Special emphasis is placed by the department on the Centre's bone marrow transplant, head and neck, neurological, gynecological, breast, and pain clinics, as these areas have demonstrated either a considerable demand for psychological services or have been perceived as patient groups most likely to experience protracted distress and which would most benefit from early and ongoing support.

The psychosocial member of a medical team may perform a diversity of tasks, such as providing education, behavioural management or adjustment counselling, advocating for patients' socio-emotional needs, mediating between patients and professionals, or acting as a community liaison. Psychosocial staff are in an enviable position as they may be the only member of the treatment team able to provide continuity of care to a patient throughout diagnosis, treatment, recurrent disease and palliative care.

Emphasis is placed not only on remedying dysfunction, but also upon its prevention. This is accomplished through routine screening upon patient entry into clinics as well as ongoing follow-up during the course of treatment. Indeed, the very presence of psychological services in what is fundamentally a medical treatment facility is indicative of this preventative approach: if the patient and family can be guided past the psychological/emotional pitfalls often associated with serious illness, it follows that compliance with treatment regimens may be enhanced, medical care will be facilitated and, in the end, the patient will benefit, not only in terms of adjustment but even, as some authors suggest, in longer survival (Spiegel, 1989; Maunsell, 1993).

Training

The Tom Baker Cancer Centre, although separate administratively, shares a site with both the Foothills

Hospital and the University of Calgary Faculty of Medicine. This proximity has enabled the department to forge links with programs at both centres which enhance the psychology training opportunities offered. The Foothills Medical centre Consortium in Clinical Psychology, a CPA-accredited (1991) program of which the Tom Baker Cancer Centre is a part, offers a one-year internship program designed to provide advanced training in the application of psychological principles to clinical concerns. Interns work closely with supervisors in the assessment and treatment of a broad variety of patient problems in diverse settings, from psychiatry services in a tertiary general hospital to outpatient pain and symptom control in the day care unit of a provincial cancer hospital.

Training in psychosocial oncology, in particular, has become a sought after feature of this internship. Students have been accepted from both Canada and the United States, and one medical student from New Zealand completed an elective at the Centre. A post-doctoral fellow funded by the Alberta Division of the Canadian Cancer Society has been in existence since 1984. Graduates of this program have accepted positions across Canada.

In 1993 the University of Calgary Faculty of Medicine expanded its program to include a Department of Oncology. Along with Divisions of Medical Oncology, Surgery, Gynecology and Radiotherapy, Psychosocial Oncology was given Divisional status, with the majority of faculty in this division being psychologists. This is further testimony to the growing awareness that the patient is a complex being, with significant psychosocial needs developing as a result of a cancer diagnosis. Medical residents will now be exposed to the psychological sequelae of cancer through seminars and formal lectures.

Opportunities for educational activities are not limited to professional environs. Psychologists, along with other psychosocial staff members, participate in ongoing community education groups such as the very successful Smoking Cessation Program. Staff receive regular invitations to speak in university faculties as well as community agencies. Cancer centres, by their very nature, have a high profile in their respective communities. Psychologists working in these facilities are able to promote greater awareness of the psychosocial impact of illness as well as to develop programs for health promotion and cancer prevention.

With cutbacks looming in the medical system, fewer staff will be expected to do more in patient care. The Tom Baker Cancer Centre, will have to strengthen its links with community agencies and provide broader based training to enhance the ability of community practitioners to meet the needs of this difficult population.

Research

With regard to research, the opportunities for psychologists seem almost limitless. Tremendous growth in interest in the psychological aspects of cancer has taken place in the last twenty years (Guex, 1994). In recent years two journals - **The Journal of Psychosocial Oncology** and **Psycho-oncology** - have been founded for the sole purpose of focusing on the psychosocial dimensions of cancer. As

well, almost all medical journals dealing with cancer place some emphasis on the psychological care of the patient. Also, most clinical studies now include psychological and/or quality of life measures as components of clinical trials.

Physician sensitivity to patient needs and psychological issues makes the Cancer Centre receptive to research and multidisciplinary team collaboration. Perhaps in no other medical setting is the psychologist more welcome as an equal and valued team member.

