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Psychosocial Well-being in Testicular Cancer Patients

MOST STUDIES of the psychological and social sequelae of the diagnosis and treatment of specific types of cancer have focussed on the first two years after diagnosis [1]. So, a study (*Eur. J. Cancer* 1991, **27**; 1071–1095) which looks at the psychological well-being of patients who survived 3 years or more after treatment for cancer of the testis is to be welcomed, at least in principle.

Stein Kassa and colleagues studied 149 patients by means of a self-rating questionnaire and compared four treatment groups: unilateral retroperitoneal node dissection; infradiaphragmatic radiotherapy; combination chemotherapy plus node dissection; and combination chemotherapy plus radiotherapy and surgery. They also administered the symptom checklist-90 (SCL-90) [2].

They included three control groups: 627 men matched for age from a population study of a Norwegian county [3]; 1,683 men from the population of Norway [4]; and 520 men from a study of positive and negative effect [5] to control for the different variables under test.

Unexpectedly, the cancer patients reported less exhaustion after a day's work, were more optimistic about their health, and were more satisfied with their work and social interaction.

Sexual problems were infrequent. Yet, the patients had greater levels of anxiety and depression. How can these paradoxical findings be explained? Kaasa *et al.* take refuge in a cognitive explanation. Cancer patients report more favourably on their life situation because they have reappraised their lives and are less concerned with trivia.

A more likely explanation is to be found in their methodology which typifies recent studies of well-being.

While there is a much greater acknowledgement by clinicians involved in cancer care of the need for studies of quality of life they tend to insist on simplicity [6]. Thus, they want a brief questionnaire which can be filled in quickly. What are the consequences of research workers falling into this trap?

Like this study, they end up with an 'in house' questionnaire which has not gone through the essential steps of instrument development and validation. Instead, they rely on only one or two items to measure key variables like sexual problems, anxiety and depression. Nor do they distinguish between worry and morbid anxiety or unhappiness and morbid depression. This may explain why they ignore instruments of much better provenance like the Hospital Anxiety and Depression Scale [7] and Rotterdam Symptom Checklist [8], and Standardised Social [9] and Psychiatric Interview [10]. This failure to use standardised instruments (apart from the SCL 90 of which, a few data are reported) makes it difficult to interpret the results and compare them with those of other studies.

Their failure to find much difference between the four treatment groups is surprising since toxicity of treatment strongly predicts psychiatric morbidity [11]. Like many studies, they fail to make any specific hypotheses about the link between treatment modulities and psychosocial sequelae. Consequently, their measuring instruments may have been too insensitive to reflect key differences.

Unlike many studies, they do include control groups. Unfortunately, each control group embraced only some of the key variables under test. Even so, psychological morbidity was greater in the cancer patients. So what?

Clinicians need to know if this morbidity can be prevented or better recognised and treated. Yet, there have been few controlled trials of psychological and psychiatric intervention. If studies of psychological and social sequelae are to gain real credibility it has to be shown that interventions are effective in the short and longer term and feasible within the constraints of the delivery of health care.

The authors' plea for cross-cultural studies is acknowledged. For, cultural factors always play an important part in the development of psychological and social morbidity as the recent Swedish/American collaborative study suggested. But, the use of trained interviewers using standardised instruments is essential.

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