Dritsa, Maria; Dobkin, Patricia L.; Fortin, Paul R.; Esdaile, John M.; Clarke, Ann E.
Brief Supportive-Expressive Psychotherapy In A Systemic Lupus Erythematosus (Sle): Changing Themes And Psychological Distress
Sociedade Portuguesa de Psicossomática
Porto, Portugal

Available in: http://www.redalyc.org/articulo.oa?id=28750202
BRIEF SUPPORTIVE-EXPRESSIVE PSYCHOTHERAPY IN A SYSTEMIC LUPUS ERYTHEMATOSUS (SLE): CHANGING THEMES AND PSYCHOLOGICAL DISTRESS

Maria Dritsa*, Patricia L. Dobkin*, Deborah Da Costa*, Paul R. Fortin**, John M. Esdaile***, Ann E. Clarke*

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 autoimmune 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 symptoms2,3.
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\(^1\). Social support seeking was associated with less pain, less psychological distress (anxiety and depression) and disability at follow-up\(^2\). 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 lifestyle adjustments; 4) coping with treatment; 5) prioritizing life values and goals; 6) losses; 7) death and dying. 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 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).

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. 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) 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. 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). The PCS and MCS are standardized to have a mean of 50 and a standard deviation of 10. 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.

The shortened version of the Social Support Questionnaire (SSQ6) was used to assess perceived availability and satisfaction with social support. 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) 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. 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. 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) 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.

The Systemic Lupus International Collaborating Clinics/American College of Rheumatology (SLICC/ACR) 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).

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. If more than one theme was explored, therapists rank ordered the themes (1=most im-
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 latter 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.

<table>
<thead>
<tr>
<th>TABLE 1 – SAMPLE CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mean</strong></td>
</tr>
<tr>
<td>Demographics</td>
</tr>
<tr>
<td>Age</td>
</tr>
<tr>
<td>Education (years)</td>
</tr>
<tr>
<td>Ethnic Origin (%)</td>
</tr>
<tr>
<td>Caucasian</td>
</tr>
<tr>
<td>Black</td>
</tr>
<tr>
<td>Asian</td>
</tr>
<tr>
<td>Other</td>
</tr>
<tr>
<td>Marital Status (%)</td>
</tr>
<tr>
<td>Single</td>
</tr>
<tr>
<td>Married</td>
</tr>
<tr>
<td>Divorce-Separated</td>
</tr>
<tr>
<td>Widowed</td>
</tr>
<tr>
<td>Clinical</td>
</tr>
<tr>
<td>SLAM-R (disease activity)</td>
</tr>
<tr>
<td>SLICC/ACR (disease duration)</td>
</tr>
</tbody>
</table>

The participants were mainly middle-aged, Caucasian and relatively well educated.

Theorepsists, 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).

Session themes, as ranked by the therapists, are presented in Table 2. In general, biomedical concerns were addressed most often, followed
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 prioritizing (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...
(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 by 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 3 – THERAPISTS’ RATINGS OF THERAPY PROCESS VARIABLES**

<table>
<thead>
<tr>
<th></th>
<th>Affective Expression</th>
<th>Level of Processing</th>
<th>Global Ratings</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sessions 1-4</td>
<td>3.24 (0.85)</td>
<td>2.93 (0.97)&lt;sup&gt;a&lt;/sup&gt;</td>
<td>2.64 (0.69)</td>
</tr>
<tr>
<td>Sessions 5-8</td>
<td>3.61 (0.78)</td>
<td>3.31 (1.01)</td>
<td>2.54 (0.85)</td>
</tr>
<tr>
<td>Sessions 9-12</td>
<td>3.58 (0.98)</td>
<td>3.49 (1.01)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.84 (0.92)</td>
</tr>
<tr>
<td>Sessions 13-15</td>
<td>3.66 (0.83)</td>
<td>3.59 (0.95)&lt;sup&gt;b&lt;/sup&gt;</td>
<td>2.84 (0.68)</td>
</tr>
</tbody>
</table>

<sup>a</sup> Means and (standard deviations); <sup>b</sup> Statistically significant difference p < .05; <sup>ab</sup> Statistically significant difference p < .03

---

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

<table>
<thead>
<tr>
<th></th>
<th>GSI&lt;63 at 6 months</th>
<th>GSI&gt;63 at 6 months</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>GSI</td>
<td>65.61 (3.66)</td>
<td>71.47 (5.47)</td>
<td>.002**</td>
</tr>
<tr>
<td>PCS&lt;sup&gt;1&lt;/sup&gt;</td>
<td>32.00 (12.82)</td>
<td>31.47 (9.08)</td>
<td>NS</td>
</tr>
<tr>
<td>Vitality&lt;sup&gt;1&lt;/sup&gt;</td>
<td>35.00 (19.81)</td>
<td>25.88 (16.51)</td>
<td>NS</td>
</tr>
<tr>
<td>Bodily Pain&lt;sup&gt;1&lt;/sup&gt;</td>
<td>43.93 (22.82)</td>
<td>33.18 (19.20)</td>
<td>NS</td>
</tr>
<tr>
<td>SSQ satisfaction&lt;sup&gt;1&lt;/sup&gt;</td>
<td>4.89 (1.25)</td>
<td>4.40 (1.53)</td>
<td>NS</td>
</tr>
<tr>
<td>Hassles</td>
<td>46.50 (18.28)</td>
<td>52.53 (21.04)</td>
<td>NS</td>
</tr>
<tr>
<td>Task coping</td>
<td>53.21 (12.83)</td>
<td>51.65 (10.99)</td>
<td>NS</td>
</tr>
<tr>
<td>Emotion coping</td>
<td>41.76 (10.22)</td>
<td>50.23 (13.21)</td>
<td>0.066</td>
</tr>
<tr>
<td>Disease activity</td>
<td>70.00 (4.77)</td>
<td>78.22 (3.21)</td>
<td>NS</td>
</tr>
</tbody>
</table>

<sup>1</sup>High scores indicate better functioning; **statistically significant
stressed 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 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.
Brief Supportive-Expressive Psychotherapy in SLE

Several studies which have demonstrated effectiveness for this type of intervention selected patients a priori, based on psychological status or created subgroups (e.g., exclusion of the death-proximal assessments in metastatic breast cancer patients; Classen et al.) 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?” 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 dur-
ing 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. 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 close inspection of this treatment for these patients? Rather than the finding that some therapy is better than no therapy, 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. 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 to 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 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.

Acknowledgements
We would like to thank doctors: Steven M. Edworthy, Susan Barr, Stephanie Enssworth, André Beaulieu, Michael Zummer, Jean-Luc Sénécal, Jean-Richard Goulet, Denis Choquette, Eric Rich, Doug Smith, Alfred Cividino and Dafna Gladman, for recruiting patients and conducting the physical examinations. We would also like to thank The Canadian Network for Improved Outcomes in Systemic Lupus Erythematosus for their assistance in patient recruitment.

REFERENCES
25. Smith CA, Wallston KA. Adaptation in patients with chronic rheumato-
26. Thompson R, Gil KM, Abrams MR, Phillips G. Stress, coping and psycholog-
32. Edworthy SM, Dobkin PL, Clarke A, et al. Group psychotherapy re-
33. Mohr DC, Boudewyn AC, Goodkin DE, Boothorn A, Epstein L. Com-
parative outcomes for individuals cognitive-behavior therapy, suppor-
tive-expressive group psychotherapy, and sertraline for the treatment of depression in multiple sclerosis. Journal of Consulting and Clini-
cal Psychology 2001; In press.