

## Psychotherapies in psycho-oncology

An exciting new challenge<sup>†</sup>

SIDNEY BLOCH and DAVID KISSANE

**Background** There is ample scope to devise forms of psychotherapy in consultation–liaison psychiatry, including the newly evolving area of psycho-oncology.

**Aims** To highlight the development of psychotherapy in psycho-oncology, providing two illustrations.

**Method** We report on conceptual and clinical research in the context of oncology and palliative care, focusing on (a) an approach for families at risk of maladaptive bereavement; and (b) a group programme for women newly diagnosed with early-stage breast cancer.

**Results** We were able to introduce new forms of psychological treatment for specific clinical groups, and anecdotal evidence points to useful benefits for participants.

**Conclusions** Psychotherapists should grasp the opportunity to bring their skills to the medical arena, but need to subject newly devised interventions to well-designed and methodologically rigorous research.

**Declaration of interest** This research has been supported by the Australian Rotary Health Fund, Bethlehem Griffiths Research Foundation and the Australian National Health and Medical Research Council.

Ever since Eysenck (1952) threw down the gauntlet, psychotherapists have been told that their interventions are ineffective. Criticism has continued despite the volume of systematic data, meta-analyses and clinical observations of crucial needs being satisfied. One unfortunate consequence is that therapists have become defensive, tending to dismiss the critics and evade the challenge of demonstrating their utility through systematic research.

This atmosphere, bedevilling psychotherapy, has been further affected in recent years by two powerful forces: one found across all medical practice, the other to do with resource allocation. The former is best summarised in the phrase ‘evidence-based medicine’: a movement dedicated to good-quality randomised controlled trials. The resource allocation issue is chiefly a function of third-party providers of funds (especially in the USA and in the context of managed care) (Green, 1999) and government bureaucracies, shying away from the provision of resources for patients who do not justify the spurious label of ‘severe mental illness’. These two factors will no doubt continue to make it difficult for psychotherapy to play a role in a range of clinical settings.

### GAINING A KNOWLEDGE BASE FOR PSYCHO-ONCOLOGY

As research clinicians in the rapidly evolving area of psycho-oncology, we have been determined to avoid getting caught in these socio-political battles, by facing the challenge of how to bring psychological interventions into the domain of clinical practice which, on the face of it, calls for an array of therapeutic programmes. The crucial requirement is the adoption of sophisticated methodology and research design, requiring careful description of the treatment under scrutiny, the particulars of

the process, the role of the therapist, and the intended beneficiaries; as well as meticulous attention to measurement of outcome. These are well-rehearsed issues; see, for instance, the four editions of the *Handbook of Psychotherapy and Behaviour Change* (Bergin & Garfield, 1994). On the other hand, we still need to remind ourselves assiduously that commitment to sound design and methodology is a *sine qua non* in gaining useful knowledge.

Ironically, at a time when fund providers continue to be stingy, new possibilities have arisen, especially in terms of the groups awaiting help. Mainstream psychiatrists, for example, are trying to establish suitable treatments for borderline and other severe personality problems (e.g., Linehan *et al*, 1991; Stevenson & Meares, 1992). Similar windows of opportunity are opening in related mental health fields. Consultation–liaison psychiatry holds particular promise. Hitherto, defining clinical problems and their extent has necessarily been the focus of research (Smith, 1998). Now that we know how extensive is the need for psychotherapeutic input, the next step is to devise novel interventions which meet the needs of these clinical groups.

Within consultation–liaison psychiatry, patients treated in oncology settings and those receiving palliative care are groups with considerable unmet needs, which revolve around fundamental life and death issues; moreover, such patients are particularly receptive to such help.

We have thus embarked on a series of interrelated trials in which the approaches devised have a sound conceptual basis (theoretical, empirical or combined), are deployed with identifiable clinical groups with specific sets of problems, are replicable through the laying down of treatment guidelines (but we eschew the idea of a rigid manual), and permit health professionals to be readily trained to master elements of the treatment under study.

We shall now present two of our programmes, necessarily briefly. The first is a therapy for families in which a parent is terminally ill, and exemplifies the use of treatment for a family predicted to be at risk for maladaptive bereavement. The second, a variant of group therapy, shows how a particular group – women with early-stage breast cancer – can benefit by dealing with the emotional experience of their illness and demands of treatment.

<sup>†</sup>See editorial, pp. 93–94, this issue.

## FAMILY GRIEF THERAPY

We can only provide an outline of the rationale and method here (for a fuller account of the background to this work and of the model see Kissane *et al*, 1996a,b, 1998a).

