Psychologic Intervention and Survival: Wishing Does Not Make It So − Letter

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Andersen et al. (1) claimed that breast cancer patients experiencing a recurrence survived longer when they had been exposed to a brief psychologic intervention an average of 11 years earlier. We are concerned that breast cancer patients, clinicians, and researchers might accept these claims at face value, leading patients to mistakenly seek and professionals to mistakenly recommend psychologic intervention to improve the quantity, rather than the quality of patient lives. Regardless of claims made by researchers invested in demonstrating the contrary, no study of psychologic intervention in which survival was an a priori end point and intervention was not confounded with improved medical surveillance and attention has demonstrated a survival benefit among cancer patients (2). The current study does not alter this conclusion. As stated previously (3) regarding the Andersen et al. parent study (4), claims about survival benefits are medical claims and should be evaluated using the same standards of evidence whether they arise from psychologic, pharmacologic, or medical interventions. Andersen et al. (1, 4) fail to meet these standards.

Results are based on an extremely small sample and an even smaller number of events. This report isolated 29 patients from the intervention group who subsequently recurred, 10 (34%) of whom survived, and 33 from the no treatment group, 8 of whom survived (25%). Although 10 (34%) of whom survived, and 33 from the patients from the intervention group who subsequently recurred, a significantly higher chemotherapy dose intensity, and no significant study arm or study arm by time effect was found for health measures. Immunologic analyses lead to inconsistent results, with a significant arm by time effect for one of three reported analyses, NKCC, but no real discussion of the clinical utility of the size of the Natural killer cell cytotoxicity (NKCC) effect in the context of null findings for Concanavalin A (Con A) and Phytohaemagglutinin (PHA). Overfitting is again a likely issue, with the smaller of the two groups having only 18 cases and an unknown number of covariates entered into models used to assess group differences. In any case, it is difficult to make sense of any biobehavioral analysis of null findings for Con A and Phytohaemagglutinin (PHA) in a sample with 34% of the cases missing (21 of 62 patients). Such a large proportion of missing data makes sense of any biobehavioral analysis invalidates any conclusions that the authors attempt to draw.

In sum, these findings do little to illuminate the complex relationships and pathways between stress, immunologic function, and tumor biology. Moreover, they risk motivating vulnerable patients to seek psychologic support for unproven reasons. Support and psychotherapeutic groups have much to offer patients, but improved survival has not been shown to be among them.

Disclosure of Potential Conflicts of Interest

No potential conflicts of interest were disclosed.

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