Palliative and Supportive Care (2006), **4**, 439–448. Printed in the USA.

DOI: 10.1017/S1478951506060573

Clinical Update: Literature Abstracts

MEASURES

Screening for Depression in Terminally Ill Cancer Patients in Japan

Akechi, T., Okuyama, T., Sugawara, Y., Shima, Y., Furukawa, T.A., and Uchitomi, Y.

Journal of Pain and Symptom Management, *31* (2006), 5–12.

This study attempted to assess the performance of several screening instruments for adjustment disorders (ADs) and major depression (MD) among terminally ill Japanese cancer patients. Two hundred and nine consecutive patients were assessed for ADs and MD using a structured clinical interview at the time of their registration with a palliative care unit, and two single-item interviews ("Are you depressed?" and "Have you lost interest?") and the Hospital Anxiety and Depression Scale (HADS) were administered. Screening performance was investigated by calculating sensitivity, specificity, the positive predictive value, negative predictive value, likelihood ratio, and stratum-specific likelihood ratios. When the screening target included both an AD and MD, the HADS is a more useful screening method than the single-item interviews. Regarding screening for MD, both single-item interviews and the HADS possess useful screening performance. Different screening instruments may be recommended depending on the depressive disorders and specific populations.

Evaluation of a One-Question Interview for Depression in a Radiation Oncology Department in Japan

Kawase, E., Karasawa, K., Shimotsu, S., Imasato, S., Ito, K., Matsuki, H., Sakano, Y., and Horikawa, N.

General Hospital Psychiatry, *28* (2006), 321–322

This study aims to clarify the validity of the brief screening measure of depression in Japan. It was the single-item interview "Are you depressed?" that provided a reliable and remarkably accurate screen in North America. The study was conducted on 282 participants receiving radiotherapy for cancer. The criterion diagnosis was given by the Structured Clinical Interview for DSM (SCID). On the basis of the receiver operating characteristic (ROC) analyses, the authors compared the results obtained the using single-item interview with major and minor depressive disorders defined by DSM-TR and calculated the sensitivity, specificity, and likelihood ratio (LR). The result of the present study indicated a sensitivity of 42% (95% CI 22%–61%) and a specificity of 86% (95% CI 82%–91%) and LR of 3.1. In conclusion, single-item interview "Are you depressed?" did not have sufficient sensitivity.

SYMPTOM CONTROL

Symptom Cluster Research: Conceptual, Design, Measurement, and Analysis Issues

Barsevick, A.M., Whitmer, K., Nail, L.M., Beck, S.L., and Dudley, W.N.

Jouranl of Pain and Symptom Management, *31* (2006), 85–95

Cancer patients may experience multiple concurrent symptoms caused by the cancer, cancer treatment, or their combination. The complex relationships between and among symptoms, as well as the clinical antecedents and consequences, have not been well described. This paper examines the literature on cancer symptom clusters focusing on the conceptualization, design, measurement, and analytic issues. The investigation of symptom clustering is in an early stage of testing empirically whether the characteristics defined in the conceptual definition can be observed in cancer patients. Decisions related to study design include sample selection, the timing of symptom measures, and the

characteristics of symptom interventions. For self-report symptom measures, decisions include symptom dimensions to evaluate, methods of scaling symptoms, and the time frame of responses. Analytic decisions may focus on the application of factor analysis, cluster analysis, and path models. Studying the complex symptoms of oncology patients will yield increased understanding of the patterns of association, interaction, and synergy of symptoms that produce specific clinical outcomes. It will also provide a scientific basis and new directions for clinical assessment and intervention.

Quality of Life and Symptom Control in Hospice Patients with Cancer Receiving Chemotherapy

Schonwetter, R.S., Roscoe, L.A., Nwosu, M., Zilka, B., and Kim, S.

Journal of Palliative Medicine, *9* (2006), 638–645

The value of palliative chemotherapy for hospice patients is difficult to quantify, and little is known about outcomes from these treatments. This study examined quality of life and symptom control in hospice patients with cancer receiving chemotherapy and in a control group of hospice patients with cancer who had not received chemotherapy for at least 3 months. Using a case-control study design matching patients by age, gender, race, and cancer diagnosis, patients receiving chemotherapy reported a similar number of symptoms as patients off chemotherapy. Global symptom distress was comparable in both groups, as was quality of life. Patients in both groups were similar at the symptom-specific level; however, patients on chemotherapy had better symptom outcomes for urination problems (p = .03), numbness/tingling (p = .03), muscle weakness (p = .07), and pain (p = .09). Patients on chemotherapy had poorer symptom control involving change in taste (p = .01) and cough (p = .01). Patients on chemotherapy were more likely than those off chemotherapy to report that chemotherapy "made them feel better" (p = .01) and "allowed better symptom control" (p = .01), indicating that patients taking chemotherapy had more subjective benefit from chemotherapy when compared to those off chemotherapy. The two groups showed no difference in the rate of survival.