Gratitude is expressed to Michael Speca and Linda Easthope for the assistance provided in the preparation of this article.

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Contact Dr Barry Bultz, Department of Psychosocial Resources, Tom Baker Cancer Centre, 1331 - 29 Street NW, Calgary, Alberta T2N 4N2

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CONFERENCE DATES

Canadian Association of Psychosocial Oncology
Annual Meeting and Conference
Theme: Ethics, economics and empathy: the challenge in oncology care
Ottawa, 2-3 June 1994
Contact: Carolyn Cashman
Coordinator, Education Services
Royal Ottawa Hospital
1145 Carling Avenue,
Ottawa K1Z 7K4

Tenth International Conference on the Care of the Terminally Ill
Montreal, 17-21 September 1994
Contact: Congress Secretariat
4260 Girouard, Ste. 100,
Montréal, Québec H4A 3C9.

XVI UICC International Cancer Congress
New Delhi, India, 30 October 1994
Contact: Mr Anthony Marchini
Administrative Secretary
International Psycho-oncology Society
Psychiatry Services
Memorial Sloan-Kettering Cancer Center
1275 York Avenue
New York, NY 10021
(Fax: 212-717-3087)

American Association for Cancer Education, Annual Conference
Louisville, Kentucky, 17-20 Nov 1994
Contact: Dr RM Chamberlain
Department of Epidemiology
MD Anderson Cancer Center
1515 Holcombe Blvd
Houston, Texas 77030

Periodicals

Journal of Nursing Care
Editors: A. Faulkner & I Scott
Publisher: Churchill Livingstone
Robert Stevenson House
1-3 Baxter's Place, Leith Walk
Edinburgh, Scotland EH1 3AF.

Journal of Cancer Education
Editor: Dr RF Bakemeier
4125 East Third Avenue
Denver
Colorado 80220.
Publisher: Hanley and Belfus Inc.
PO Box 1377
Philadelphia, PA 19105-9696

Journal of Psychosocial Oncology
Editor: JR Zabora
Department of Patient and Family Services
The Johns Hopkins Oncology Center
600 N. Wolfe Street
Baltimore, MD 21205.
Publisher: Haworth Press
10 Alice Street
Binghamton, NY 13904-9981

Psycho-Oncology
Editor: JC Holland
Memorial Sloan-Kettering Cancer Center,
1275 York Avenue, New York 10021
Publisher: John Wiley Inc
New York.

**A Special Section of
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**Une Section spéciale
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de la santé 1994, Vol 2(1)**
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**Annual Conference 1994 --
Penticton**

**---- Congrès annuel 1994
Penticton**

The following symposia have been planned by the section for this year's conference in Penticton/
Les symposiums suivant sont planifiés par la section, pour le congrès annuel à Penticton:

1. Qualitative Research in Health Psychology

Moderator: Michael Murray, Memorial University

a) **Analysing popular accounts of health and illness** by Michael Murray, Memorial University of Newfoundland

b) **Causal attributions as revealed in the life stories of women with arthritis** by Vaughan Miller, University of British Columbia

c) **Women's experience with myocardial infarction: a phenomenological approach** by Michele Bowers, University of British Columbia

d) **Telling stories: constructing meaning in focused interviews** by Cynthia Mathieson, Mount Saint Vincent University.

2. Hospital Psychology: Challenges and Opportunities

Moderator: Murray Schwartz, Victoria General Hosp.

a) **Is this an opportunity or just a disaster?** by Murray Schwartz, Victoria General Hospital, Halifax

b) **Challenges in Health Care Facilities** by Michael King, Calgary General Hospital

c) **Designer decentralized hospital organization: how does psychology look?** by Brian Ridgeley, Sunnybrook Health Sciences Centre, Toronto

d) **Hospital psychology: the challenge of the new management** by David Duncan, Peel Memorial Hospital, Brampton

e) **In defense of the management matrix** by Bob Robinson, Alberta Children's Hospital, Calgary.

In addition, there will be a further 24 papers on a variety of topics presented as posters./

En outre, il y aurait 24 articles de sujets variés, présentés par affiche.

