BRIEF SUPPORTIVE-EXPRESSIVE PSYCHOTHERAPY IN A SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): CHANGING THEMES AND PSYCHOLOGICAL DISTRESS

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Abstract

The aim of this study was to describe the process of Brief Supportive-Expressive Group psychotherapy provided to women with systemic lupus erythematosus (SLE) in the context of a randomized clinical trial. A secondary objective was to contrast baseline characteristics in patients whose psychological distress decreased over time compared to those who remained distressed.

Sixty-two women with SLE participated. Thirty-five reported clinically significant psychological distress at study entry. Therapists rated predominant themes, affective expression and emotional processing after each session.

Emotional processing increased significantly over the course of therapy (F=33.44, p<.02). Women with more severe and generalized distress at baseline were less likely to show improvements at the 6 month follow-up (t= -3.14, p<.005). Baseline disease activity or damage did not differ between patients who were no longer clinically distressed at 6 months follow-up and those who remained distressed.

Key-words: *Group psychotherapy; Themes; Psychological distress; Systemic lupus erythematosus.*

INTRODUCTION

Lupus is a relatively rare chronic auto-immune disease that affects primarily women in their childbearing years. It is characterized by an unpredictable course of remissions and exacerbations. The etiology of lupus is unknown and there is currently no cure. Common symptoms include fatigue, lassitude, fever, weight loss, skin rash, hair loss and pain. Less frequent, but more severe symptoms involve specific organs including the cardiorespiratory, renal, hematologic, and neurological systems [1]. Given the highly variable nature of the disease and treatment (e.g., immunosuppressant agents) that can have serious side effects, it is not surprising that many patients experience significant psychological distress at some point in time during their illness.

Research linking psychosocial factors and manifestations of lupus reveals that patients report emotional reactions to their disease (i.e., anxiety and depression) and that these problems seem to influence health outcomes and quality of life. Concurrent and prospective associations have been found among major and minor stressors, depression, anxiety and joint pain/inflammation, rash, and abdominal symptoms[2,3].

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Dobkin *et al.*[4], reported that 43% of their sample experienced clinically significant psychological distress on the following scales of the Symptom Checklist-90-R (SCL-90-R): somatization, interpersonal sensitivity, anxiety, phobic anxiety, and psychoticism. More severe hassles (minor stressors), lower self-esteem and less social support were associated with greater psychological distress.

Others have shown that lupus patients who use more passive coping strategies, such as avoidance, self-blame and wishful thinking concurrently experience greater physical disability, social disability and depression[5]. Social support seeking was associated with less pain, less psychological distress (anxiety and depression) and disability at follow-up[5]. Collectively, these findings show consistent relationships between negative emotional states and poor physical outcomes, as well as the positive impact of social support on health status. There is an emerging literature indicating that medical patients with severe and unpredictable illnesses may benefit from psychological interventions that address negative emotional states and reinforce social support[6,7].

Brief Supportive-Expressive group psychotherapy is one such intervention[8]. This approach combines interpersonal existential therapy with group support and specific coping-skills training. The focus is on creating a supportive environment in which patients can openly express their thoughts and feelings. Such coping skills have been associated with improved quality of life as well as positive emotional and physical well-being[9]. Results of the first randomized clinical trial for metastatic breast cancer patients showed that following the one-year intervention, women improved in many ways: better coping, less confusion and fatigue, and a two-fold increase in survival compared to women in the control group[10]. A Canadian replication of this study showed that women in the Supportive-Expressive therapy group showed improvements in mood and reported less pain, but there were no significant effects on survival time[11]. This intervention has been adapted to other chronic diseases such as HIV[12] and inflammatory bowel disease[13]; results have been promising.

Theoretically, themes of importance for patients with chronic medical conditions are as follows: 1) biomedical; 2) altered physical functioning 3) required life style adjustments; 4) coping with treatment; 5) prioritizing life values and goals 6) losses; 7) death and dying[6]. The process of therapy usually commences with exploration of topics that involve little affect such as medical status and treatment. Typically, as the therapy progresses patients begin discussing increasingly more personal issues (e.g., the doctor-patient relationship, intimacy) that are more charged with affect and concern interpersonal relationships.

Given the phase of life when a lupus diagnosis is usually made (the second decade) and the potential for disruption in normal daily activities, career and family plans, women with lupus often face concerns that cause intense emotional reactions. However, little is known about the relative importance of the aforementioned themes in the context of therapy with these patients. A better understanding of the process of therapy may help clinicians design effective interventions and orient professionals treating this patient population.