A Comparison of Symptom Prevalence in Far Advanced Cancer, AIDS, Heart Disease, Chronic Obstructive Pulmonary Disease and Renal Disease

Solano, J.P., Gomes, B., and Higginson, I.J.

Journal of Pain and Symptom Management, *31* (2006), 58–69

Little attention has been paid to the symptom management needs of patients with life-threatening diseases other than cancer. In this study, we aimed to determine to what extent patients with progressive chronic diseases have similar symptom profiles. A systematic search of medical databases (MEDLINE, EMBASE, and PsycINFO) and textbooks identified 64 original studies reporting the prevalence of 11 common symptoms among end-stage patients with cancer, acquired immunodeficiency syndrome (AIDS), heart disease, chronic obstructive pulmonary disease, or renal disease. Analyzing the data in a comparative table (a grid), we found that the prevalence of the 11 symptoms was often widely but homogeneously spread across the five diseases. Three symptoms—pain, breathlessness, and fatigue—were found among more than 50% of patients for all five diseases. There appears to be a common pathway toward death for malignant and nonmalignant diseases. The designs of symptom prevalence studies need to be improved because of methodological disparities in symptom assessment and designs.

Midazolam as Adjunct Therapy to Morphine in the Alleviation of Severe Dyspnea Perception in Patients with Advanced Cancer

Navigante, A.H., Cerchietti, L.C., Castro, M.A., Lutteral, M.A., and Cabalar, M.E.

Journal of Pain and Symptom Management, *31* (2006), 38–47

The mainstay of dyspnea palliation remains altering its central perception. Morphine is the main drug and anxiolytics have a less established role. This trial assessed the role of midazolam as adjunct therapy to morphine in the alleviation of severe dyspnea perception in terminally ill cancer patients. One hundred and one patients with severe dyspnea were randomized to receive around-the-clock morphine (2.5 mg every 4 h for opioid-naive patients or a 25% increment over the daily dose for those receiving baseline opioids) with midazolam rescue doses (5 mg) in case of breakthrough dyspnea (BD) (Group Mo), around-the-clock midazolam (5 mg every 4 h) with morphine rescues (2.5 mg) in case of BD (Group Mi), or around-the-clock morphine (2.5 mg every 4 h for opioid-naive patients or a 25% increment over the daily dose for those receiving baseline opioids) plus midazolam (5 mg every 4 h) with morphine rescue doses (2.5 mg) in case of BD (Group MM). All drugs were given subcuta-

neously in a single-blinded way. Thirty-five patients were entered in Group Mo, 33 entered in Mi, and 33 entered in MM. At 24 h, patients who experienced dyspnea relief were 69%, 46%, and 92% in the Mo, Mi, and MM groups, respectively ($p = .0004$ and $p = .03$ for MM vs. Mi and MM vs. Mo, respectively). At 48 h, those with no dyspnea relief (no controlled dyspnea) were 12.5%, 26%, and 4% for the Mo, Mi, and MM groups, respectively ($p = .04$ for MM vs. Mi). During the first day, patients with BD for the groups Mo, Mi, and MM were 34.3%, 36.4%, and 21.2%, respectively (p = n.s.), whereas during the second day, these percentages were 38%, 38.5%, and 24%, respectively (p = n.s.). The data demonstrate that the beneficial effects of morphine in controlling baseline levels of dyspnea could be improved with the addition of midazolam to the treatment.

Economic Evaluation of Oral Treatments for Neuropathic Pain

Cepeda, M.S. and Farrar, J.T.

Journal of Pain, *7* (2006), 119–128

The effectiveness of amitriptyline, carbamazepine, gabapentin, and tramadol for the treatment of neuropathic pain has been demonstrated, but it is unknown which one is the most cost-effective. We designed a cost–utility analysis of a hypothetical cohort with neuropathic pain of postherpetic or diabetic origin. The perspective of the economic evaluation was that of a third-party payer. For effectiveness and safety estimates, we performed a systematic review of the literature. For direct cost estimates, we used average wholesale prices and the American Medicare and Clinical Laboratory Fee Schedules. For utilities of health states, we used the Health Utilities Index. We modeled 1 month of therapy. For comparisons among treatments, we estimated incremental cost per utility gained. To allow for uncertainty from variations in drug effectiveness, safety, and amount of medication needed, we conducted a probabilistic Monte Carlo simulation. Amitriptyline was the cheapest strategy, followed by carbamazepine, and both were equally beneficial. Gabapentin was the most expensive as well as the least beneficial. A multivariable probabilistic simulation produced results similar to the base-case scenario. In summary, amitriptyline and carbamazepine are more cost-effective than tramadol and gabapentin and should be considered as first-line treatment for neuropathic pain in patients free of renal or cardiovascular disease. Prescription practices should be based on the best available evidence, which includes the evaluation of the medication's cost-effectiveness. This does not mean that the cheapest or the most expensive, but rather the most cost-effective medication should be chosen—the one whose benefits are worth the harms and costs. We report a cost-effectiveness evaluation of treatments for neuropathic pain.