Election Time

Nominations are required for the positions of President-elect and Secretary-Treasurer who will assume office at the 1994 Annual Meeting.

The current officers are Jerry Devins (Chair) and Patricia Dobkin (Secretary-Treasurer).

If you are interested in either of these positions or would like to assist in any way in the running of the section, please contact me.

Le temp d'élection

Des mises en candidature pour les postes de futur-président et de secrétaire-trésorier sont requises. Ces personnes assumeront leurs fonctions lors de l'assemblée annuelle.

Le président courant est Jerry Devins et la secrétaire-trésorier est Patricia Dobkin.

Si vous intéressez à ces postes ou vous voulez d'assister la section informez-moi, s'il vous plaît.

-MM

Physical Disability and Social Policy

Jerome E. Bickenbach

University of Toronto Press: Toronto
1993, 327 pages
Softcover, \$24.95
ISBN 0-8020-7419-7

In this excellent and well-considered book, the author explores principles that should guide the formulation of social policy, that is the rules our institutions use to decide what we as a society owe to those of us who have physical disabilities. With the World Health Organization's conceptual framework of impairment, disability, and handicap as an organizational tool, the book argues that current social policy is fragmented and contradictory.

This current disorganization appears to lie in the fact that there are diverse models of social policy that address primarily one or the other of the dimensions in the WHO classificatory system. After considering the strengths and weaknesses of these biomedical, economic, and socio-political models, the author argues for the need for a paradigm that integrates these approaches and addresses the interrelated aspects of what he calls "disablement".

A focus for this integration, the author proposes, is the concept of equality of capability. As he puts it, "What is required to respond to disability is capacitation and accommodation, and more often than not these things require the creation or strengthening of social relationships that respond to the interactional nature of the particular disability".

A question that should be answered, though, is "For whom is this an excellent book?" Clinicians who are looking for a text with straightforward implications for what should be done to help persons with disabilities will be disappointed with the highly abstract and theoretical presentation. Those, however, who are involved in larger issues of policy

analysis and health service planning, whether they are clinicians or not, will find this a fertile and instructive volume.

Although there is a long road to travel in preparing a solid theory of social policy that is relevant to disablement, and one which will provide clear guidelines for action, this monograph concludes on an optimistic note of pointing to the concept of equality of capability as a viable principle around which to form this theory.

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Health and Optimism

Christopher Peterson
and Lisa M. Bossio

Collier Macmillan: Don Mills, Ontario
1991, 214pp
Hardcover, n.p.
ISBN 0-020924981-3

This book is a brief but readable summary of research focused on the psychological trait optimism. Although the book purports to provide new research on the relationship between positive thinking and physical well-being, it is essentially an overview of a broad program of research based on attribution theory.

The authors clearly distinguish between optimism and Pollyanna type attitudes and define optimism as "a set of beliefs that lead people to approach the world in an active fashion" (p. 9). Importantly, Peterson and Bossio clarify what optimism is and is not, i.e., it is not a rigid trait, but is reality based and reflects productive activity.

The research project that was the impetus for this book was the longitudinal **Harvard Study of Adult Development** of young adult men. Although an important finding of this study was the relation between global-

stable causal attributions about health and health status at specific intervals years later, the correlations between attributions and health status at each of the follow-up periods were quite low.

This project and the focus of most of the research described in this book is based on the construct explanatory style defined as how an individual explains the causes of positive and negative events and outcomes. Explanatory style is generally measured by the Attributional Styles Questionnaire or by the CAVE (Content Analysis of Verbal Explanations) technique. Both are self-report instruments that assess causal attributions in terms of their locus, stability, and globality. Optimistic styles are reflected in internal, stable and global attributions for positive events, whereas pessimistic styles for similar events are external, unstable, and specific.

By providing an overview of the research on optimism and pessimism the authors attempt to establish the link with health. I particularly appreciated the set of criteria provided for evaluating research findings that link psychological states and physical health. Evidence from health issues such as the common cold, cancer, and immune system competence is compelling. Appropriately the authors caution the reader that there are still many unanswered questions, and that the findings should not be overstated. Moreover, the folly of blaming victims of illness because of their psychological states is reinforced.