The present report examines data not previously explored in the published clinical trial with these patients testing the efficacy of Brief Supportive-Expressive group psychotherapy[14]. While lupus patients in both the treatment and control groups showed improvements over time[15], these changes could not be attributed to the psychological intervention[14]. Here, we focus on the patients randomized to the group therapy arm in order to probe the themes addressed, their frequency and relative importance for this patient population and changes in themes over the course of therapy. Therapists' ratings of affective expression and processing were also examined. Given that some patients' psychological distress decreased over time, baseline characteristics of patients who showed improvements were compared to those patients who remained distressed at 6 months follow-up.

METHODS

Participants

Women with a diagnosis of lupus according to American College of Rheumatology criteria[16] were invited to participate in the study by their physician from nine immunology/rheumatology centers across Canada. Exclusion criteria included: the presence of severe cognitive deficits, psychosis, inability to attend weekly psychotherapy sessions or communicate adequately in English or French. Physicians were not directed to select patients based on disease severity, activity or level of psychological distress. (For a full description of all study participants see Dobkin *et al* [14]).

Procedures

Once informed consent was obtained, patients completed a battery of questionnaires (described below) at baseline, post-treatment, and 6 and 12 months post-treatment. Following the completion of baseline questionnaires patients were contacted by telephone by the therapist and interviewed to determine if the patient understood the type of therapy being offered and to ensure that there were no contraindications (e.g., suicidal tendencies, unwilling to commit to weekly sessions). They were subsequently examined by a rheumatologist blinded to group status.

Intervention: Brief Supportive-Expressive Group Psychotherapy

The intervention evaluated was developed by Spiegel and his colleagues at Stanford University in California over a period of 20 years[17]. Manuals and videotapes are available and were used to train therapists. Dr. Classen, who works closely with Dr. Spiegel and co-authored the treatment manual, trained and provided feedback to the therapists in this study. The therapists were doctoral level psychologists or Master's level social workers with at least one year experience as group therapists with medical patients. All sessions were audio-taped and reviewed weekly by one of the investigators (PLD), who provided ongoing supervision to the therapists. Dr. Classen reviewed the third session for each group and provided feedback directly to the therapists. There was not a predetermined order of themes, as therapists used a non-directive approach, following the group theme rather than imposing one. At the end of each session, a brief self-hypnosis exercise was carried out with the guidance of the therapist. Participants were encouraged to practice it at home in between sessions.

We modified the program slightly to suit lupus patients (e.g., less emphasis on dying), although the brief (i.e., 12 session) version for the non-metastatic breast cancer patients required very few changes. We did not, however, use co-therapists, nor include family members in separate groups due to logistical restraints. Treatment was conducted in small groups of lupus patients who met weekly for 12 weeks. Each session was 90 minutes long and was provided in French or English, depending on patients' mother tongue. Booster sessions were offered once per month for three months following the termination of intensive treatment to reinforce changes and encourage the transfer of new experiences into daily life. Thus, treatment involved a total of 22.5 hours of direct patient contact.

Measures

The *Symptom Checklist 90-Revised* (SCL-90-R)[18] is a 90-item self-report questionnaire that reflects psychological symptom patterns of psychiatric and medical patients as experienced in the past week. It consists of nine primary dimensions which include: somatization, obsessive-compulsive, interpersonal sensitivity, depression, anxiety, hostility, phobic anxiety, paranoid ideation, and psychoticism. The nine subscales can be combined to describe three global indices of distress: 1) the Global Severity Index (GSI) 2) Positive Symptom Distress Index and 3) The Positive Symptom Total. The GSI combines both the number and intensity of symptoms and is considered to be the best single indicator of psychological distress. Higher scores on the SCL-90-R indicate greater psychological distress. Normative data and standardized T scores facilitate interpretation, clinically significant psychological distress is detected when T scores on the GSI scale are 63 or greater.

The *Short Form Health Survey* (SF-36™) is a psychometrically sound and widely used measure which consists of 36 items and measures eight aspects of health and well-being: physical functioning, role limitation due to physical health, bodily pain, general health, vitality, social functioning, role limitation due to emotional problems, and mental health[19]. Of the 36 items, 20 refer to the past month. Scores on each subscale vary from 0 to 100 with higher scores indicating better health status. Recently, it has been shown that the SF-36™ subscales can be summarized into two component scores: the physical health component summary (PCS) and the mental health component summary (MCS)[20]. The PCS and MCS are standardized to have a mean of 50 and a standard deviation of 10[21]. Correlations obtained between the eight subscales and the two summary scores support the mental and physical health distinction. This has recently been shown to be the case for Canadian Women[22].

The shortened version of the *Social Support Questionnaire* (SSQ6) was used to assess perceived availability and satisfaction with social support[23]. The SSQ6 is psychometrically sound and consists of 6 items that are subdivided into two subscales. Six items assess network size (SSQ-N) and the remaining six measure satisfaction with the available social support (SSQ--S). Given the modest intercorrelation between the two subscales, it has been suggested that the two scores be examined separately. Network size scores range from 0 to 9, higher scores reflecting a larger social support network. Scores on the satisfaction subscale range from 0 to 6, with higher scores indicating greater satisfaction.

