

Results: At six weeks parents with repressive coping had significantly lower depression scores than those without (6.65 vs 11.83, two sided t-test $p = 0.011$) but at 40 weeks the difference was non-significant. This was because the mean scores of those with repressive coping had increased (from 6.65 to 8.84) but those of the remainder had decreased (from 11.83 to 6.65). However there was a marked gender difference. Among mothers with repressive coping there was a mean increase in depression scores of 4.13 from 6 to 40 weeks, whilst in the remainder there was a decrease of 4.24. These mean differences were significantly different from each other (two sided t-test, $p = 0.027$). Among fathers the depression scores of those without repressive coping increased somewhat (by 2.2), and in those with repressive coping there was little change (by 0.2). Exploration using categorical variables was limited by low numbers. Those who worsened by 0.3 s.d. or more, or improved by 0.3 s.d. or more, and those who stayed within 0.3 s.d. of zero change were compared. Within the repressive coping group 3/8 worsened by 0.3 s.d. or more contrasted with 2/25 of those without repressive coping (OR 6.90, 95% CI 0.90-52.7), and 2/8 improved compared to 15/25 in the remainder (OR 0.22, 95% CI 0.04-1.3).

Conclusions: These preliminary data suggest that in mothers of children with cancer a coping strategy that puts an emphasis on denial of emotions may be associated subsequently with a greater level of depression. In fathers, by contrast repressive coping appeared to be effective, at least up to 40 weeks following diagnosis.

864

POSTER

Bad news from the patient's perspective: an analysis of the written narratives of newly diagnosed cancer patients

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Purpose: Advice papers in medicine dealing with how to tell patients bad news rely almost exclusively on the opinion of the physician. What is lacking is empirical studies from the perspective of the patient. The purpose of the present study was to analyse how patients with recently diagnosed cancer narrate the manner in which they received their diagnosis, and to discuss this in relation to bad-news papers and related research.

Methods: A consecutive series of 187 patients who had received their cancer diagnosis 2-8 months prior to the outset of this study were asked to describe the manner in which they learned of their diagnosis in writing. The contents of the 138 submitted written narratives were sorted according to experiences of the Setting, Care and Disease Information.

Results: A crucial finding was that the participants often described experiences from the first contact with hospital staff to the end of their treatment, rather than as a single instance of diagnosis communication. The relational meaning of these experiences was obvious. Information on treatment was of the utmost significance. No one required more prognostic information.

Conclusion: From the perspective of the physicians, bad-news focuses on how to provide information about diagnosis and prognosis in the course of a single diagnostic consultation. From the patient's perspective, bad news reflects the process of being diseased by cancer, and how medical services are available when one is in need of establishing a helping relationship. In this relationship information about diagnosis and treatment is more a means than an end. Further conceptualisation of the patient-physician relationship from the perspective of the patient would benefit greatly from interdisciplinary collaboration with the social sciences.

865

POSTER

Euthanasia – Emotional and juridical aspects of euthanasia. Experiences from the last five years

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To be able to perform euthanasia in the incurable diseased patient with cancer you have to comply with a lot of juridical criteria to obey the law in the Netherlands.

Interesting is that the emotional steps a patient usually has to take to come to such a grave decision are in my experience in harmony with the law.

People are very much attached to life and when they feel life slips away they become more and more conscious of the small things that make them happy and they move their borders.

As a doctor you go with the patient through this emotional process which takes a lot of your time and empathy and in the end of the process you fulfil also the requirements of the law.

The written statement, obligatory in the law, forces the patient to clarify his/her thoughts about the situation that will make life unbearable in the end.

Once there is complete clarity about what the patient experiences as unbearable suffering and once there is an agreement with the doctor there comes almost always a peaceful state of mind.

The knowledge that if you can't bear anymore you don't have to together with good palliative care makes euthanasia sometimes unnecessary in the very end.

866

POSTER

Oesophageal cancer: perceptions and informed consent in an African population

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Purpose: To evaluate the perceptions of patients with oesophageal cancer about their illness and treatment, and to determine the role, if any, of the informed consent process in a South African population.