Chapter 3 is a review of several lines of research by other investigators and provides additional evidence of how positive thoughts may be related to good health. The research that is briefly highlighted includes: dispositional optimism, hardiness, self-efficacy, social support, stress, coping, inhibited power motivation, Type A Behavior Pattern, and bereavement. The authors go on to speculate about the origins of optimism. Early influences in people's lives that might be related to the development of traits such as optimism/pessimism are highlighted (e.g. Piaget's theory of developmental stages, Carol Dweck's work on adult feedback).

Biological and emotional routes

through which optimism and pessimism might affect health are the focus of the next chapter. However, the authors remain consistently cognitive in their perspective. They posit that the "process of bolstering one's well-being must start with thoughts and beliefs" (p. 90). The early research on animals and learned helplessness is summarized and linked to physiological processes and emotional routes (e.g. depression).

Optimists are portrayed as being better at problem-solving, goal setting, perseverance, are higher achievers, and have more healthful habits, whereas pessimists act helplessly and are passive. Optimism is considered a highly stable disposition, yet the authors suggest several forms of psychotherapy that they feel could usefully affect the attributional styles of adults (e.g., behaviour modification, rational emotive therapy, and cognitive therapy). This chapter would benefit from some reference to the recent constructivist therapies because of their focus on individuals' constructions of meaning (e.g., Mahoney, Guidano, Liotti, or Neimeyer).

The final chapter provides an interesting historical overview of investigations on how the mind and body influence one another. The authors speculate on a shift in North American society to a more pessimistic world view. An important but very brief discussion on the distinction between primary control (optimism) and secondary control is a tease for further research on optimism when optimism is not enough.

Overall, the reader is provided with a capsule summary of an extensive research program that is still ongoing, and for this reason alone it is worth reading. The book is suitable for an undergraduate course or seminar in health psychology. However, the experienced researcher or advanced student will be frustrated by the lack of detail and omission of thorough conceptual and methodological criticisms of explanatory style and the concepts optimism/pessimism.

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No Time for Nonsense: Getting Well Against the Odds

*Ronna Fay Jevne
& Alexander Levitan*

LuraMedia
1989, 211 pages
Paperback, n.p.
ISBN 0-

This book joins the growing number of self-help books available to medically ill patients seeking to cope with their diseases. These texts vary in their scope, depth, and value, and therefore, need to be examined carefully. I have reviewed this one with the main question in mind, "How will this be understood by the reader?"

The book is divided into nine sections: (1) Introduction, (2) Perspective, (3) Resources, (4) Communication Skills, (5) Feelings, (6) Body, (7) Self-help, (8) Endings, and (9) Conclusion. True to the title, the authors waste no time getting their points across. The pace, however, may overwhelm a patient who has never considered such serious matters (e.g., pain, suffering, death) previously. As a health psychologist while reading each brief, advice-packed chapter I nodded in agreement; yet, in the back of my mind, I kept wondering how the "uninitiated" would assimilate this condensed version of what usually takes many years of life experience and much introspection to acquire.

In fact, the title reflects the distorted (?) Western sense of there not being enough time. In my opinion, one's perception of time pressure contributes to psychological and somatic complaints. In a typically cognitive-behavioural manner, the book appeals to logic, but fails to develop adequately other aspects of the self that may contribute to healing or "self-actualizing". While a passing acknowledgement to spirituality is made, my experience with seriously ill patients has shown me that this aspect of their lives may take on larger dimensions than implied by this book.

(I refer the reader to Borysenko (1993) for an in-depth discussion of this issue.)

While the humor injected throughout the text may appeal to some, others may find it alien or even offensive (e.g. "Death and Other Tough Goodbyes"). A more serious problem, in my view, is the superficial treatment of various topics. For example, the chapter teaching hypnosis suggests that this technique is simple to learn ... just "see a switchboard in your brain with a switch for each and every part of your body" (p 171). Some information provided is inaccurate (e.g. the effectiveness of treatment for nausea and anticipatory nausea and vomiting). Finally, my last reservation concerns the minority of medically ill patients who also have significant psychological problems. This book is not for them.