Since the family is commonly the primary provider of care for the terminally ill sufferer from cancer, the way in which it functions is likely to be a key determinant of the emotional well-being of its members (Kissane *et al*, 1996b). In earlier work describing family grieving, we were able to identify five types of family, using core relational dimensions of functioning derived from the Family Environment Scale (Moos & Moos, 1981): cohesiveness, conflict and expressiveness. Half the families managed effectively, either enjoying high cohesiveness, minimal conflict and open expressiveness (*supportive*) or able to handle conflict through their capacity to be expressive and cohesive (*conflict-resolving*). In these families, grief waned and psychosocial outcome was excellent. A fifth of the families were distinguished by high conflict, low cohesiveness and poor expressiveness (*hostile*) or had moderate levels of these (*sullen*); in each type, psychosocial morbidity was marked. A third of the families were *intermediate* in their scoring levels but the outcome still tended to be poor.

Given these patterns, we have been able to screen patients undergoing palliative care and their families in order to recognise those at risk. Furthermore, inspection of scores has facilitated mapping out which aspect of the family environment is especially complicated.

Applying our typology, we conducted a pilot study with 15 at-risk families with the aim of improving functioning. We also created guidelines to serve the needs of trainee therapists, which were subsequently refined; they cover such aspects as recruitment, establishing rapport, adhering to a focus and dealing with the ending. We are now conducting a randomised controlled trial with 85 families to examine feasibility and effectiveness.

### The model

To help families adjust during palliative care and subsequent bereavement, we concentrate on improving functioning, particularly in the three domains described above. Associated goals are to promote

the sharing of grief and the family's ability to grapple with concerns and problems. Given such a circumscribed approach, we have adopted a time-limited therapy focusing on goals mapped out with the family, and avoiding delving into long-standing family or personality difficulties.

### Selecting and preparing the family

Families have been recruited from many sources – oncology clinics and hospital departments, private oncologists and palliative care services. Referrers, increasingly familiar with our model, identify suitable families. Screening for at-risk families follows, using three relevant subscales (comprising a Family Relations Index) from the Family Environment Scale (Moos & Moos, 1981). Eligible families are randomly allocated to therapy or to a no-treatment group, following an informed consent process. The model and its rationale are described in detail to the family; at no stage do we label them as pathological or dysfunctional. Instead, we stress that families may benefit from coming together to explore concerns about their ill relative and about the family as a whole.

### The course of therapy

Therapy progresses sequentially through phases of assessment, identifying relevant issues, the focused treatment itself and ending. During the assessment (two sessions usually) participants are invited to share their story of the illness and its effect on themselves. Data are gathered about family functioning, including communication, sources of support, emotional involvement, and capacity to resolve difficulties, including conflict, allocation of roles and the like. A detailed family tree is done to identify losses and the nature of relationships, to apportion importance to the concerns raised; this in turn permits the family to assume shared responsibility for features they would like to alter. Family functioning is focused on three fields we have delineated as central: promoting cohesiveness, expression of thoughts and feelings, and effective conflict management.

No matter what concerns the family raises, common themes emerge. The imminent death of the ill relative is obviously prominent. Often, a member will ask about prognosis and so pave the way for the family's contending with the subject of death. Anticipatory grief invariably finds a voice, with members divulging their sense

of pending loss. Members are encouraged to ventilate this grief but also to exploit creatively the time remaining. Closely related is bidding farewell, which is pivotal, entailing completion of unfinished business, recognising each person's contribution in the family and expression of hopes and wishes.

Caring at both practical and emotional levels is intrinsic to the therapy. At a practical level, roles and specific tasks can be delineated and actual plans made, applying a problem-solving approach. Emotional caring calls for attention when the family is buffeted by uncertainty and helplessness. The dying member's anxiety about burdening the family can be alleviated by spouse and children being encouraged to express gratitude for what they have received from him or her in the past. Intimacy between members may be reinforced or disrupted as a part of the farewell. Any obstacles to expression of intimacy can be looked at and an effort made to remove them.

Other customary themes involve cultural and religious rituals and their relevance to strengthening the family's resources, the impact of loss on younger children, necessary (albeit circumscribed) confrontation with events in the family's history such as previous bereavement, psychiatric disturbance and relational tensions, and (following the death) the acute pain and suffering provoked by loss.

