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Use of alternative medicine by women with breast cancer

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Use of Alternative Medicine by Women with Breast Cancer

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To the Editor: Burstein et al. report fascinating data on the use of alternative medicine by patients with breast cancer (June 3 issue).[1] Both the authors and the writer of the accompanying editorial[2] conclude that newly initiated use of alternative medicine is a marker for distress in such patients. However, the survey conducted by Burstein et al. suffers from serious drawbacks. There is a lack of base-line data for most of the variables, except for the components of the Medical Outcomes Study 36-Item Short-Form Health Survey (SF-36), for which a "recall base line" is available, and the samples in the subgroups are small. There are no intergroup differences in physical or mental health according to the recall base-line data obtained with the SF-36. For these reasons, the hypothesis that the use of alternative therapies is a marker for distress rests predominantly on variables with no base-line data. This leaves the results open to other interpretations. For instance, one could postulate that new users of alternative medicine showed considerable long-term benefits from these treatments, because the largest longitudinal changes were consistently documented in this group. Alternatively, if one assumes the missing base-line values to be similar between the groups, one might speculate that new use of alternative medicine led to considerable harm in those who tried it.

The notion that use of alternative medicine is a marker for distress is interesting and may well be correct, but the data presented by Burstein and colleagues[1] are too weak to prove either their or my hypothetical interpretations.

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2. Holland JC. Use of alternative medicine -- a marker for distress? N Engl J Med 1999;340:1758-1759.

To the Editor: The negative connotation that Burstein et al. give to distress in the context of breast cancer is disconcerting. Rather, the resolution to leave no stone unturned is a powerful motive that can translate distress into action and an assumption of responsibility. Moreover, the actual levels of distress manifested by the women in the study were mild, and the distress was temporary. Holland's description of the distressed women as "not psychologically strong" is disrespectful.

The idea that inquiry into the use of alternative medicine might be a variable in screening women for distress is misguided. How can one expect physicians to ask their patients about the use of alternative medicine when the physicians themselves are not knowledgeable about this topic? Medicine is at its best when it is patient-centered. It is incumbent on us to offer compassion and not merely to screen for distress. Use of alternative medicine is not a marker of distress but rather a marker of our failure as physicians to fulfill the obligation to "cure sometimes, heal often, comfort always."

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To the Editor: The reassuring findings of the study by Burstein et al. were that most patients informed their physicians about their use of alternative therapies, that there was no evidence that commitment to conventional therapies was weakened, and that the relaxation techniques and self-help groups used by many of the patients were plausibly conventional rather than alternative practices.

It is important to note that the mean self-reported depression measure used by Burstein et al. was within the normal range for women and well below established clinical cutoff points,[1,2] making it unlikely that much of the transient increase in psychological distress among users of the various alternative therapies represented a clinically significant mental disorder. Our reading of the data reported by Burstein et al. is that, in the months after a diagnosis of breast cancer, some women had mild-to-moderate distress and, as a result, sought nonpsychiatric treatment. Their distress resolved, but it is unclear whether its resolution was due to the effectiveness of the intervention or the passage of time. Some distress after receiving a diagnosis of cancer is to be expected, and it usually resolves without intervention. Focusing on women who are apparently able to manage distress on their own, as Burstein et al. suggest, will diffuse efforts to identify patients requiring intensive and professional intervention.

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To the Editor: Before one concludes that questions about beginning use of alternative medicine could serve to identify patients who are vulnerable to psychological distress, the sensitivity and specificity of such an approach need to be determined. In the report by Burstein et al., patients who began the use of alternative medicine after receiving a diagnosis of breast cancer reported greater distress and worse quality of life on several measures assessed three months after surgery, but the differences between the means for the groups of women who did or did not initiate alternative therapies were not very large. Consequently, it is likely that the groups consisting of nonusers and continuous users of alternative medicine also contained a statistically significant number of patients with high levels of distress. If that surmise is correct, then the sensitivity and specificity of a question such as, "Did you start using alternative medicine after you were treated for breast cancer?" to detect distress will be rather low. Brief, self-reported measures with established validity and reliability offer a much better alternative for cancer centers that wish to screen for psychological distress.[1]

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To the Editor: Burstein et al. found that the highest level of functioning on five of the seven measures at 12 months after surgery for breast cancer was achieved by women who used alternative psychological therapies before surgery (Table 5 of the article). These women also showed the most improvement from the 3rd to the 12th month on three of the seven measures, and it was actually the new users of alternative psychological therapies who had the most improvement on the other four measures. Obviously, alternative medicine has some value.

In her editorial, Holland states that the study contradicts the stereotype of the strong, assertive woman who chooses alternative medicine. This stereotype, however, may not be far off the mark. The new user of alternative medicine may be more knowledgeable about the enormity of breast

cancer, and so more susceptible to anxiety and depression. Her determination to take action may result in distressing disillusionment several months later if she had believed that alternative medicine could cure cancer.