In summary, this book may be helpful for those patients who wish to deal with their illness in a highly logical manner and for those who are free of psychological disorders. I would recommend it only to those who feel that they do not have the time to address these issues more thoughtfully.

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The Elderly Caregiver: Caring for Adults with Developmental Disabilities

Karen A. Roberto

SAGE: Newbury Park, CA
1993, 216 pages
Paperback, \$23.95
ISBN 0-8039-5021-7

Caring for adults with developmental disabilities requires an understanding of the services provided in the community. This text's objective is to achieve this understanding in a coherent manner. In addition to enlightening the reader with its contemporary knowledge of the field, the text is well-organized and includes some of the most impressive empirical work conducted in this area. As well, it provides some good suggestions for future research.

The individual writers included represent a cross-section of academics, clinicians and case workers who are integrally involved in the research and practice of gerontology. The work provides a comprehensive perspective on family caregivers, aging caregivers and the aging of people with developmental disabilities who are recipients of care.

At a time when numerous books on deinstitutionalization, community care of the mentally ill, and the intellectually impaired are appearing on the market, it is a great pleasure to see a book that is well-rounded. Aside from its gerontological aspects, the book addresses several important, yet frequently ignored topics such as federal deficits and the cost of health care. The book provides an up-to-date review of several issues: the concerns of older caregivers for aging adults with developmental disabilities and Alzheimer's in the community, the impact on older caregivers and the service community, and practice, research and policy directives in gerontology. A comprehensive and well-organized table of research studies is provided to highlight studies that relate specific sequelae to particular contextual factors.

Roberto organizes her book into four major sections, each of which contains several chapters (11 in all). Several of the chapters were particularly noteworthy. In Part I Roberto provides an excellent review of the literature related to family caregivers. This chapter is worth reading by anyone interested in conducting a study on this issue. It considers the definition of the older caregiver, the consequences of caregiving, the role of siblings and other informal care providers and the interface with formal services. The findings reveal several similarities between family caregivers of older adults and those of aging individuals with developmental disabilities.

The chapter by Heller provides an excellent review of the research literature examining changes in burden and placement desire. She also employs the use of the life-span perspective to examine the impact of burden, predictors of burden, out-of-home placement, difference in stressors and other practical issues.

Part II (Issues and concerns of older caregivers) examines several practical issues including biopsychosocial changes in individuals with Down Syndrome and considers the potential effects on the aging caregivers and aging adults with this impairment.

Part III (Interactions between older caregivers and the service community) and Part IV (Practice, research and policy directives) highlight the extent of the problems associated with caregivers involving urban vs rural case management. The authors address issues such as current care, future services and research needs.

Both of these parts are well written and thoughtful and should stimulate professionals and caregivers to broaden their perspectives regarding populations at risk and their understanding of the impact of the aging process among the providers and recipients of care in the community. The authors provide excellent ideas for methods of assessing the problems facing the population in question.

Roberto and her contributors

should be commended for providing the range of material as well as for the bold attempts particularly in integrating this diverse area.

Although my overall impression of this book is favourable, there was a minor drawback. The text somehow omitted the psychoeducational and behavioural interventions for family caregivers who are frail and burdened by their responsibilities (see references below). Despite this minor drawback I recommend this book as a valuable text for researchers, practitioners and students of gerontology. Further, it will serve as an invaluable book for caregivers themselves. It has undoubtedly made a significant contribution to the field.

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Director

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Health Psychology: An Introduction to Behavior and Health (2nd edn)

Linda Brannon & Jess Feist

Wadsworth: Belmont, CA.
1992, 544 pages
Hardback, n.p.
ISBN 0-534-16536-2

This is an introductory health psychology textbook written for undergraduate psychology students. The book is easy to read and covers both research and applied issues. The first chapters introduce health psychology and the research methods used in this area. Subsequent chapters focus on specific topics such as stress, pain, cardiovascular disease, cancer, compliance, drug addiction, dieting, and exercise. Most chapters start with a brief case study and each chapter is followed by a summary, glossary, and short annotated list of suggested readings.