The validated *Coping Inventory for Stressful Situations* (CISS[24]) was used to assess coping style. The CISS is a 44-item questionnaire that assesses cross-situational coping preferences. It consists of three subscales that measure task, emotional and avoidance coping. The CISS subscales have been found to be reliable with coefficients ranging from 0.77 to 0.90. The task-oriented (e.g., adjust my priorities; schedule my time better) and emotional (e.g., get angry; worry about what to do) coping strategies have consistently been linked with physical and mental health outcomes in previous studies[25,26]. Higher scores indicate more use of the coping style.

The revised version of the *Hassles Scale* was used to assess stress during the past month[27]. This validated and reliable version consists of a list of 54 minor stressors that can occur in daily life. Respondents indicate the degree of distress they have experienced as a result of various events. Responses on each item vary from "not at all/not applicable" (0) to "extremely severe" (3). Total scores can vary from 0 to 162, with higher scores reflecting greater stress.

The *Systemic Lupus Activity Measure* (SLAM--R[28]) was used to measure disease activity. The SLAM-R is a reliable and valid measure of disease activity in a number of organ systems – constitutional, integument, ocular, reticuloendothelial, pulmonary, cardiovascular, gastrointestinal, neuromotor, musculoskeletal, hematologic, and renal. Although validation data is only available on the original SLAM-R, the differences between the original and revised versions are minor. The SLAM-R is based on physician examination and laboratory assessment that includes a complete blood cell count, erythrocyte sedimentation rate, creatinine and urinalysis. Scores may range from 0 (no disease activity) to 84 (maximum disease activity). Based on our experience, a score over 8 indicates moderate to severe clinical activity.[29]

The *Systemic Lupus International Collaborating Clinics/American College of Rheumatology* (SLICC//ACR)[30,31] *Damage Index* was used to measure disease damage. The SLICC/ACR is a physician--rated index that assesses cumulative organ damage due either to the disease, complications of therapy, or concurrent illness such as cancer. It includes 12 categories: ocular, neuropsychiatric, renal, pulmonary, cardiovascular, peripheral vascular, gastrointestinal, musculoskeletal, skin, premature gonadal failure, diabetes and cancer. Total scores range from 0 (no damage) to 46 (maximum damage)[30,31].

Therapist Ratings (completed after each session; see Appendix for a sample of the form used)

Themes: A list of themes, based on the treatment manual, for the session was created by our team and therapists were asked to indicate which one predominated during a particular session[17]. If more than one theme was explored, therapists rank ordered the themes (1=most important, 2=second). These included biomedical themes, loss, body image, uncertainty, control, acceptance, reprioritizing. Therapists were also asked to report and rank order any other themes that were discussed (e.g., sexual relationships).

Affective Expression: Affective expression that occurred during each session was rated on a scale of 1-5. The instructions to the therapists were as follows: "Circle the number which best describes the strongest level of affective expression that occurred in this session on a scale of 1--5, 1 being" "no affect" or "intellectual" and 5 being" "deep and strong expression of affect".

Affect Processed: The level of processing following the emotional expression was also rated. The instructions to the therapists were as follows: "Having in mind the strongest level of affective expression that occurred in the session, circle the number representing the level of processing that took place at that time. In other words, rate the extent to which the group attempted to explore these feelings and deepen their understanding. Rate on a scale of 1-5 with 1 being "no exploration" and 5 being "deep exploration resulting in a new level of understanding".

Global Rating of Session: The quality of the overall session was rated as follows: 1=poor, 2=good, 3=very good, and 4=excellent.

Data Subset

The original randomized clinical trial included a 12 months post-treatment assessment, however for the purposes of this paper we subdivided the distressed patients into two groups: those who improved by the 6 month follow-up and those who did not. We chose this endpoint, rather than the 12 month post-treatment period because the former included booster sessions and the later was too distal to assume results were influenced by therapy process-related factors.

RESULTS

Participants

The sample for this report includes 62 women. Selected demographic characteristics and clinical variables are presented in Table 1. The participants were mainly middle-aged, Caucasian and relatively well educated.