Dexmedetomidine: A Novel Analgesic with Palliative Medicine Potential

Jackson, K.C., 3rd, Wohlt, P., and Fine, P.G.

Journal of Pain and Palliative Care, Pharmacotherapy, *20* (2006), 23–27.

Dexmedetomidine has gained popularity in anesthesia and critical care for use in deep sedation and analgesia due to a combination of its efficacy and safety compared with other available agents (e.g., opioids, benzodiazepines, propofol) conventionally used in these settings. This brief review is meant to introduce this unique agent to the palliative care field, as dexmedetomidine may hold promise for patients in hospice and palliative care settings whose symptoms are refractory to usual therapies. [Be sure to be clear in the abstract that more studies are warranted and its role is not well defined and is complicated by significant drug interactions, invasive i.v. route and has a significant side effect profile.]

Characteristics of Depression in Hemodialysis Patients: Symptoms, Quality of Life and Mortality Risk

Drayer, R.A., Piraino, B., Reynolds, C.F., 3rd, Houck, P.R., Mazumdar, S., Bernardini, J., Shear, M.K., and Rollman, B.L.

General Hospital Psychiatry, *28* (2006), 306–312

Depression is often underrecognized in patients with end-stage renal disease. We interviewed outpatients at an urban dialysis facility using a criterion-based case-finding instrument to assess the rates, clinical correlates, and outcomes of depression. The Primary Care Evaluation of Mental Disorders Mood Module and the nine-item Patient Health Questionnaire were used to assess depression. We measured health-related quality of life using the Kidney Disease and Quality of Life Short Form, and medical comorbidities were measured using the Charlson Comorbidity Index. We compared the sociodemographic and clinical characteristics and health-related quality of life of depressed and nondepressed patients using t tests and the chi-square test, and we used a Cox regression model to test the relationship between depression and

mortality. We interviewed 62 patients and followed them for a mean of 29 months (range, 0.1–36). Seventeen (28%) had major or minor depression. Depressed patients were younger and had lower health-related quality of life than did nondepressed patients. Depression predicted mortality (HR = 4.1, 95% CI = 1.5–32.2, $p < .05$) after adjusting for age, gender, race, medical comorbidities, albumin, kt/V, and/or the presence of diabetes. Depression is common and associated with decreased health-related quality of life and increased mortality in hemodialysis patients. Clinical trials are necessary to examine whether treatment of depression can improve these outcomes.

EXISTENTIAL AND SPIRITUAL CARE

How Well Trained Are Clergy in Care of the Dying Patient and Bereavement Support?

Williams, M.L., Cobb, M., Shiels, C., and Taylor, F.

Journal of Pain and Symptom Management, *32* (2006), 44–51

Although comparatively few people have regular contact with a church or spiritual leader, during times of terminal illness or bereavement, clergy are expected to be available and able to provide support. This study was carried out to determine the perceptions of clergy on the training they had received in supporting the dying patient and the bereaved. A sample of clergy working in the diocese of Sheffield was sent a questionnaire to assess what skills and knowledge clergy believed they had in this area, together with areas where they would wish for further training. The questionnaire was developed with input from hospital, hospice, and academic chaplains, and palliative care consultants. A subsidiary questionnaire was sent to clergy training colleges to evaluate the teaching offered. There was a trend across all denominations that those who had trained more recently were more likely to have received relevant training. Most clergy believed that they possessed adequate liturgical skills, but 13% felt they possessed none or little skill in pastoral care of the dying. Seventy-one percent indicated that they would like further training in pastoral care of the dying and 66.3% desired training in care of the bereaved. Of the 50% of training colleges that responded, the number of hours of training on pastoral care of the dying ranged from 6 to 36 h (median 23 h and mean 25 h) and only 26% believed that their training in pastoral support skills was comprehensive. This study suggests that care of the dying and the bereaved is identified by clergy as an area in need of further training by the majority of clergy and should be part of the core curriculum within clergy training colleges and late training programs.

Dignity in the Terminally Ill: Revisited

Chochinov, H.M., Krisjanson, L.J., Hack, T.F., Hassard, T., McClement, S., and Harlos, M.