Throughout treatment, problem-solving is highlighted as a strategy to enhance family functioning. Factors complicating family life are subject to clarification and available options sorted out to deal with them. The family is encouraged to seek a clearer understanding of its functional and dysfunctional patterns and to appreciate members' own capacity to make choices and act upon them. Conflict-bound issues particularly warrant exploration. Recognising entrenched, maladaptive 'scripts' (Byng-Hall, 1995) is vital, since inherent in them are blaming, avoidant and denying features, all of which hamper effective functioning. Not all tensions are eradicable: indeed, members learn that some of their differences are inevitable, and that this requires mutual respect and tolerance. At the same time, forgiveness for past neglect of the feelings of others is central.

### Ending therapy

As the family wrestles with concerns and begins to function better, the interval

between sessions is extended. A point is reached when a plan to end therapy is indicated. Residual worries and unfinished business may need explicit attention and either be dealt with in the final stage or flagged as agenda for another intervention, such as individual therapy for one or more members.

The exchange of feelings about ending therapy serves well to model a healthy adaptation to mourning and loss. With the imminent withdrawal of the therapist, the family anticipates future priorities and continuing or new needs. They are encouraged to persist in examining their functioning as a group, with the added caveat that problems worked on previously might recur and need their systematic attention. Finally, as a corollary of empowerment throughout therapy, the family is encouraged to celebrate their assets and new learning.

### Comment

The pilot study of 14 families and the current trial involving 40 families thus far, indicate that our model is feasible and relevant in the context of palliative care. We have a rational basis on which to identify and encourage at-risk families to participate in a treatment where psychopathology is sidelined and replaced by affirmation of their potential to utilise existing strengths. By stressing these strengths as a means to prevent or minimise psychosocial morbidity, treatment remains brief (an average 6–10 sessions over 6–12 months, straddling the death) and relatively focused. The impressions of the 15 therapists and the two supervisors, in tandem with feedback provided by virtually all families who have participated hitherto, indicate that the therapy is relevant, with its consistent emphasis on cohesiveness, conflict resolution and expressiveness. However, only the definitive trial will establish just how effective family grief therapy is in enhancing family functioning, resolving grief and preventing psychosocial morbidity.

## COGNITIVE-EXISTENTIAL GROUP THERAPY

Psychiatric morbidity associated with a cancer diagnosis is high, with rates two to three times that in the general community (Dean, 1987; Hughson *et al*, 1988; Kissane *et al*, 1998b). This is due partly to the threat to life that the diagnosis brings, as well as to the effects of surgery,

chemotherapy and radiotherapy. There is a compelling argument for psychotherapeutic help to enhance adjustment and quality of life. Moreover, such a serious life event makes patients willing to embrace therapies which foster a review of their lives and the setting of future priorities.

Although patients in psycho-oncology undoubtedly need to be offered a choice of individual, group or family approaches, a group model has particular advantages in terms of the support network that develops for participants. They attain a sense of shared experience and mutual support which is likely to endure beyond the formal treatment, by the exchange of telephone numbers and periodic social gatherings. This perception may well be pivotal, since it has been shown that social isolation is as powerful as smoking and high cholesterol in elevating mortality rates (House *et al*, 1988).

The composition of the group needs to be based both on the type of cancer (e.g. groups for patients with breast, bowel or prostate) and the stage of disease (early or advanced), so that specific concerns can be dealt with appropriately. For example, we have developed our cognitive-existential model for women with early-stage breast cancer (Kissane *et al*, 1997).

Meta-analyses of interventions in psycho-oncology reveal notable effect sizes for psycho-educational approaches: moderate for those that focus on coping, and small to moderate where boosting mood is the goal (Devine & Westlake, 1995; Meyer & Mark, 1995; Sheard & Maguire, 1996). The duration of treatment, the training and experience of the therapist, and the appropriateness of the model probably contribute to outcome here. We have observed that patients with early-stage cancer and a reasonable prospect of survival are comfortable with briefer therapies (6–12 sessions), whereas those suffering advanced cancer have a need for continuing support, given their greater experience of loss and profound existential challenge. The model warrants diligent mapping out. The consultation-liaison psychiatrist experienced in psycho-oncology is well placed to determine this and to offer therapy tailored to unique needs.

### The model

In the case of women with early-stage breast cancer, above and beyond a psycho-educational dimension we have

drawn on Yalom's (1980) existential ideas, Bowlby's (1979) work on loss and grief and Moorey & Greer's (1989) cognitive-behavioural approach as applied individually.

We have delineated six goals in our cognitive-existential model that are part of the overall aim of improving quality of life: facilitating grief over multiple losses, altering maladaptive cognitive patterns, enhancing problem-solving and coping skills, fostering a sense of mastery and creative engagement with life, promoting a supportive environment, and providing an opportunity to sort out future priorities. In pursuit of these goals, we resist the temptation to delve into long-standing personality or other psychosocial difficulties (which are more appropriately tackled in individual long-term therapy) by adhering to a time-limited and focused framework. Groups of six to eight patients are led by two co-therapists, at least one of them a woman, and are held weekly for 90 minutes for an average 20 sessions.