TABLE 1 – **SAMPLE CHARACTERISTICS**

	Mean	***SD***	***Range***
Demographics			
Age	42.2	11.0	19.00-64.8
Education (years)	14.2	2.6	8-18
Ethnic Origin (%)			
Caucasian	86.9		
Black	4.9		
Asian	4.9		
Other	3.3		
Marital Status (%)			
Single	32.8		
Married	37.7		
Divorce-Separated	26.3		
Widowed	3.3		
Clinical			
SLAM-R (disease activity)	7.6	3.9	0-17
SLICC/ACR	1.6	1.8	0-7
(disease duration)	11.2	8.54	.01-33.9

Therapists, Group Attendance and Themes Addressed

Eight therapists from 7 cities (in 9 clinics) ran 1 or 2 groups of 4 to 8 patients (for a total of 11 groups) depending on the success of recruitment in a particular centre (e.g., Toronto: n=9; Calgary: n=31). Patients randomized to group psychotherapy attended an average of 12.02 (SD=2.98; median=13) of the 15 sessions. A dose-effect was not evident as the number of sessions attended was uncorrelated with changes in outcomes at the 12 month follow--up: including psychological distress (r= 0.15, 95% confidence interval [CI] -0.12, 0.39), physical health status (r=0.024, 95% CI -0.24, 0.28), mental health status (r=0.06, 95% CI -0.20, 0.31), and disease activity (r= -0.036, 95% CI -0.22, 0.29)[15].

Session themes, as ranked by the therapists, are presented in Table 2. In general, biomedical concerns were addressed most often, followed

TABLE 2 – **THERAPISTS' OVERALL RATINGS OF THEMES**

	Most important	*Second most important*	*Overall Frequency*
Biomedical	48.6%	17.1%	70/165 (42.7%)
Loss	41.9%	33.9%	62/165 (37.6%)
Body Image	25.0%	37.5%	40/165 (24.2%)
Uncertainty	25.0%	40.0%	40/165 (24.2%)
Control	35.2 %	27.8%	54/165 (32.7%)
Acceptance	22.6 %	40.3%	62/165 (37.6%)
Reprioritizing	20.8 %	41.7%	48/165 (29.0%)
Other	52.8 %	23.6%	89/165 (53.94%)

by themes of loss and acceptance. Next, we examined themes and therapists' ratings by stage of group. We separated the sessions into: beginning sessions (1-4, n=44), middle sessions (5-8, n=44), end sessions (9-12, n=44), as well as booster sessions (13-15, n=33).

In the beginning sessions, the most frequent themes were biomedical (n=21), loss (n=21), body image (n=19) and acceptance (n=19). Under the category other (n=19) the most frequent themes were family/social relationships (n=9) and the doctor-patient relationship (n=4). In terms of rank, biomedical concerns were rated as the most important theme (52.4% of the time). Loss themes were ranked as most important 38.1% of the time, followed by control (25%), body image (21.1%) and acceptance (10.5%).

In the middle sessions, the most frequent themes included loss (n=18), control (n=18) biomedical (n=17) and acceptance (n=17). Themes of loss were rated as most important 50.0% of the time, control 55.6% of the time, biomedical issues 35.3% and acceptance ranked highest in importance 5.9% of the time. The category of other was used 26 times, family/social relationships (n= 17) as well as death (n=5) were frequent topics. Compared to the beginning sessions, themes of family/social relationships doubled in frequency, at this phase of therapy.

For the end sessions, the most frequent themes were biomedical (n=16), followed by control (n=14) and acceptance (n=13). Biomedical concerns ranked as the most important theme 56.3% of the time, control 21.4% and acceptance 38.5% of the time, respectively. Under the category of other (n=29), family relationships (n=15) remained the most frequent theme. Although themes of loss were discussed, termination issues were brought up only twice.

Finally, during the three booster sessions, the most frequently reported themes were biomedical (n=16), acceptance (n=13), loss (n=12), and reprioritizing (n=11). Those which ranked highest in importance most often were biomedical (50%), acceptance (46.2%), loss (33.3%) and uncertainty (25%). Other themes discussed (n=15) included family/social relationships (n=7) and termination (n=5).

Process Variables

Next, we examined the level of affective expression, level of processing, and global ratings, as a function of stages of the group. As shown in Table 3, there appeared to be an increase in the amount of affective expression, the level of processing of the affect expressed, as well as global ratings of the sessions, as the groups progressed. Analysis of variance revealed a significant change in level of processing over time (F=3.44, p<.02). *Post-hoc* Tukey tests, show that there was a significant difference in level of processing between beginning and end stages (p<.05) as well as beginning and booster sessions (p<.03).

Patients' Psychological Distress Over Time

Initially, 35 (56.5%) women in the therapy group were distressed (i.e., obtained a GSI T-score of 63 or greater). At post-treatment 23

TABLE 3 – **THERAPISTS' RATINGS OF THERAPY PROCESS VARIABLES**

	Affective Expression	*Level of Processing*	*Global Ratings*
Sessions 1-4	3.24 (0.85)[1]	2.93 (0.97)[a,b]	2.64 (0.69)
Sessions 5-8	3.61 (0.78)	3.31 (1.01)	2.54 (0.85)
Sessions 9-12	3.58 (0.98)	3.49 (1.01)[a]	2.84 (0.92)
Sessions 13-15	3.66 (0.83)	3.59 (0.95)[b]	2.84 (0.68)

[1]Means and (standard deviations); [a] Statistically significant difference p<.05; [b] Statistically significant difference p<.03

(65.7%) of the 35 remained distressed and 7 (20.0%) were no longer clinically distressed, 5 (14.3%) failed to return their questionnaires. At 6 months post-treatment, of the 35 who were clinically distressed at baseline, 17 (48.6%) of the 35 remained distressed, 13 (37.7%) were no longer distressed and 5 (14.3%) failed to return their questionnaires.