Journal of Palliative Medicine, *9* (2006), 666–672

Several studies have been conducted examining the notion of dignity and how it is understood and experienced by people as they approach death. The purpose of this study was to use a quantitative approach to validate the Dignity Model, originally based on qualitative data. Themes and subthemes from the Dignity Model were used to devise 22 items; patients were asked the extent to which they believed these specific issues were or could be related to their sense of dignity. Of 211 patients receiving palliative care, "not being treated with respect or understanding" (87.1%) and "feeling a burden to others" (87.1%) were the issues most identified as having an influence on their sense of dignity. All but 1 of the 22 items were endorsed by more that half of the patients; 16 items were endorsed by more than 70% of the patients. Demographic variables such as gender, age, education, and religious affiliation had an influence on what items patients ascribed to their sense of dignity. "Feeling life no longer had meaning or purpose" was the only variable to enter a logistic regression model predicting overall sense of dignity. This study provides further evidence supporting the validity of the Dignity Model. Items contained within this model provide a broad and inclusive range of issues and concerns that may influence a dying patient's sense of dignity. Sensitivity to these issues will draw care providers closer to being able to provide comprehensive, dignity-conserving care.

The Caregiver's Perspective on Existential and Spiritual Distress in Palliative Care

Boston, P.H. and Mount, B.M.

Journal of Pain and Symptom Management, *32* (2006), 13–26

There is a paucity of research relating to how palliative caregivers conceptualize, identify, and provide for spiritual and existential domains of care. Focus groups comprising experienced palliative care providers participated in three semistructured 2–2.5-h interviews, which were transcribed and subjected to thematic analysis. Eight themes were revealed: conceptualization of spirituality,

https://doi.org/10.1017/S1478951506060573 Published online by Cambridge University Press

creating openings, issues of transference and countertransference, cumulative grief, healing connections, the wounded healer, sustaining a healing environment for the caregiver, and challenges and strengths for the spiritual and existential domains of palliative care. Although the spiritual and existential domains were variously conceived by experienced care providers, their significance for both patient and caregiver was affirmed. Transference and countertransference issues and the "wounded healer" concept were considered fundamental to effective care. Strategies for promoting therapeutic depth discussion were suggested and the importance of self-awareness and staff support emphasized.

The Influence of Awareness of Terminal Condition on Spiritual Well-Being in Terminal Cancer Patients

Leung, K.K., Chiu, T.Y., and Chen, C.Y.

Journal Pain and Symptom Management, *31* (2006), 449–456

We developed a Spirituality Transcendence Measure (STM) and studied whether awareness of terminal illness affects spiritual well-being in terminal cancer patients. Three sources of spiritual transcendence—the situational, the moral and biographical, and the religious aspect—were assessed in the STM. Cronbach's alpha of the STM was .95, and the principal axis factor analysis extracted only one factor. Thirty-seven terminal cancer patients with male predominance (59.5%) were studied. Awareness of terminal illness was associated with a higher total STM score ($Z = -2.21, p = .027$), along with the individual scores for each of the three transcendences ($Z = -2.39$, $p = .017$; $Z = -2.71$, $p = .007$; and $Z = -1.96$, $p = .050$). Acceptance of death was associated with a higher situational score ($Z = 2.01$, $p = .046$) and a higher religious score ($Z = -2.27$, $p = .023$). Announcement of testament was associated with a higher situational score ($Z = -2.30$, $p = .021$). We conclude that awareness of terminal illness is associated with spiritual well-being. Telling the complete truth is necessary even when dealing with terminal conditions.

Religious Coping Is Associated with the Quality of Life of Patients with Advanced Cancer

Tarakeshwar, N., Vanderwerker, L.C., Paulk, E., Pearce, M.J., Kasl, S.V., and Prigerson, H.G.

Journal of Palliative Medicine, *9* (2006), 646–657

For patients confronting a life-threatening illness such as advanced cancer, religious coping can be an important factor influencing their quality of life (QOL). The study's main purpose was to examine the association between religious coping and QOL among 170 patients with advanced cancer. Both positive religious coping (e.g., benevolent religious appraisals) and negative religious coping (e.g., anger at God) and multiple dimensions of QOL (physical, physical symptom, psychological, existential, and support) were studied. Structured interviews were conducted with 170 patients recruited as part of an ongoing multi-institutional longitudinal evaluation of the prevalence of mental illness and patterns of mental health service utilization in advanced cancer patients and their primary informal caregivers. Patients completed measures of QOL (McGill QOL questionnaire), religious coping (Brief Measure of Religious Coping [RCOPE] and Multidimensional Measure of Religion/Spirituality), self-efficacy (General Self-Efficacy Scale), and sociodemographic variables. Linear regression analyses revealed that after controlling for sociodemographic variables, lifetime history of depression, and self-efficacy, greater use of positive religious coping was associated with better overall QOL as well as higher scores on the existential and support QOL dimensions. Greater use of positive religious coping was also related to more physical symptoms. In contrast, greater use of negative religious coping was related to poorer overall QOL and lower scores on the existential and psychological QOL dimensions. Findings show that religious coping plays an important role for the QOL of patients and the types of religious coping strategies used are related to better or poorer QOL.