Unfortunately, this book has a number of serious weaknesses. For example, the writers state that one of psychology's most important contributions to behavioural medicine is psychology's expertise in measurement (p28). I agree with them. But if they feel that measurement is so important, why did they only devote three pages (pp 26-28) specifically to measurement issues? Furthermore, the term "measurement" does not appear in the index. In addition, their description of psychometric reliability is too brief and their description of psychometric validity fails to mention construct validity. Yet another measurement-related problem is their failure to use metric or SI units.

The text also contains some inaccuracies. For example, they claim that Kulik and Mahler (1987) investigated the effects of providing their subjects with information about their postoperative roommates (p239) but Kulik and Mahler actually looked at the effects of their subjects' preoperative roommates. There are also several errors in the authors' presentation of diabetes mellitus. They state that both Type 1 and Type 2 diabetes are caused by insulin

deficiency (p293), but Type 2 diabetics often have elevated insulin levels. They also completely fail to mention that a very important characteristic of Type 2 diabetes is a low sensitivity to insulin. Furthermore, the presentation of the complications associated with diabetes in one table (Table 11.1, p293) is both incorrect and inconsistent with the text directly below the table. The text correctly lists some of the complications that diabetics are prone to.

Finally, Brannon and Feist focus almost exclusively on the United States. Instructors who want to provide their students with information about Canadian issues will have to supply additional material.

When I started reading this book I expected to like it because I liked Feist's (1990) personality textbook. But as a result of the inaccuracies, some of which are noted above, and its lack of attention to measurement issues, I cannot recommend this book.

References

Feist J (1990) **Theories of Personality** (2nd edn). Holt: Fort Worth.

Kulik J, & Mahler H (1987) Effects of preoperative roommate assignment on preoperative anxiety and recovery from coronary bypass surgery. **Health Psychology**, 6, 525-543.

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The Social Context of the Chronic Pain Sufferer

Ranjan Roy

University of Toronto Press: Toronto
1992, 183 pages
Paperback, \$19.95
ISBN 0-8020-7360-3

This book is divided into three parts. Part one, Conceptual Issues consists of a single chapter of sixteen pages overviewing social and

psychological issues. Part two, Assessment Issues, contains four chapters titled - Pain, loss and grief; Life events and pain; Childhood abuse and neglect: Pain in adulthood; and Interpersonal issues: The patient's family system. In section two he raises the concept of psychogenic pain and the pain prone patient, originally conceptualized by Engel (1959), which emphasises the role of pain in the expiation of guilt. The role of childhood abuse in the development of chronic pain in adulthood, as understood by Engel's psychodynamic concepts, is reviewed again in the chapter on Dynamic psychotherapy.

Part three, Methods of intervention, consists of four chapters titled - Social strategy interventions; Task-centred approach; Dynamic psychotherapy and pain; and Crisis intervention. Each chapter briefly summarizes a particular psychological treatment strategy. Roy's intent is to discuss critical areas of dislocation in patients' lives caused by chronic pain. In addition to providing a review of the related literature, he provides numerous clinical vignettes from his own practice.

The book addresses topics in the assessment and treatment of chronic pain that are not regularly found in the chronic pain literature. Consequently, not a great deal of literature exists for some of these topics. What literature is available is presented without much critical or methodological review. However, for the novice mental health professional who wishes to broaden his or her view of assessment considerations and treatment options for chronic pain patients, this book would prove interesting reading. Roy delivers on his promise that his book represents "a departure from the trodden path" (p.xiv).

References

Engel G (1959) 'Psychogenic' pain and the pain-prone disorder. **American Journal of Psychiatry**, 26, 899-918.

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**Books received/
Livres reçus**

M Silberfeld & A Fish (1994)
**When the Mind Fails: A Guide to
Dealing with Incompetence.**
University of Toronto Press: Toronto

S. Néron (1993)
L'Anxiété et La Panique.
Éditions du Méridien: Laval

LJ Martelli et al (1993)
**When Someone You Know Has
AIDS**
Crown: New York

AW Siegman & JTW Smith (1993)
Anger, Hostility, and the Heart.
Erlbaum: New Jersey.