First, we examined baseline differences between those who showed improvements at the 6-month follow-up compared to those who remained distressed. Table 4 shows the means and standard deviations on selected variables. Patients who were no longer distressed at follow-up had significantly lower baseline GSI scores (93rd percentile versus 98th percentile) (t(29)=-3.14, p<.005). A trend was evident for emotional coping, in that women who were no longer distressed at follow-up used less emotional coping at baseline. There were no significant group differences on baseline disease activity or patients' perceptions of their physical health status (PCS).

As shown in Table 5, at the 6 month follow--up, patients who were no longer distressed also showed the following improvements: increased vitality, less bodily pain, satisfaction with social support; moreover, they reported fewer hassles and less reliance on emotional coping. However, after controlling for multiple comparisons, only the differences for hassles and emotional coping remained statistically significant. (t(29)=-3.76, p<.002 ; t(29)=-4.25, p<.0001, respectively).

We subsequently examined changes on SCL-90-R subscales scores over time for those who showed improvements at 6 months compared to those who remained distressed (Table 6). Differences were examined at baseline and post-treatment. Those who improved obtained scores above the 63 cut-off on 3 out of the 9 subscales, whereas those who remained dis-

TABLE 4 – **GROUP MEANS AND STANDARD DEVIATIONS FOR BASELINE SCORES**

	GSI<63 at 6 months	*GSI>63 at 6 months*	*p*
GSI	65.61 (3.66)	71.47 (5.47)	.002**
PCS[1]	32.00 (12.82)	31.47 (9.08)	NS
Vitality[1]	35.00 (19.81)	25.88 (16.51)	NS
Bodily Pain[1]	43.93 (22.82)	33.18 (19.20)	NS
SSQ satisfaction[1]	4.89 (1.25)	4.40 (1.53)	NS
Hassles	46.50 (18.28)	53.53 (21.04)	NS
Task coping	53.21 (12.83)	51.65 (10.99)	NS
Emotion coping	41.76 (10.22)	50.23 (13.21)	0.066
Disease activity	7.00 (4.77)	7.82 (3.21)	NS

*[1]High scores indicate better functioning; **statistically significant*

TABLE 5 – **GROUP MEANS AND STANDARD DEVIATIONS AT THE 6 MONTH FOLLOW-UP**

	GSI T<63	*GSI T> 63*	*p*
PCS[1]	37.88 (10.90)	30.35 (10.42)	0.065
Vitality[1]	48.46 (21.64)	29.12 (21.88)	0.023
Bodily Pain[1]	59.07 (23.44)	33.71 (27.92)	0.013
SSQ Satisfaction[1]	5.31 (0.63)	4.47 (1.25)	0.036
Hassles	31.92 (15.10)	53.76 (18.02)	.001**
Task Coping	53.46 (13.05)	51.47 (12.2)	0.671
Emotional Coping	32.07 (7.30)	48.53 (13.28)	.001**

*[1]High scores indicate better functioning; ** statistically significant*

TABLE 6 – **MEANS (SD) PSYCHOLOGICAL DISTRESS SCORES AT BASELINE AND POST-TREATMENT BASED ON IMPROVEMENTS AT 6 MONTHS**

	Baseline		*Post-treatment*	
	Improved (n=13)	*Distressed (n=17)*	*Improved (n= 12)[2]*	*Distressed (n=16)*
Somatization	67.46 (5.89)[1]	72.35 (6.09)	64.33 (6.34)	72.81 (9.25)
Obsessive-compulsive	67.46 (5.86)	72.35 (6.09)	64.00 (8.73)	72.25 (6.42)
Interpersonal sensitivity	60.61 (7.61)	69.71 (7.18)	55.75 (9.06)	67.38 (7.46)
Depression	64.84 (4.51)	69.41 (4.18)	60.67 (6.85)	68.88 (4.40)
Anxiety	60.92 (6.33)	68.82 (6.23)	57.00 (8.50)	69.19 (7.41)
Hostility	58.77 (9.6)	63.94 (10.05)	54.83 (10.04)	63.19 (9.99)
Phobic anxiety	51.38 (8.77)	60.76 (10.97)	46.83 (5.15)	61.69(13.18)
Paranoid ideation	56.00 (10.28)	64.88 (10.17)	52.08 (9.88)	64.56 (7.98)
Psychoticism	60.76 (7.84)	69.88 (7.91)	55.83 (8.22)	69.93 (6.11)
GSI	65.62 (3.66)	71.47 (5.46)	60.92 (7.33)	71.56 (6.14)