Screening the Soul: Communication Regarding Spiritual Concerns among Primary Care Physicians and Seriously Ill Patients Approaching the End of Life

Holmes, S.M., Rabow, M.W., and Dibble, S.L.

American Journal of Hospice & Palliative Care, *23* (2006), 25–33

The purpose of this study was to explore the spiritual concerns of seriously ill patients and the spiritual-care practices of primary care physicians (PCPs). Questionnaires were administered to outpatients ($n = 65$, 90% response rate) with end-stage illness and to PCPs ($n = 67$, 87% response rate) in a diverse general medicine practice. Most patients (62%) and PCPs (68%) considered it important that physicians attend to patients' spiritual concerns. However, few patients reported receiving such care,

and most (62%) did not think it was the PCP's job to talk about spiritual concerns. Although both seriously ill outpatients and PCPs assert the importance of spiritual concerns, PCPs often do not provide spiritual care. Appropriate provision of spiritual care within a diverse population of seriously ill outpatients is complex, necessitating appropriate and attentive screening.

Suffering at the End of Life in the Setting of Low Physical Symptom Distress

Abraham, A., Kutner, J.S., and Beaty, B.

Journal of Palliative Medicine, *9* (2006), 658–665

Alleviation of suffering is a fundamental goal of medicine, especially at the end of life. Although physical distress is a component of suffering, other determinants likely play a role. This study attempted to elucidate these other components in an effort to understand the nature of suffering better. A prospective cohort study was conducted in the Population-based Palliative Care Research Network (PoPCRN) among English-speaking adults. Data were collected at hospice admission and at frequent intervals until death or discharge. This paper presents patient-reported data collected at the first available assessment after admission, using the Condensed Memorial Symptom Assessment Scale (MSAS; 0 = *not distressing*, 4 = *very distressing*), the McGill Quality of Life Questionnaire (MQOL; 0 = *worst QOL*, 10 = *best QOL*) and two suffering scales, overall suffering and suffering caused by physical symptoms (0 = *not suffering*, 10 = *extreme suffering*). The study population (n = 48) was limited to those with physical symptoms less than "somewhat" distressing on the MSAS-PHYS. Respondents were divided into two groups: no–mild overall suffering (0–3) and moderate–severe overall suffering (4–10) and compared based on demographics, MQOL scores, MSAS-PSYCH scores, and suffering caused by physical symptoms. Mean age was 70 years (range, 33–91), mean Karnofsky score 46, 46% married, 54% male, 71% cancer, 93% non-Hispanic white. Compared to patients reporting no–mild overall suffering, patients reporting moderate–severe overall suffering were more likely to have a diagnosis other than cancer (83% vs. 57%, p = .05), be younger (65 vs. 75 years, p = .02), and have lower scores on the MQOL-psychological subscale (6.4 vs. 8.0, p = .02) and overall QOL scale (6.2 vs. 7.2, p = .04). No significant differences were noted with respect to gender, marital status, MSAS-PSYCH, or MQOL existential and support subscales. Study patients reporting worse overall suffering also reported worse suffering caused by physical symptoms (6.3 vs. 2.1, $p < .0001$). There was little association between the MSAS-PHYS score and either overall suffering (correlation coefficient = .18, p = .21) or suffering resulting from physical symptoms (correlation coefficient = .22, p = .13). Patients reporting lack of distress resulting from physical symptoms did not necessarily indicate lack of suffering because of physical symptoms or lack of overall suffering. Factors other than physical symptom distress, such as diagnosis, age, and QOL, appear to affect the perception of suffering. To better address suffering at the end of life, care must be taken to understand differences between physical symptom distress, suffering caused by physical symptoms, and overall suffering.

PSYCHOSOCIAL INTERVENTIONS

Family Focused Grief Therapy: A Randomized, Controlled Trial in Palliative Care and Bereavement

Kissane, D.W., McKenzie, M., Bloch, S., Moskowitz, C., McKenzie, D.P., and O'Neill, I.