HC Traue & JW Pennebaker (1993)
Emotion, Inhibition and Health.
Hogrefe & Huber: Kirkland, WA.

EP Sarafino (1994)
**Health Psychology: Biopsychosocial
Interactions (2nd edn)**
John Wiley: Rexdale, ON.

NJ Fox (1994)
**Postmodernism, Sociology and
Health**
University of Toronto, Toronto.

Periodicals

**Journal of Clinical Psychology
in Medical Settings**
Editor: RH Rozensky
Department of Psychiatry
Evanston Hospital/ Northwestern
University Medical School
2610 Ridge Avenue
Evanston, Illinois 60201-1789.

**Journal of Rehabilitation
and Health**
Editor: AJ Goreczny
Behavioral Science Research
Institute, University of Pittsburgh
School of Medicine, 204 McAlister
Drive, Pittsburgh PA 15235.

Journals published by Plenum
Publishing, 233 Spring Street, New
York, NY 10213-0008

CONFERENCE DATES

**Eighth European Conference on
Health Psychology**
Alicante, Spain
13-15 July 1994
Contact: Lisbet Sorensen
Dp'to Psicologia de la Salud
Facultad de Medicina, Iniversidad de
Alicante, Campus de Saint Joan, Ap
Correos 374, E-3080 Alicante, Spain

**36th Annual Scientific Meeting of
the American Association for the
Study of Headache**
Chicago
24-26 July 1994
Contact: Melissa Bishop,
Senior Meeting Manager,
AASH Headquarters,
875 Kings Highway, Suite 200,
Woodbury, New Jersey 08096.

XII World Congress of Cardiology
Berlin, Germany
10-14 September 1994
Contact: ECCO, Central Office, 22
Rue Juste-Olivier, PO Box 299, CH-
1260 Nyon, Switzerland.

**Second World Conference on
Bioethics**
Buenos Aires, Argentina
24-26 October, 1994
Contact: Escuela Latinoamericana de
Bioética Fundación,
Dr JM Mainetti,
Colle 508e 16 y 18,
(1893) MB Gonnet, Argentina.

**Fifth International Conference on
Stress Management**
Theme: Stress at the workplace: health
and productivity
Noordwijkerhout, The Netherlands
2-6 April 1995
Contact: Congress Secretariat
Van Namen & Westerlaken
Congress Organization Services
PO Box 1558,
NL-6501 BN Nijmegen,
The Netherlands

INFORMATION

**The Canadian Health
Psychologist**
Edited by Michael Murray

The Canadian Health Psychologist is produced by the Health Psychology Section of the Canadian Psychological Association and distributed to all members of that section. It is designed to serve as a discussion forum for any issues of relevance to psychologists working in the area of physical health. The editor welcomes brief articles, reports of events, letters, news of members, research and intervention reports, book reviews and announcements. Articles should be no longer than 2000 words with ideally no more than six references, and with an abstract in English and in French. If possible, articles should be submitted in ASCII format on a 3/2" diskette.

"The opinions expressed in this newsletter are strictly those of the author and do not necessarily reflect the opinions of the Canadian Psychological Association, its officers, directors or employees."

**Le psychologue canadien
de la santé**
Édité par Michael Murray

Le psychologue canadien de la santé est produit par la section de psychologie de la santé de la Société canadienne de psychologie et est distribué à tous les membres de cette section. Son but est de servir comme agent de discussion pour psychologues qui travaillent dans le domaine de la santé physique. Les articles courts, rapports d'événements, lettres, nouvelles des membres, rapports de recherche et d'intervention, des comptes rendus et annonces sont la bienvenue chez le rédacteur pour soumission. Idéalement, les articles ne devraient pas dépasser 2,000 mots avec moins de 6 références ou moins et si possible, incluent un résumé en français et en anglais. Aussi, si possible, les soumissions devraient être présentées en format ASCII sur une disquette de 3 pouces et demi.

"Les opinions exprimés dans ce bulletin sont strictement ceux de l'auteur et ne reflètent pas nécessairement les opinions de la Société canadienne de psychologie, ses officiers, ses directeurs, ou ses employés."

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