[1]Standard T scores for all subscales of the SCL-90-R

[2]Two patients that completed their baseline and 6 month assessment failed to return their questionnaires at post-treatment.

tressed obtained scores greater or equal to 63 on 8 out the 9 subscales, at baseline. Of particular interest are the differences of the interpersonal sensitivity and hostility scales. Higher scores on the interpersonal sensitivity scale indicate feelings of inadequacy and inferiority, marked discomfort during interpersonal interactions and negative expectations regarding interpersonal exchanges. Higher scores on the hostility scale reflect a greater tendency to experience irritability, rage and resentment and a greater tendency to display anger. At post-treatment those who remained distressed showed elevations on 8 of the 9 subscales, indicating highly generalized distress. Patients who improved showed elevations only on the somatization and obsessive-compulsive subscales, indicating more focused concerns.

DISCUSSION

From a statistical standpoint we concluded in a previous report[15] that Brief Supportive-Expressive group therapy was not effective for patients with lupus. Yet, the psychotherapists among our team members were uneasy with this conclusion because some patients seemed to benefit in ways we may not have measured (e.g., adjusted life goals, accepted their disease better). This perception was supported by recent analyses of secondary outcomes such as illness intrusiveness, that is illness induced disruptions to lifestyles, activities and interests[32]. Our collaborators showed significant improvements on illness intrusiveness in relationships and personal development, and intimacy at 6 and 12 months post-treatment for patients in the therapy group[32]. Thus, we explored in more depth the process of therapy, based on therapists' reports which were completed following each session. While this type of therapy may not be optimal for all patients with SLE (consistent with Mohr *et al.*[33], using the same intervention with depressed multiple sclerosis patients), listening to audio-taped sessions encouraged us examine the data further. Given there is no existent coding system to assess the integrity of the intervention, we designed a form (attached) to capture the key components of the group therapy.

When examining all therapy sessions, the three most dominant themes were: biomedical, loss and acceptance. These are typical of patients' concerns with a variety of chronic medical diseases[6]. Much like group therapy process as described by Yalom[34], patients discussed more interpersonal themes (family, doctor-patient relationships) as they moved from beginning to ending sessions. Biomedical concerns (e.g., side effects of treatment, disease-related disability) were salient throughout the sessions. However, increases in ratings of emotional expression and processing indicate that they were explored in more depth as the sessions progressed.

In Brief Supportive-Expressive group therapy the level of affective expression and processing of issues in the "here and now" is considered crucial to the intervention. Both of these variables increased, with significant statistical changes in level of processing, (as seen in Table 3) over time. Also, therapists' overall rating of sessions improved over time. While we do not have data from independent sources, the standard deviations indicate that there were variations across sessions. Nonetheless, in our previous report we noted that there was no therapist effect across sites where the intervention was provided.

Several studies which have demonstrated effectiveness for this type of intervention selected patients *a priori*, based on psychological status[11] or created subgroups (e.g., exclusion of the death-proximal assessments in metastatic breast cancer patients; Classen *et al*[35]) in *post hoc* analyses. While we did not have the statistical power to adequately answer the question, "Did patients who were distressed at baseline (as measured by the SCL-90-R) benefit from the group therapy?"[14], we posed a different question herein i.e., "Were there baseline differences between patients who improved compared to those who did not?". It is noteworthy that while physicians did not select patients based on need for psychotherapy *per se*, 56.5% of those assigned to group psychotherapy reported symptoms indicating significant distress. Thus, we subdivided the distressed patients into two groups: those who improved by the 6 month follow-up and those who did not.

Distressed patients who improved over time were less distressed at the beginning of treatment than those who failed to improve. Although not statistically significant, they also were less reliant on emotional coping when faced with stressors. At follow-up, patients who improved in terms of psychological distress also improved on quality of life variables (e.g., bodily pain, vitality), stress and emotional coping. It is important to note that, despite improvements, physical health status in women who were no longer distressed at the 6 month follow-up (i.e., PCS scores) were significantly lower than norms for Canadian women in both groups, indicating that these women perceived themselves as being in poor health.

Closer examination of subscale elevations on the SCL-90-R revealed what can be interpreted as a more generalized and more severe form of distress in women who showed no improvements, compared to more specific symptoms (i.e., somatization, obsessive-compulsive, depression) in women who improved. Several clinical hypotheses may explain these findings. There were noteworthy differences on hostility and interpersonal sensitivity between women who improved as opposed to those that remained distressed. Perhaps high discomfort during interpersonal interactions, negative expectations regarding interpersonal behaviors, in combination with feelings of anger and resentment, limited the benefits these women could obtain within a group context. Alternatively, perhaps the patients who remained distressed did so due to continued physical illness, as we have shown that when in an active disease state, lupus patients manifest more psychological distress[36]. While we did not have physician-rated scores at this follow-up period, the quality of life ratings indicate that these women perceived themselves as being ill.

