VOLUME 31 · NUMBER 31 · NOVEMBER 1 2013

JOURNAL OF CLINICAL ONCOLOGY

EDITORIAL

Marriage Is As Protective As Chemotherapy in Cancer Care

David W. Kissane, *Monash University, Victoria, Australia; Memorial Sloan-Kettering Cancer Center and Weill Cornell Medical College, New York, NY*

See accompanying article on page 3869

What is the price of a happy marriage, a secure family, and a network of well-connected friends within our communities today? Aizer et al[1] present noteworthy findings in the article that accompanies this editorial, which suggest that being single, separated, divorced, or widowed significantly increases the risk of oncologic presentation with already metastatic cancer, reduced adherence to state-of-the-art treatment, and greater likelihood of earlier death from this cancer. On the basis of the National Cancer Institute's SEER Medicare data from 734,889 contemporary Americans (2004 to 2008), these incontrovertible data come from the 10 leading cancers, apply to both men and women, and create profound implications for our models of cancer care.[1] Strikingly, the benefits of marriage are comparable to or greater than anticancer treatment with chemotherapy.

How challenging it can be to get the single and socially disconnected person to join a support group. Our psycho-oncology programs have not adequately identified isolated, widowed, or separated individuals who may be struggling alone with the treatment of cancer. Yet we know that the provision of practical support increases the likelihood of adherence to evidence-based treatment 3.6 times.[2] Indeed, belonging to a close and cohesive family increases the likelihood of adherence 1.7-fold, whereas being in an unstable family environment makes the risk of nonadherence 1.5 times higher.[2] Cancer centers would do well to screen for the at-risk family, where use of the *Family Relationships Index* has been well validated as a tool to identify those families with reduced cohesion, communication, or conflict resolution.[3] The provision of family-focused therapy ought to be a routine outpatient service for couples and families in modern cancer care.[4,5]

Meta-analyses have also shown that unrecognized clinical depression is strongly associated with poor adherence to medical treatment.[6] Distress screening has been recommended as the sixth vital sign, and although this has been slowly adopted, such early recognition leads to effective treatment with benefits. For instance, McLaughlin et al[7] showed successful treatment of depression post routine computer screening to assist its recognition at a cancer center, while Gallo et al[8] at the primary care level showed reduced cancer mortality from screening for and treatment of depression. Meta-analyses of the impact of depression on cancer mortality confirm increased death rates between 19% and 39%.[9,10] Clinicians at all levels are challenged to both recognize and actively treat clinical depression.

Aizer et al[1] recommend that the oncologist recognizes a patient's single status as a warning sign for the existence of poor social support. Referral of the socially isolated and alienated to psycho-oncology services is warranted. Sharing distress and grief with another person facilitates adaptive healing and improved coping. Indeed, group therapy both prevents and ameliorates clinical depression and can promote adherence to anticancer therapy.[11] Much hope was held that cancer support groups would improve survival, yet careful studies, powered to detect a 15% difference in survival, failed to do so.[12] A ceiling effect might have resulted from the inclusion of married persons. Should future studies target single status as an eligibility criterion, with larger cohort sizes to detect a smaller, yet worthwhile gain? Clinical leadership of these groups would be most important to retain membership of the socially isolated and create an inclusive, cohesive group environment. Effective group facilitation is an expert clinical skill, necessitating staffing ratios adequate to deliver such services.

Communication skills training becomes another method to better care for the vulnerable patient with cancer. Requiring no additional consultation time, empathic skills can be developed that ameliorate distress and depression, with the potential to enhance adherence to recommended medical treatments.[13] The time has arrived for comprehensive cancer centers to make communication skills training a mandated component of fellowship training in oncology. Through such means, the whole of the multidisciplinary treatment team can deliver optimal supportive care.

For psycho-oncology and supportive services to be able to address the needs of patients with cancer and their families, adequate staffing levels with psychiatrists, psychologists, and social workers are vital to be able to deliver group, couple, and family therapy services alongside individual care. The development of these programs is a challenge for our times. More training programs are needed, but institutions also need to open up staffing lines for services to be adequately responsive to unmet needs. Aggressive symptom management that includes treatment of depression and anxiety to optimize coping and provide support has recently been shown to extend survival further than conventional chemotherapy in patients with lung cancer.[14]

At the public health level, media communication about preventive screening for early detection of cancer warrants closer attention to message framing to reach the socially isolated with reduced health literacy. Community outreach through libraries, hairdressing salons,

supermarkets, and gas stations are innovative ways to promote cancer screening. Personalized tailoring of health promotion advertisements to minority communities is vital. Legislation that restricts tobacco use in public facilities, limits the sale of paan, gutka, and snus to the young, and ensures health insurance support for human papillomavirus vaccination to both adolescent boys and girls is crucial.