American Journal of Psychiatry, *163* (2006), 1208–1218

The aim of family-focused grief therapy is to reduce the morbid effects of grief among families at risk of poor psychosocial outcome. It commences during palliative care of terminally ill patients and continues into bereavement. The authors report a randomized, controlled trial. Using the Family Relationships Index, the authors screened 257 families of patients dying from cancer: 183 (71%) were at risk, and 81 of those (44%) participated in the trial. They were randomly assigned (in a 2:1 ratio) to family-focused grief therapy (53 families, 233 individuals) or a control condition (28 families, 130 individuals). Assessments occurred at baseline and 6 and 13 months after the patient's death. The primary outcome measures were the Brief Symptom Inventory, Beck Depression Inventory, and Social Adjustment Scale. The Family Assessment Device was a secondary outcome measure. Analyses allowed for correlated family data and employed generalized estimating equations based on intention to treat and controlling for site. The overall impact of family-focused grief therapy was modest, with a reduction in distress at 13 months. Significant improvements in distress and depression occurred among individuals with high baseline scores on the Brief Symptom Inventory and Beck Depression Inventory. Global family functioning did not change. Sullen families and those with intermediate functioning tended to improve overall, whereas

depression was unchanged in hostile families. Family-focused grief therapy has the potential to prevent pathological grief. Benefit is clear for intermediate and sullen families. Care is needed to avoid increasing conflict in hostile families.

Working with Families in Palliative Care: One Size Does Not Fit All

King, D.A. and Quill, T.

Journal of Palliative Medicine, *9* (2006), 704–715

Comprehensive palliative care requires that family concerns are understood and addressed. Yet medical professionals frequently lack formal training in family systems concepts and, therefore, may be unprepared to engage in family-inclusive approaches to treatment. To address this problem, we selectively review the literature on working with families in end-of-life settings and offer specific recommendations for involving families as collaborators in the care process. Based on existing theory regarding the development of family communication styles and problem-solving abilities, we propose a tentative framework for understanding and responding to a range of common family dynamics encountered in palliative care and hospice settings. In light of the lack of empirical studies in this area, we conclude with recommendations for future research.

How Well Do Family Caregivers Cope after Caring for a Relative with Advanced Disease and How Can Health Professionals Enhance Their Support?

Hudson, P.L.

Journal of Palliative Medicine, *9* (2006), 694–703

Support for families during a person's advanced disease and also into the bereavement period is a major component of palliative care. However, because of the gaps in bereavement research in this area, there is a lack of evidence-based direction for health professionals. This study sought to explore family caregiver perceptions of their relative's death and assess how well they were coping. Caregivers were also asked to identify which health professional strategies helped them prepare for and respond to their relative's death. Two months after their relative's death primary family caregivers (n = 45) of patients with advanced cancer completed a structured interview and were also assessed to determine if they were confronted by traumatic grief. Seven percent of caregivers were confronted by traumatic grief; most caregivers perceived they were coping reasonably well and could identify positive outcomes related to their experience. Caregivers noted the significant benefits of receiving comprehensive information to prepare them for the future and expressed appreciation for the support provided by specialist palliative care services. There is a large body of literature that highlights the negative consequences of being a family caregiver to a person with advanced disease. The sample population in this study, however, seemed to be reasonably well functioning; the results of the study were therefore somewhat surprising. A research agenda and key clinical implications are outlined in order to aid direction in targeting bereavement interventions.

Preparedness for the Death of a Loved One and Mental Health in Bereaved Caregivers of Patients with Dementia: Findings from the REACH Study

Hebert, R.S., Dang, Q., and Schulz, R.

Journal of Palliative Medicine, *9* (2006), 683–693

Although it has been suggested that family and friends who are prepared for the death of a loved one have less distress, the relationship between preparedness and bereavement mental health is inconclusive. The objective of this study was to determine the relationship between preparedness for the death and mental health in bereaved caregivers of dementia patients and explore predictors of preparedness. Standardized assessment instruments and structured questions were used to collect data at study entry and at 6, 12, and 18 months. Multiple caregiving-related variables were collected. Bereaved caregivers reported whether they were "not at all" prepared or prepared for the death of their loved one. Two hundred twenty-two bereaved caregivers participated. Twenty-three percent of caregivers were not prepared for the death. These caregivers had more depression, anxiety, and complicated grief symptoms. Black caregivers, caregivers with less education, those with less income, and those with more depressive symptoms prior to the death were more likely to perceive themselves as "not at all" prepared. In contrast, the amount of pain the care recipient was in prior to death was positively associated with preparedness. Despite providing high-intensity care, often for years, many bereaved caregivers perceived themselves as unprepared for the death. These caregivers had more depression, anxiety, and complicated grief symptoms. Future work should be directed to confirming these findings and determining how best to intervene with high-risk caregivers.

Hypnosis for Procedure-Related Pain and Distress in Pediatric Cancer Patients: A Systematic Review of Effectiveness and Methodology Related to Hypnosis Interventions

Richardson, J., Smith, J.E., McCall, G., and Pilkington, K.