Richard H. Rubes, Ph.D.
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To the Editor: Although I do not quarrel with the data or methods of the study, I believe the conclusions drawn by Burstein et al. and reiterated in Holland's accompanying editorial are unfounded and misleading for several reasons. Holland states as fact that women with breast cancer who used alternative medicine "turned to alternative medicine to alleviate their distress." However, the motivation to use any type of health care is complicated, and it is misleading to paint the picture as simplistically as Holland does, especially because some new users of these therapies were not distressed. All we can fairly conclude is that in the group of women with breast cancer who were studied by Burstein et al., psychological distress explains some of the variance in their use of alternative therapies.

I agree with Holland that management of patients' distress should "be an integral part of the treatment they are receiving." However, rather than viewing alternative therapies as solely negative, is it not possible that some of the more frequently used therapies, such as relaxation, imagery, and massage, can improve the quality of life and psychological well-being of patients, and perhaps influence their medical outcome?

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To the Editor: Burstein et al. found that women receiving adjuvant chemotherapy accounted for about 64 percent of new users of healing therapies and about 74 percent of new users of psychological therapies. Psychological distress during adjuvant treatment is common, and although scores on the depression scale of the Center for Epidemiologic Studies were higher among the new users of alternative therapies, they were similar to those found in women with breast cancer by Ganz et al.[1] The ranges of these scores are not consistent with clinical depression and may be only a response to the diagnosis and to the effects of treatment. In the study by Burstein et al., there was improvement in scores at one year among women who reported new use of alternative practices, perhaps as a result of a decrease in physical symptoms of distress, effectiveness of the complementary methods, or confidence in self-care and control. Persistent differences in sexual satisfaction at 12 months among the groups of women may relate to younger age (about 61 percent and 79 percent of new users of healing and psychological therapies, respectively, were no older than 50 years) or use of chemotherapy. Lack of preparedness for chemotherapy-induced menopause and severity of menopausal symptoms can influence a woman's quality of life.[1,2]

Use of alternative practices as a prompt to identify psychological distress is ill-advised. Use of complementary therapies may represent a woman's attempt to alleviate physical or psychological symptoms of distress or to retain some personal control. Younger age and severity of physical symptoms are known risk factors for psychological distress among women treated for breast cancer with adjuvant therapy. Perhaps these factors should serve as a prompt for further assessment and intervention.

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The authors reply:

To the Editor: A concern voiced by several correspondents is that use of alternative medicine is not a valid diagnostic or screening test for clinically significant distress. This is a misinterpretation of our conclusions; we did not propose that use of alternative medicine should be a screening or diagnostic test. We reported that new use of alternative medicine was associated with impaired quality of life and greater psychosocial distress as measured by a variety of standard instruments validated in studies of patients with breast cancer. We suggested that since patients who engage in such practices report somewhat higher levels of distress, on average, than those who do not, it is particularly important for clinicians to inquire about their physical and psychological symptoms.

Psychosocial distress is relatively common among patients who have recently received a diagnosis of breast cancer, leading to the suggestion of formal screening for all such patients.[1] Because this practice is not widespread, it may be helpful for physicians to be familiar with the characteristics or markers that identify patients who may be at high risk for distress. Drs. Knobf and Pasacreta note that previous studies have found that younger age, physical symptoms, and specific cancer treatments are such risk factors. In our multivariate models, we found that even when these factors were taken into account, new use of alternative medicine was independently associated with poorer scores on measures of mental health, depression, fear of recurrence, and physical symptoms.

Several correspondents address the possible causal relation between alternative medicine and distress. They speculate that alternative medicine might either contribute to or alleviate such symptoms or be an appropriate response to the understandable stress of cancer diagnosis. Our study sought to characterize factors related to the initiation of alternative health practices, and the results

revealed that psychosocial distress was such a factor — possibly one of many, as suggested by Astin's comments. Unlike most previous studies of the use of alternative medicine, our study was longitudinal, rather than cross-sectional. We agree with the correspondents that the temporal patterns we observed raise a number of interesting questions about the nature of the causal relations between alternative-medicine use and psychosocial functioning, questions that could not be fully answered in this study. We are gratified that our work prompted a number of interesting hypotheses, however, and hope that it may encourage additional research in this area. Prospective, longitudinal studies that specifically examine the clinical activity and side effects of these practices and the motivations behind them will be particularly informative.

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- Druss, B. G., Rosenheck, R. A. (2000). Use of Practitioner-Based Complementary Therapies by Persons Reporting Mental Conditions in the United States. *Arch Gen Psychiatry* 57: 708-714 [Abstract] [Full Text]

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