What have we learned from our closer inspection of this treatment for these patients? Rather than the finding that some therapy is better than no therapy[37], we see that this approach may have been beneficial for a subgroup of the patients with lupus, particularly those who were *not* overwhelmed by distress at the start of group work. Not only is this logical but is consistent with Blatt and Felsen who concluded that "different kinds of folks may need different kinds of strokes" with regard to the effect of patients' characteristics on therapeutic process and outcomes[38]. Women who benefited less also perceived themselves to be sicker. This indicates that more attention needs to be paid to disease status as a moderating factor in psychotherapy research with medical patients, particularly in diseases where there is a waxing and waning pattern. With regard to the group process, according to therapists' ratings, lupus patients expressed and processed emotions relating to illness specific themes similarly to those generally referred to in the literature on group psychotherapy for medically ill patients. This finding lends support the treatment's integrity.

While the information contained herein regarding Brief Supportive-Expressive group therapy is novel, one limitation is that it is based on therapists' notes. Shaw and Dobson[39] have pointed out that correlations between evaluations from videotapes and those based on process notes are low. Our therapists' forms were more standardized than process notes, but they may contain reporter bias. Nonetheless, we felt they reflected what transpired during sessions accurately enough to examine them further. Perhaps this report will stimulate the development of a method to rate Brief Supportive-Expressive group therapy such that future research can explore therapy processes more thoroughly.

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REFERENCES

1. Klippel JH. Systemic lupus erythematosus: demographics, prognosis, and outcome. *J Rheumatol* 1997; suppl 48: 67-71.
2. Adams SGJ, Dammers PM, Saia TL, Brantley PJ, Gaydos GR. Stress, depression, and anxiety predict average symptom severity and daily symptom fluctuation in systemic lupus erythematosus. *J Behav Med* 1994; 17: 459-477.
3. Omdal R, Husby G, Mellgren SI. Mental health status in systemic lupus erythematosus. *Scandinavian Journal of Rheumatology* 1995; 24: 142-145.
4. Dobkin PL, Fortin P, Joseph L, Esdaile JM, Danoff DS, Clarke AE. Psychosocial contributors to mental and physical health in patients with systemic lupus erythematosus. *Arthritis Care Res* 1998; 11: 23-31.
5. McCracken LM, Semenchuk EM, Goetsch VL. Cross-sectional and longitudinal analyses of coping responses and health status in persons with systemic lupus erythematosus. *J Behav Med* 1995; 20: 179-187.
6. Spira JL. Understanding and developing psychotherapy groups for medically ill patients, in James L.Spira (ed): *Group therapy for medically ill patients*. New York, The Guilford Press; 1997: 3-51.
7. Dobkin PL, Da Costa D. Group psychotherapy for medical patients. *Psychology, Health & Medicine* 2000; 5: 87-96.
8. Spira JL, Spiegel D. Psychiatric care of the medical patient, in Stoudemire & B.Fogel (ed): *Group psychotherapy for the medically ill*. New York, Oxford University Press; 1993: 31-50.
9. Auerbach SM. Stress management and coping research in the health care setting: an overview and methodological commentary. *J Consult Clin Psychol* 1989; 57: 388-395.
10. Spiegel D, Bloom JR, Kraemer HC, Gottheil E. Effect of psychosocial intervention on survival of patients with metastatic breast cancer. *Lancet* 1989; 14: 888-891.
11. Goodwin PJ, Leszcz M, Ennis M, et al. The effect of group psychosocial support on survival in metastatic breast cancer. *The New England Journal of Medicine* 2001; 345: 1719-1726.
12. Kelly JA, Murphy DA, Bahr GR, et al. Outcome of cognitive-behavioral and support group brief therapies for depressed, HIV- infected persons. *Am J Psychiatry* 1993; 150: 1679-1686.
13. Maunder RG. Psychotherapy for inflammatory bowel disease: New prospects, in Williams CN (ed): *Trends in Inflammatory Bowel Disease Therapy*. Halifax 1999; 185-200.
14. Dobkin PL, Da Costa D, Joseph L, et al. Counterbalancing patient demands with evidence: Results from a pan-Canadian RCT of brief supportive expressive group psychotherapy for women with SLE. *Ann Behav Med* 2002; In press.