Journal of Pain and Symptom Management, *31* (2006), 70–84

The aim of this study was to systematically review and critically appraise the evidence on the effectiveness of hypnosis for procedure-related pain and distress in pediatric cancer patients. A comprehensive search of major biomedical and specialist complementary and alternative medicine databases was conducted. Citations were included from the databases' inception to March 2005. Efforts were made to identify unpublished and ongoing research. Controlled trials were appraised using predefined criteria. Clinical commentaries were obtained for each study. Seven randomized controlled clinical trials and one controlled clinical trial were found. Studies report positive results, including statistically significant reductions in pain and anxiety/distress, but a number of methodological limitations were identified. Systematic searching and appraisal has demonstrated that hypnosis has potential as a clinically valuable intervention for procedure-related pain and distress in pediatric cancer patients. Further research into the effectiveness and acceptability of hypnosis for pediatric cancer patients is recommended.

The Effect of a Physical Exercise Program in Palliative Care: A Phase II Study

Oldervoll, L.M., Loge, J.H., Paltiel, H., Asp, M.B., Vidvei, U., Wiken, A.N., Hjermstad, M.J., and Kaasa, S.

Journal of Pain and Symptom Management, *31* (2006), 421–430

The purpose of this pilot study was to assess the effects of a physical exercise program on physical performance and quality of life (QOL) in a population with incurable cancer and a short life expectancy. Thirty-four patients participated in a 50-min group exercise program twice a week for 6 weeks. Physical performance was measured by three tests: "6-min walk test," "timed repeated sit to stand," and "functional reach." Fatigue was measured by the Fatigue Questionnaire. QOL was assessed by the European Organization for Research and Treatment of Cancer Core Quality of Life Questionnaire. The outcome variables were assessed before and after the intervention. The walk length increased and the "timed repeated sit to stand" was reduced ($p < .05$). Emotional functioning improved and physical fatigue was reduced ($p < .05$). Physical exercise seems to be a feasible way to improve well-being among patients with incurable cancer. Future randomized trials are needed to confirm the results.

Effect of Maintenance Therapy with Varenicline on smoking Cessation: A Randomized Controlled Trial

Tonstad, S., Tonnesen, P., Hajek, P., Williams, K.E., Billing, C.B., Reeves, K.R., and Varenicline Phase 3 Study Group

JAMA, *296* (2006), 64–71

The majority of cigarette smokers who achieve abstinence relapse within the first year and require many attempts before achieving permanent abstinence. Evidence to support pharmacological treatment for relapse prevention is insufficient. The objective of the study was to determine whether smokers who quit after 12 weeks of treatment with varenicline, a selective alpha4beta2 nicotinic acetylcholine receptor partial agonist, maintain greater continuous abstinence rates (defined as not a single "puff" of a cigarette) than placebo controls during an additional 12 weeks of treatment and until 52 weeks after treatment initiation. We used a randomized controlled trial conducted at multiple medical clinics in seven countries with follow-up to 52 weeks after study baseline. Of 1927 cigarette smokers recruited between April 2003 and February 2004 and treated for 12 weeks with open-label varenicline titrated to 1 mg twice per day, 1236 (64.1%) did not smoke, use tobacco, or use nicotine replacement therapy during the last week of treatment and 62.8% ($n = 1210$) were randomized to additional treatment or placebo. Participants were randomly assigned to receive either double-blind varenicline, 1 mg twice per day ($n = 603$) or placebo ($n = 607$) for an additional 12 weeks. Carbon monoxide-confirmed continued abstinence during weeks 13 to 24 and weeks 13 to 52 of the study. The carbon monoxide-confirmed continuous abstinence rate was significantly higher for the varenicline group than for the placebo group for weeks 13 to 24 (70.5% vs 49.6%; odds ratio [OR], 2.48; 95% confidence interval [CI], 1.95–3.16; $p < .001$) as well as for weeks 13 to 52 (43.6% vs 36.9%; OR, 1.34; 95% CI, 1.06–1.69; $p = .02$). Adverse events reported in the open-label period were mostly mild; no difference in adverse events between varenicline and placebo was observed during the double-blind period. Smokers who achieved abstinence for at least

https://doi.org/10.1017/S1478951506060573 Published online by Cambridge University Press

7 days at the end of 12 weeks of open-label varenicline treatment and were randomized to receive an additional 12 weeks of varenicline treatment showed significantly greater continuous abstinence in weeks 13 to 24 compared with placebo. This advantage was maintained through the nontreatment follow-up to week 52. Varenicline may be an efficacious, safe, and well-tolerated agent for maintaining abstinence from smoking.

QUALITY OF PALLIATIVE CARE

The Seattle Pediatric Palliative Care Project: Effects on Family Satisfaction and Health-Related Quality of Life

Hays, R.M., Valentine, J., Haynes, G., Geyer, J.R., Villareale, N., McKinstry, B., Varni, J.W., and Churchill, S.S.