Methods: Two hundred black patients with advanced squamous cell carcinoma of the oesophagus were interviewed. The median age was 54 and the male to female ratio was 3:1. Most of the patients were from a low socio-economic status with an income of R500 or less per month (72%), often unemployed (47.5%), and with only primary school education (75.5%). They completed a perception of illness questionnaire, where after they were informed about their illness, the possible treatment options, the benefits it may have, the possible side effects, as well as that they could withdraw at any time without affecting the standard of care. Within 48 hours, the perception questionnaire was once again completed.

Results: Before the informed consent process, 92% of the patients did not know what was wrong with them or what the available treatment options were. However, almost all the patients (95%) indicated that they wanted information about their illness and treatment. After the informed consent process, 96% knew that they had cancer, while 91% of the patients indicated that they preferred receiving information (albeit of a negative nature) because it removed uncertainty. Most of the patients (75%) indicated that they used the information as a coping mechanism. Overall, the informed consent process significantly improved the knowledge as well as the perception scores ($p < 0.0001$).

Conclusion: The informed consent process is a valuable tool in our population to provide patients with information they need, to alter their perceptions for the better, and to help them cope with this life threatening disease.

867

POSTER

Recurrence: the emotional challenges and opportunities for patients & providers

J. Thompson. Park Nicollet Clinic, Oncology, Minneapolis, MN, USA

In this presentation we will draw upon the lessons learned in clinical practice as well as hear the words of patients as we examine our work with those facing recurrence. The emotional challenges of advanced cancer are enormous and yet, there are many straightforward, simple ways to support and enhance coping.

Through lecture and discussion, we will look at the following:

- Nourishing hope as an illness progresses.
- The benefits of clinician self-disclosure.
- Placing the locus of control with the patient.
- The four things that patients report they most want to hear from their health care providers when facing recurrence.

Attention will be given throughout this presentation to some of the accompanying emotional challenges for us as clinicians when we work with those facing cancer's return.

868

POSTER

Walking in the shadow: examining a model for group psychotherapy with patients facing advanced cancer

J. Thompson. Park Nicollet Clinic, Oncology, Minneapolis, MN, US

This presentation will introduce a group therapy model for individuals challenged with metastasis or recurrence. Through the example of one group now embarking on its ninth year, the following elements of the group experience will be highlighted:

- Distinctions between a support group and a psychotherapy group.
 - Group membership: referrals, screening, and selection.
 - The task of creating "community" - developing a spirit of mutual caring.
 - Sample group exercises and activities.
 - Dealing with member deaths - preparing for and integrating loss.
 - The therapist facilitator - qualifications, emotional challenges and self-care.
 - Weaving in the spiritual - group rituals and traditions.
- This is a practice based rather than a research based presentation and will have relevance for anyone involved in group work with oncology patients.

869

POSTER

Psychological and physical support after breast cancer surgery (BCS): a new comprehensive approach

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BCS, either conservative, or demolitive, is a dramatic experience for women. Afterwards, women have the emotional waiting for the subsequent therapies and the need to think about their social, affective and working life in a new way. Since June 2000, our oncological division started a comprehensive, multidisciplinary activity for BC patients (pts) after surgery.

This activity addressed to small groups (8 women) of surgically resected BC pts and was conducted by a psychologist, a psychiatrist, a physiotherapist and a medical oncologist. After the first multidisciplinary visit, our pts meet twice-a-week for 5 weeks. Each meeting is structured in two different parts: the first part focuses on the physical recovery, while the second part is dedicated to psychological support. We decided to use the group model, because we believe that it is the best way for pts to elaborate their own experiences and talk about the impact disease has had on their life. During these meetings, pts can compare their own feelings, fears and experiences with one another. Until now, 4 groups of BC pts (24 women) have been followed. Two pts didn't participate due to family problems, while another one was excluded because of her own refusal of her oncological disease. During the first meeting of each group, 2 tests were administered (COPE and BDI test), in order to perform a baseline psychological evaluation. These 2 tests, together with another individual psychological visit will be administered 12 months later. A comprehensive multidisciplinary approach to breast cancer surgically resected pts allows us to 'cure' the disease and 'take care' of the pts.