15. Dobkin PL, LEAP Group. Living with lupus: a Pan-Canadian prospective study. *J Rheumatol* 2001; 28: 2442-2248.
16. Tan EM, Cohen AS, Fries JF, et al. The 1982 revised criteria for the classification of systemic lupus erythematosus. *Arthritis & Rheum* 1982; 25: 1271-1277.
17. Classen G, Diamond S, Soleman A, Fobair P, Spira JL, Spiegel D. Supportive-expressive group therapy: a manual of psychosocial intervention for women with recurrent breast cancer, in Anonymous Stanford, CA, Psychosocial Laboratory; Stanford University School of Medicine; 1991: 1-173.
18. Derogatis LR. *SCL-90-R: Administration, scoring and interpretation manual.* Minneapolis, National Computer System; 1994.
19. Ware JE, Sherbourne CD: The MOS 36-item short-form health survey (SF-36). I. Conceptual framework and item selection. *Med Care* 1992; 30: 473-483.
20. Ware JE, Kosinski M, Bayliss MS, McHorney CA, Rogers WH, Raczek AE. Comparison of methods for the scoring and statistical analysis of SF-36 health profile and summary measures: summary of results from the Medical Outcomes Study. *Med Care* 1995; 33: 64-79.
21. Ware JE, Kosinski M, Keller SD. *SF-36 Physical and mental health summary scales: a user's manual*, Boston (MA), The Health Institute; 1994.
22. Hopman WM, Towheed T, Anastassiades T, et al. Canadian normative data for the SF-36 health survey. *Can Med Assoc J* 2000; 163: 265--271.
23. Sarason IG, Sarason BR, Shearin EN, Pierce GR. A brief measure of social support: practical and theoritical implications. *J Soc Pers Relationships* 1987; 4: 497-510.
24. Endler NS, Parker JDA: *Coping inventory for stressful situations manual*. Toronto (Canada), Multi-Health Systems Inc.; 1990.
25. Smith CA, Wallston KA. Adaptation in patients with chronic rheumatoid arthritis: application of a general model. *Health Psychol* 1992; 11: 151-162.
26. Thompson RJ, Gil KM, Abrams MR, Philips G. Stress, coping and psychological adjustment of adults with sickle cell disease. *J Consult Clin Psychol* 1992; 60: 433-440.
27. DeLongis A, Folkman S, Lazarus RS. The impact of daily stress on health and mood: psychological and social resources as mediators. *J Pers Soc Psychol* 1988; 54: 486-495.
28. Liang MH, Socher SA, Larson MG, Schur PH. Reliability and validity of six systems for the clinical assessment of disease activity in SLE. *Arthritis & Rheum* 1989; 32: 1107-1118.
29. Abrahamowicz M, Fortin P, du Berger R, Nayak V, Neville C, Liang MH. The relationship between disease activity and expert physician's decision to start major in active systemic lupus erythematosus: a decision aid for development of entry criteria for clinical trials. *J Rheumatol* 1998; 25: 277-284.
30. Gladman DD, Ginzler E, Goldsmith C, Fortin P, Liang MH, Urowitz MB. The development and initial validation of the SLICC/ACR damage index for SLE. *Arthritis & Rheum* 1996; 39: 363-369.
31. Gladman DD, Urowitz MB, Goldsmith C, Fortin P, Ginzler E, Gordon C. The reliability of the SLICC/ACR damage index in patients with SLE. *Arthritis & Rheum* 1997; 40: 809-813.
32. Edworthy SM, Dobkin PL, Clarke A, et al. Group psychotherapy reduces illness intrusiveness in systemic lupus erythematosus. *J Rheumatol* 2002; Submitted.
33. Mohr DC, Boudewyn AC, Goodkin DE, Bostrom A, Epstein L. Comparative outcomes for individual cognitive-behavior therapy, supportive-expressive group psychotherapy, and sertraline for the treatment of depression in multiple sclerosis. *Journal of Consulting and Clinical Psychology* 2001; In press.
34. Yalom ID. *The theory and practice of group psychotherapy*, New York, Basic Books; 1995.
35. Classen C, Butler LD, Koopman C, et al: Supportive-expressive group therapy and distress in patients with metastatic breast cancer. *Arch Gen Psychiatry* 2001;58:494-501.
36. Dobkin PL, Da Costa D, Dritsa M, et al. Quality of life in SLE patients during more and less active disease states: differential contributors to mental and physical health. *Arthritis Care Res* 1999; 12: 401-410.
37. Wampold BE, Mondin GW, Moody M, Stich F, Benson K, Ahn HN. A meta-analysis of outcome studies comparing bona fide psychotherapies: empirically, "All must have prizes". *Psychol Bull* 1997; 122: 203--215.
38. Blatt SJ, Felsen I. Different kinds of folks may need different kinds of strokes: the effect of patients' characteristics on therapeutic process and outcome. *Psychotherapy Research* 1993; 3: 245-259.
39. Shaw BF, Dobson KS. Competency judgments in the training and evaluation of psychotherapists. *J Consult Clin Psychol* 1988; 56: 666--672.