Journal of Palliative Medicine, *9* (2006), 716–728

This paper presents the components of a pediatric palliative care demonstration program implemented in Seattle during the period 1999–2001. It reports findings from the evaluation of quality of life and family satisfaction among enrolled participants. The program was designed to enhance patient–provider communication using the Decision-making Tool (DMT) and experimented with comanagement by clinicians and insurers to support decision making in advanced serious pediatric illness. The project design consisted of ethical decision making, provider education, and flexible administration of health benefits through co-case management between insurers and care providers. The evaluation study design is a nonexperimental pretest, posttest design comparison of pediatric quality of life, and family satisfaction at program entry with repeated measures at 3 months after program entry. Quality of life was measured with parent proxy reports of health-related quality of life using the PedsQL Version 4.0, and family satisfaction was measured with a 31-item self-administered questionnaire designed by project staff. Forty-one patients ranging in age from infancy to 22 years old were enrolled in the program over a 2-year period. Parents consented to participate in the evaluation study. Thirty-one specific diagnoses were represented in the patient population; 34% were some form of cancer. Improvements in health-related quality of life over baseline were observed for 21 matched pairs available for analysis in each domain of health-related quality of life; positive changes in reports of emotional well-being were statistically significant. Improvements over baseline in 14 of 31 family satisfaction items were statistically significant. Pediatric palliative care services that focus on effective communication, decision support, and co-case management with insurers can improve aspects of quality of life and family satisfaction.

Sudden Traumatic Death in Children: "We Did Everything, but Your Child Didn't Survive"

Truog, R.D., Christ, G., Browning, D.M., and Meyer, E.C.

JAMA, *295* (2006), 2646–2654

When caring for children who become suddenly and catastrophically ill, clinicians must simultaneously attend to a complex and rapidly evolving medical situation as well as to the equally challenging demands of establishing compassionate relationships with family members and communicating well with colleagues. An 18-month-old toddler was brought to the hospital with severe head injury after being struck by a car. Over a period of hours, her condition evolved from prognostic uncertainty to the diagnosis of brain death and considerations of organ donation. Against this medical backdrop, the clinicians successfully established a trusting relationship with family members by careful attention to their emotional, informational, and care needs as they absorbed the devastating prognosis, took in the results of the brain death examination, and considered the option of organ donation. This case illustrates the importance of interdisciplinary communication, the vital role of social workers and other psychosocial providers with expertise in working with families, and the critical significance of mutual care and support for the clinicians who accompany families through these tragic life events.

COMMUNICATIONS

Patient-Physician Communication in the Context of Persistent Pain: Validation of a Modified Version of the Patients' Perceived Involvement in Care Scale

Smith, M.Y., Winkel, G., Egert, J., Diaz-Wionczek, M., and DuHamel, K.N.

Journal of Pain and Symptom Management, *32* (2006), 71–81

The purpose of this study was to evaluate the psychometric properties of a modified version of the Perceived Involvement in Care Scale (M-PICS), a measure designed to assess pain patients' perceptions of patient health care provider communication during the medical consultation. Eighty-seven breast cancer outpatients with persistent pain com-

pleted a battery of questionnaires, including the M-PICS. A factor analysis supported four factors. Factor 1 reflected health care provider information behaviors; Factor 2, health care provider facilitation of patient involvement; Factor 3, patient information provision; and Factor 4, patient participation in decision making. The M-PICS total had an internal consistency of .87; alphas for subscales ranged from .80 to .90. M-PICS scores related to measures of patient characteristics and outcomes, including pain-related communication barriers, psychological status, quality of life, and health care satisfaction, in predicted ways. The M-PICS is a reliable and valid measure of perceived patient–provider communication in the context of persistent pain.

Concerns about Losing Control when Breaking Bad News to Terminally Ill Patients with Cancer: Physicians' Perspective

Friedrichsen, M. and Milberg, A.

Journal of Palliative Medicine, *9* (2006), 673–682

The objective of this paper was to study and explore problems perceived by physicians when breaking bad news to advanced cancer patients about discontinuing or not offering tumor-specific treatment due to incurable cancer. We used a qualitative phenomenographic interview study. The setting was the county of Ostergotland in Sweden. The participants were 30 physicians with different demographic characteristics. According to the physicians' answers, breaking bad news was perceived as involving a risk of losing control in different ways, regarding emotions, oneself, confidence, professionalism, and patient trust. Four different main categories described as problems were identified: perceptions focusing on existential thoughts, relationships, knowledge, and perceptions related to time and environmental disturbances. Physicians perceived that breaking bad news to dying patients with cancer involved a risk of losing control. Existential thoughts and a lack of knowledge contribute to this risk. Theoretical education in existentiality/spirituality and clinical practice in a palliative context may help maintaining control.