Our humanity is relational at its essence—we are tribal people, drawn into connection with one another to share what is most meaningful and fulfilling in life. Our medicine needs to follow a parallel paradigm: healing care that is both person- and family-centered in its expression. Several factors join together in the sociodemographic of being single—those with potentially fewer social supports, less education, membership within minorities, and limited health literacy—in short, those most in need. Aizer et al[1] have reminded us of the power of human attachment in showing the contribution of marital status to survival. They stress why medicine ought not to be governed by money but by humanistic, culturally sensitive, and comprehensive care. Our response must be to develop targeted supportive programs to attend to those most in need—a paradigmatic change in the focus of healing care that truly accompanies the biologic and scientific pursuits of medicine. In the words of that 16th century axiom, "To cure sometimes, to relieve often, to comfort always (Anonymous)."

AUTHOR'S DISCLOSURES OF POTENTIAL CONFLICTS OF INTEREST

The author(s) indicated no potential conflicts of interest.

REFERENCES

1. Aizer AA, Chen M-H, McCarthy EP, et al: Marital status and survival in patients with cancer. J Clin Oncol 31:3869-3876, 2013

2. DiMatteo MR: Social support and patient adherence to medical treatment: A meta-analysis. Health Psychol 23:207-218, 2004

3. Edwards B, Clarke V: The psychological impact of a cancer diagnosis on families: The influence of family functioning and patients' illness characteristics on depression and anxiety. Psycho-Oncology 13:562-576, 2004

4. Zaider TI, Kissane DW: Couples therapy in advanced cancer: Using intimacy and meaning to reduce existential distress, in: Watson M, Kissane DW (eds): Handbook of Psychotherapy in Cancer Care. Chichester, England, Wiley-Blackwell, 2011, pp 161-173

5. Kissane DW, McKenzie M, Bloch S, et al: Family focused grief therapy: A randomized controlled trial in palliative care and bereavement. Am J Psychiat 163:1208-1218, 2006

6. DiMatteo MR, Lepper HS, Croghan TW: Depression is a risk factor for noncompliance with medical treatment: Meta-analysis of the effects of anxiety and depression on patient adherence. Arch Int Med 160:2101-2107, 2000

7. McLachlan SA, Allenby A, Matthews J, et al: Randomized trial of coordinated psychosocial interventions based on patient self-assessments versus standard care to improve psychosocial functioning of patients with cancer. J Clin Oncol 19:4117-4125, 2001

8. Gallo JJ, Bogner HR, Morales KH, et al: The effect of a primary care practice-based depression intervention on mortality in older adults: A randomized trial. Ann Intern Med 146:689-698, 2007

9. Satin JR, Linden W, Phillips MJ: Depression as a predictor of disease progression and mortality in cancer patients: A meta-analysis. Cancer 115:5349-5361, 2009

10. Pinquart M, Duberstein PR: Depression and cancer mortality: A meta-analysis. Psychol Med 40:1797-1810, 2010

11. Kissane DW, Grabsch B, Clarke DM, et al: Supportive-expressive group therapy for women with metastatic breast cancer: Survival and psychosocial outcome from a randomized controlled trial. Psycho-Oncology 16:277-286, 2007

12. Goodwin PJ, Leszcz M, Ennis M, et al: The effect of group psychosocial support on survival in metastatic breast cancer. N Engl J Med 345:1719-1726, 2001

13. Kissane DW, Bylund CL, Banerjee S, et al: Communication skills training for oncology professionals. J Clin Oncol 30:1242-1247, 2012

14. Temel JS, Greer JA, Muzikansky A, et al: Early palliative care for patients with metastatic non-small-cell lung cancer. N Engl J Med 363:733-742, 2010

DOI: 10.1200/JCO.2013.51.5080; published online ahead of print at www.jco.org on September 23, 2013