### Selecting and preparing group members

Participants are referred from a range of oncology services (hospitals, clinics and private specialists). Generally, we need to bring together women from two or three sources to form a group efficiently, since no single oncology service has sufficient numbers to support such a programme. About two-thirds of the women approached for a randomised controlled trial were willing to participate ( $n=303$ ).

Preparation is vital in minimising dropout. Each prospective member meets individually with the co-therapists to share her expectations and to be oriented to the group's goals and norms. Unlike psychodynamic group therapy, the women are encouraged to exchange phone numbers and to meet informally over refreshments after each session.

### The course of therapy

The group is launched with women invited to share their 'stories' of cancer. They tend to focus initially on medical aspects, but soon convey considerable grief and other emotions. Members also share many of their fears, problems in coping and negative thinking.

Typical themes emerging over the first few sessions are: anxiety about death; fear of recurrence; living with uncertainty; grief

over various losses; change in body and self-image; treatment and its demanding nature; relationships with doctors, partners, family and friends; sexuality; and future priorities.

Women are taught the elements of problem-solving and how to identify and then weigh up alternative solutions. Highlighting this process paves the way for its deployment as a coping strategy. A cognitive dimension is incorporated, through therapists inquiring about parallel thoughts and attitudes when feelings are expressed. Homework is set after about five sessions, with members asked to monitor their thoughts systematically. Hand-outs on typical thinking errors and the concept of automatic negative thoughts are distributed, to help the group members to discern unhelpful ways of thinking and to replace them with more adaptive patterns. Assertiveness and relaxation training, as well as anger management, are woven into the programme where appropriate.

Our experience has shown that therapists do not need to adhere to a rigid sequence of interventions. Rather, through flexible adoption of issues raised by the women, all the themes mentioned above are ultimately covered. Moreover, the process allows for more implicit group learning.

Naturally, any group approach is accompanied by difficulties for the therapists. For instance, they need to promote tolerance over differences between members in the way they deal with problems. Informal contact outside the group is nurtured, but not at the cost of excluding a member. The model does not lend itself to transference interpretations, even though therapists may observe transference patterns in individual patients and the group as a whole. The key issue, however, is to ensure that transference does not impede the group's progress.

The problem of a member's cancer progressing occurs periodically, and may cause intense group distress. Therapists must ensure that the affected woman does not withdraw in an effort to protect her fellows. Since all the women continue to be exposed to distressing 'cancer stories' in their lives, recurrence of breast cancer in a member provides a means to review their coping responses to underlying existential threats and concerns.

### Ending therapy

The group may try to deny that it will end, by making plans to maintain contact and

### CLINICAL IMPLICATIONS

- Psycho-oncology offers ample scope for devising appropriate forms of psychotherapy. No one psychotherapeutic approach will suffice; instead, specific forms are needed to meet particular clinical needs.
- A family approach is most apt to promote adaptive family functioning as part of palliative care.
- A group approach suits women with a recent diagnosis of breast cancer who are challenged to make the best adjustment possible.

### LIMITATIONS

- Psycho-oncology is a new field and there are gaps in our knowledge of the prevalence and nature of psychosocial morbidity.
- Innovative treatments need to be carefully thought out before their application in the clinical arena.
- The two therapies described in these pages are still in the process of being tested through randomised controlled studies.

SIDNEY BLOCH, FRCPsych, Department of Psychiatry, DAVID KISSANE, FRANZCP, Centre for Palliative Care, University of Melbourne

Correspondence: Professor Sidney Bloch, Department of Psychiatry, University of Melbourne, St Vincent's Hospital, Fitzroy, Melbourne 3065, Australia. Fax: +61 3 9819 0635; e-mail: s.bloch@medicine.unimelb.edu.au

(First received 12 February 1999, final revision 26 October 1999, accepted 26 October 1999)

mutual support afterwards. Therapists, however, need to stress firmly that the group as experienced will cease, so that this promotes active mourning, and also a revisit to the grief experienced in earlier losses inherent in confronting cancer. We check for any unfinished business, review accomplishments and the question of further consolidation, and revise future aspirations.

### Comment

Our blend of the existential and cognitive has proven most apt for women with early-stage breast cancer, although confirmation of quality of life gains is presently under analysis. We suspect that the model may well serve patients with other forms of early-stage cancer. By contrast, we are also studying a quite different model for women with metastatic breast cancer, given that their concerns and challenges are radically different from those with an early-stage type.