870

POSTER

Psychological adaptation to cancer

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Diagnosis of cancer involve psychological distress. The common psychological distress in cancer patients are anxiety and depression.

Purpose: The aim of the study was to assess the level of anxiety and depression.

Methods: Spielberger State-Trait Anxiety Inventory and Beck Depression Inventory were analyzed. Forty haematological patients were examined. They were 25 women and 15 men in aged 26-80 years. They were out patients, follow-up patients during remission as well as hospitalized patients in different stage of diseases and therapy.

Results: Obtained data pointed out higher prevalence of state of anxiety for patients aged <50 years, but the trait was comparable among all groups of age. The median of state of anxiety was higher for patients during the first 3 months of diagnosis. The level of state and trait of anxiety was higher for women than men. But there were no differences in relation to patients with different diagnosis. The study showed that, about 50% of examined patients suffered more often depression than all other patients and was prevalent during the first 3 months of diagnosis. Depression was more often for women than men, but there were no significant differences between patients with different of cancer diseases.

Conclusion: The study highlighted the need for routine screening for anxiety and depression among haematological patients. Psychological intervention (pharmacological or psychotherapy) could reduce disease-related distress, improving psychological functioning and the quality of life cancer patients. It could help patients to cope with their illness, especially that more cancer patients are living longer with the diagnosis.

871

POSTER

Oncologic psychological functioning: in search of a developmental pattern

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Purpose: This study intends mainly to validate the theory of centrifugal pattern in oncological patients differentiating the relationship patterns established with both parents by the oncological patient during different life stages, from childhood to the present life moment. Another purpose consists in differentiating variables such as the recent and non-recent losses and stressful life events, specific personality traits, self-concept and the present level of anxiety and depression of oncological patients in order to validate the current lines of theoretic development in psycho-oncology.

Methods: In this study participated 93 subjects, divided into three equal dimensioned groups: an oncological clinical group, an insulin dependent clinical control group and a normal control group. The instruments used were: the Family Circle Drawing Test (DCRF), the Hospital Anxiety and Depression Scale (HADS), the Clinical Inventory of Self-Concept (ICAC) and a structured interview elaborated specifically for this study based on the main variables mentioned in the literature concerning the personality traits and the difficulties of individuals with cancer and other chronic diseases.

Results: Statistical analysis showed that the drawings of the oncological group differed significantly ($p < .05$) from those of both control groups, demonstrating a clear pattern of emotional separatedness towards both parents in all life stages particularly after puberty ($p < .001$). In addition to the results obtained with this test, other relevant results were obtained as to the main difficulties felt by subjects concerning their relational sphere.

Conclusion: The study demonstrates that a specific relational pattern differentiates the oncological patients from other comparison groups as to the relationship with both parents. Results supported the theory of centrifugal pattern as well as some assertions of contemporary theories in psycho-oncology.

872

POSTER

Social and Psychological Aspects of Cancer Patient's Decision Making in Russian Clinical Practice

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Subject: The years after Perestroika in the former Soviet Union brought, besides the others, the great changes in understanding and guarantees of human rights, according to the Helsinki Agreement. It has influence on patient's position in decision making in the process of cancer treatment. We look for the new psychological method of approach to the communication with cancer patients in the new situation of the free information about disease and proposed treatment, more independent patient's personal choice. The situation is complicated in modern Russian not stable society with uncontrolled and not grounded methods of treatment, sometimes offered to the patients.

Procedure: In 120 cancer patients we compared the quantity of the patients, who signed "Patient Information and Informational Consent" and the quantity of the patients, who refused to participate in the new drug's effectiveness study. There were two groups of the patients: with (group a, n=60) and without (group b, n=60) physician's counseling and psychologist's supportive care. We used psychological diagnostics of the personal features also for the explanation of the different styles of decision making in cancer patients.

Results: The percentage of the patients, who agree to participate in offered study increases to 93% in group a, in comparison to 63% in group b. There is need of more structured information in communication with the patients with high anxiety score and the need of the psychological supportive care in the patients with labile emotions, depressive mood and posttraumatic stress.

Conclusion: In the modern Russian clinical practice there is an evidence of the significant role of the individual psychological approach in cancer patients in the pretreatment period.