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BREAST CANCER PATIENTS AND ALTERNATIVE TREATMENT

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A interview study was carried out in two groups of breast cancer patients, in the order to give a more detailed description of who and why they use alternative treatment (AT).

One group consisted of 92 women with *primary* breast cancer interviewed 1 year after start of adjuvant treatment. The other consisted of 42 patients with *metastatic* disease interviewed half a year after start of therapy.

The results showed that about 50% in both group used AT, primarily dietary supplements. The women had either read about the products or had them recommended by family and friends. Significantly more women with metastatic disease were recommended to use AT by family and friends. A main reason for using AT was a desire among the women to become more active in relation to the disease and its treatment.

Concerning effect, significantly more women with primary disease felt that the AT had a positive impact upon their general well-being, compared to women with metastatic disease. Very few of the women thought that the AT would have any influence upon the cancer.

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INDIVIDUAL PSYCHOLOGICAL SUPPORT FOR CANCER PATIENTS

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In the research project "Support-Care-Rehabilitation: Co-operation between surgical/oncological clinics and primary care teams in the care of cancer patients", individual psychological support (IPS) for the patients with newly diagnosed cancer is tried out.

Patients diagnosed with colo-rectal-, ventricle-, breast- and the prostate cancers in Uppsala county are asked to participate in the study. Seventy-five percent accepts. So far (10/2 1995) 165 patients have been randomised to IPS and been called to a first session. The IPS has its theoretical grounds in the cognitive behaviour therapy. A few weeks after the completion of the IPS a questionnaire concerning the IPS is mailed to the patients.

The majority of the randomised patients come to a first session. About 30% of these come back for a second session and about 40% continue with longer contact. So far 54 patients have answered the questionnaire. The majority of the respondents feel that the IPS came right in time. Most of the patients feel that their problems were addressed completely, although 30% stated that they had no problems. About 80% stated that the IPS was helpful for them in coping with worries for the disease, and in coping with negative thoughts and depression.

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CANCER PATIENTS RELATIVES (CPR) DIAGNOSIS DISCLOSURE PREFERENCES (DDP) ACCORDING TO EMOTIONAL DISTURBANCES LEVEL

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Sixty-two CPR were asked about their DDP; also rated anxiety and depression levels they observed (HAD (Hospital Anxiety and Depression) scale version for an external observer (HADeo)) in their cancer relatives. On the other hand patients (pts) answered HAD scale. *Results:* (a) CPR for pts: 64.5% of CPR preferred not to give truth diagnosis to pts as they feared them becoming depressed or committing suicide. Other 29% chose to give full information, and the remaining 6.4% had no preferences. (b) CPR for themselves: in case CPR would have cancer in future, 53.2% would prefer to be informed, 21% would not and 25.8% do not have opinion (being differences between (a) and (b) significant at $P < 0.037$). (c) HADeo and DDP to pts were significantly linked to levels of observed anxiety and depression: CPR who preferred not to inform pts rated depression and anxiety ($\overline{x} = 6.6$, $\overline{x} = 7.55$) higher than those who preferred to inform ($\overline{x} = 3.55$, $\overline{x} = 3.33$) at levels of $P < 0.034$ for depression and $P < 0.001$ for anxiety. Pts rated themselves as less depressed and anxious than CPR did (for depression $\overline{x}$pts = 4.27 $\overline{x}$CPR = 5.47, $P < 0.005$ and for anxiety $\overline{x}$pts = 5.65 $\overline{x}$CPR = 6.21, P 0 < 0.0005). *Conclusions:* in our Hospital CPR prefer mainly to hide truth diagnosis to pts. However they would prefer to be informed in case they would have cancer. Levels of emotional disturbances observed by CPR in their relatives may lead to this attitude. Patients rated lower anxiety and depression scores than CPR attributed to them.

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DIFFERENCES IN COPING IN PARENTS OF PEDIATRIC CANCER PATIENTS AND THE RELATION WITH PSYCHOLOGICAL DISTRESS

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Introduction: How parents cope with cancer in their child may influence psychological functioning with time. Differences in coping in couples may impact psychological distress negatively.

Method: In a longitudinal controlled study parents of pediatric cancer patients completed the Goldberg General Health Questionnaire (measuring psychological distress), and the Utrecht Coping List (a Dutch standardised coping list, measuring active problem focusing, palliative reaction pattern, avoidance, social support seeking, depressive reaction pattern, expression of emotions and comforting cognitions) shortly after diagnosis (T1) and 12 months (T2) later.

Results: On T1 differences in couples in their use of palliative reaction pattern and expression of emotions correlate for fathers with psychological distress ($P < 0.005$ and $P < 0.05$ resp.). For mothers no correlations were found. On T2 no correlations were found for fathers. However, for mothers differences in couples in their use of active problem focusing, avoidance, depressive reaction pattern and expression of emotions were found to correlate with psychological distress ($P < 0.05$, $P < 0.01$, $P < 0.001$, $P < 0.05$ respectively).

Conclusion: Differences in the use of coping in couples results for fathers in more psychological distress shortly after diagnosis and for mothers one year later.

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DO PATIENTS' ATTITUDES TO CANCER CHEMOTHERAPY DIFFER FROM THAT OF DOCTORS, NURSES, AND THE GENERAL PUBLIC?

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Cancer patients' attitudes to chemotherapy were compared with those of doctors, nurses, and healthy individuals. Ninety-eight new cancer patients were included together with 42 healthy controls, 44 oncologists, 35 surgeons, 32 oncology nurses, and 70 surgical nurses. A questionnaire presented a hypothetical situation involving a toxic chemotherapy regimen. Nine percent of the patients (5% < 50 years, 28% > 70 years) and 6% of the surgical nurses would not accept the treatment under any circumstances. Among the other groups, none categorically refused chemotherapy. Each were asked to indicate the minimal benefit with respect to chance of cure, life prolongation, and symptom relief they would demand to accept the chemotherapy treatment. The patients and the surgical nurses were most reluctant. Though, the average age was significantly higher among patients when compared to the other groups. Patients under 50 years which matched the oncologists, surgeons, and controls with respect to age, cohabitant status, children, and age of youngest child, were significantly more willing to accept the chemotherapy regimen. Among the professionals, the oncologists were most willing to accept the therapy, whereas surgical nurses and surgeons were least willing. The healthy controls placed between the oncologists and oncology nurses. Our study shows substantial differences in attitudes to chemotherapy between subsets of patients, between patients and therapists, and between the professional groups. It also demonstrates that some patients (patients <40 years) will accept highly toxic chemotherapy regimens with only minimal hope of benefit. In the palliative setting these discrepancies are constantly challenging our professional integrity.