### Meeting therapeutic need

In describing these two models – family grief therapy and cognitive–existential group therapy – we see challenging developments occurring in psycho-oncology and palliative care. Both family and group approaches can help in dealing with clinical issues that commonly arise in specific phases of patients' illnesses. This endeavour in consultation–liaison psychiatry leads to therapies for specific clinical groups whose needs at present are not being met. A range of other therapeutic possibilities warrants similar attention in offering comprehensive care for the medically ill. The scope is enormous, but is also full of promise.

### ACKNOWLEDGEMENTS

We thank all our therapists who have contributed so enthusiastically to these programmes, and clinicians who have referred patients.

## REFERENCES

- Bergin, A. & Garfield, S. (eds) (1994)** *Handbook of Psychotherapy and Behaviour Change* (4th edn). New York: Wiley.
- Bowlby, J. (1979)** *The Making and Breaking of Affectional Bonds*. London: Tavistock Press.
- Byng-Hall, J. (1995)** *Rewriting Family Scripts*. New York: Guilford.
- Dean, C. (1987)** Psychiatric morbidity following mastectomy: pre-operative predictors and types of illness. *Journal of Psychosomatic Research*, **31**, 385–392.
- Devine, C. & Westlake, G. (1995)** The effects of psychoeducational care provided to adults with cancer: meta-analysis of 116 studies. *Oncology Nursing Forum*, **22**, 1369–1381.
- Eysenck, H. (1952)** The effects of psychotherapy: An evaluation. *Journal of Consulting Psychology*, **16**, 319–324.
- Green, S. (1999)** The ethics of managed mental health care. In *Psychiatric Ethics* (eds S. Bloch, P. Chodoff & S. Green). Oxford: Oxford University Press.
- House, J. S., Landis, K. R. & Umberson, D. (1988)** Social relationships and health. *Science*, **241**, 540–544.
- Hughson, A. V., Cooper, A. F., McArdle, C. S., et al (1988)** Psychosocial consequences of mastectomy: levels of morbidity and associated factors. *Journal of Psychosomatic Research*, **32**, 383–391.
- Kissane, D., Bloch, S., Dowe, D., et al (1996a)** The Melbourne Family Grief Study I: Perceptions of family functioning in bereavement. *American Journal of Psychiatry*, **153**, 650–658.
- , —, **Ongheña, P., et al (1996b)** The Melbourne Family Grief Study II: Psychosocial morbidity and grief in bereaved families. *American Journal of Psychiatry*, **153**, 659–666.
- , —, —, **et al (1997)** Cognitive-existential group therapy for patients with primary breast cancer – techniques and themes. *Psycho-Oncology*, **6**, 25–33.
- , —, **McKenzie, M., et al (1998a)** Family grief therapy: A preliminary account of a new model to promote healthy family functioning during palliative care and bereavement. *Psycho-Oncology*, **7**, 14–25.
- , **Clarke, D., Ikin, J., et al (1998b)** Psychological morbidity and quality of life in Australian women with early stage breast cancer: a cross-sectional survey. *Medical Journal of Australia*, **169**, 192–196.
- Linehan, M. M., Armstrong, H. E., Suarez, A., et al (1991)** Cognitive-behavioural treatment of chronically parasuicidal borderline patients. *Archives of General Psychiatry*, **48**, 1060–1064.
- Meyer, T. & Mark, M. (1995)** Effects of psychosocial interventions with adult cancer patients: a meta-analysis of randomised experiments. *Health Psychology*, **14**, 101–108.
- Moorey, S. & Greer, S. (1989)** *Psychological Therapy for Patients with Cancer: A New Approach*. London: Heinemann.
- Moos, R. & Moos, B. (1981)** *Family Environment Scale Manual*. Palo Alto, CA: Consulting Psychologists' Press.
- Sheard, T. & Maguire, P. (1996)** The effects of psychological interventions on anxiety and depression in oncology: Results of two meta-analyses. *Psycho-Oncology*, **5** (suppl.), 19.
- Smith, G. C. (1998)** From consultation–liaison psychiatry to psychosocial advocacy: maintaining psychiatry's scope. *Australian and New Zealand Journal of Psychiatry*, **32**, 753–756.
- Stevenson, J. & Meares, R. (1992)** An outcome study of psychotherapy in borderline personality disorder. *American Journal of Psychiatry*, **149**, 358–362.
- Yalom, I. D. (1980)** *Existential Psychotherapy*. New York: Basic Books.