

Psycho-oncology: a coming of age

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Every once in a while there is a mini renaissance in an area of medicine. The flowering of research that has taken place world-wide in the field of psycho-oncology in the last decade is one such example. This deepening interest in all the different psychological aspects of cancer, with the prevention of psychiatric morbidity and the development of a healthy adaptation being the main outcome aims, has led to hundreds of publications in recent years, along with the launching of two high-quality journals, the *Journal of Psychosocial Oncology* and the *Journal of Psycho-Oncology*. There have been numerous robust research findings proving the efficacy of psychosocial interventions in cancer patients on a range of outcome measures (Stein *et al.*, 1993; Fawzy *et al.*, 1995). The search for conclusive evidence of the positive effects of psychological therapy on disease progression and hence survival rates has also developed, becoming a holy grail for researchers in mind/body medicine, and has been brought tantalisingly within reach by a number of well-controlled trials (Spiegel *et al.*, 1989; Richardson *et al.*, 1990; Fawzy *et al.*, 1993; Ratcliffe *et al.*, 1995).

Theory

As defined by Holland (1992), psycho-oncology is concerned with the two psychological dimensions of cancer: the emotional response of patients at all stages of disease, and those of their families and their caretakers (psychosocial); and the psychological, behavioural and social factors that may influence cancer morbidity and mortality (psychobiological). Hitherto hazy concepts such as 'coping styles' and 'stress' now have been refined and incorporated into qualitative research studies (Rowland & Holland, 1989; Jarrett *et al.*, 1992; Parle *et al.*, 1996). The concept of 'quality of life' as an important measurable end-point for evaluating treatments is applied now to many branches of medicine but was developed first among cancer patients (Fallowfield, 1990). The examination of factors that help or impede psychological adjustment has been researched and evaluated at each step of the cancer patient's 'journey', from how bad news is communicated,

through helping to identify unresolved concerns, information sharing, psychological support for individuals and their families, to the difficulties of adjusting to lasting remission or the profound existential crisis on entering palliative care (Maguire & Howell, 1995).

The development of a holistic approach to the treatment of cancer patients arose in large part from vocal user groups expressing their unhappiness with the medical system and creating their own supportive networks. Research since has shown that cancer patients indeed suffer considerable psychological distress and psychiatric morbidity, with a prevalence of psychiatric disorder in the range 23–47% (Derogatis *et al.*, 1983; Greer, 1994). It has been demonstrated that distress can be alleviated and the risk of developing an anxiety state or affective disorder can be minimised by refining bad-news interviews, by attending carefully to patients' information needs and by providing psychological support for patients and their families from the time of diagnosis (Fallowfield *et al.*, 1995; Butow *et al.*, 1996).

Most psychological interventions offered as an adjunct to the medical care of recently diagnosed cancer patients aim to prevent distress and enhance coping styles. It has been shown that patients whose predominant coping style is characterised by 'anxious preoccupation' or 'helplessness' tend to be poorly adjusted and at greater risk of psychiatric morbidity than patients who are able to reappraise positively their predicament and who show a 'fighting spirit' coping style (Greer *et al.*, 1989). In addition, behavioural techniques such as special relaxation and guided imagery have been shown to have positive effects on mood and quality of life during treatment (Walker *et al.*, 1999). The clinical usefulness (e.g. decreased amount of pain reported, reduction of chemotherapy-induced nausea, decreased drop-out from treatment, decreased general practitioner/consultant consultations) and therapeutic effectiveness (e.g. lasting psychological adjustment) of such psychosocial interventions are no longer in doubt (Greer *et al.*, 1992; Fallowfield, 1995). What is needed now is the imagination and the will to create effective working structures for their practical implementation.

Practice

Since the 1970s, involvement of mental health professionals in the multi-disciplinary treatment of cancer patients has been welcomed increasingly by oncologists and their staff. However, it has been argued that the traditional role of the liaison psychiatrist is not adequate in meeting the diverse and complex needs of the cancer patient. 'Liaison-consultation' is the approach recommended in the joint report of the Royal College of Physicians and the Royal College of Psychiatrists (1995) to address the psychological needs of medical patients. In practice this model is often a compromise arrangement offering no more than minimal emergency care of medical in-patients and emergency department attenders (Royal College of Physicians and Royal College of Psychiatrists, 1995). In a recent paper, Barraclough (1997) highlights the importance for focused discussion on how the contribution of psychiatrists and other mental health professionals can best be integrated with that of general hospital staff in oncology and palliative care units, the primary health care team and voluntary workers. In both cancer centres and district general hospitals there is a need for appropriately trained psychiatrists to help develop dedicated psycho-oncology services, possibly linked with other aspects of liaison-consultation work. Different service models have been advocated but, whichever model is chosen, a multi-professional approach is needed in which the overlapping contributions of different disciplines, including psychiatry, complement each other rather than lead to duplication or rivalry (Barraclough, 1997). Where such services flourish, the psycho-oncologist works as part of the treatment team so that the psychosocial intervention does not come to be regarded by patients or staff as an 'extra' but is seen to be an integral part of the treatment programme (Kissane & Smith, 1996). The psycho-oncology team may comprise a consultant liaison psychiatrist, psychiatric trainees, psychologists, clinical nurse specialists (usually nurses with a background in oncology and trained in counselling), social workers and counsellors (either trust or charity funded). There is evidence to show that with adequate training specialist cancer nurses can accurately identify the majority of cancer patients who are likely to need psychological or psychiatric help (Maguire & Falconer, 1988). The liaison-consultation role of the psycho-oncologist is broad but covers the following areas.

Assessment and pharmacotherapy

Acute referrals will be for patients suffering adjustment disorder, anxiety and depression

with or without suicidal ideation; less commonly they will be for patients with dissociative disorders and confusional states. Following these contacts, formal psychiatric assessment will be undertaken and a treatment plan established, with the use of psychotropic medication and/or psychological interventions where indicated. The latter would include brief information-based counselling, cognitive psychotherapy for the more seriously depressed and group psychotherapy as a longer term treatment. Surprisingly little has been published on the use of antidepressants in depressed cancer patients, despite this being the most common diagnosis. The symptom structure of depression in this patient group is identical to that of depression in non-cancer patients (Middelboe *et al.* 1994) and yet there have been only four properly conducted placebo controlled studies to date. Both Costa *et al.* (1985) and Van Heeringen & Zivkov (1996) have conducted studies of mianserin in patients with breast cancer and found a significant reduction of depressive symptoms. Evans *et al.* (1988) have reported that treatment with adequate doses of imipramine resulted in significant reductions in depressive symptoms and improvement of quality of life in patients with gynaecological cancer. Razavi *et al.* (1996) in a large multi-centre trial using fluoxetine found no difference between treatment and placebo groups on a number of depression rating scales, although there was a modest improvement in global psychological adjustment as measured by the Revised Symptom Check-List (SCL-90-R) in the treatment group. There has been no study that has compared the efficacy of psychotherapy versus pharmacotherapy in cancer patients with depression, although in other patient groups the two therapy options in combination frequently has been found to be more effective than either on their own (Twillman & Manetto, 1998).

Education and training

The training of other health care professionals working in cancer care (e.g. oncologists, junior doctors, nurses, social workers, clergy, etc.) is central to the role of the psycho-oncologist. Intensive workshops have been developed to teach physicians and nurses the interviewing, assessment and counselling skills they need. These generally have been found to be effective in bringing about attitude changes and in improving communication skills. They have led also to a higher recognition and referral rate of patients with affective disorder and body image or sexual problem, with a consequent reduction in psychiatric morbidity (Maguire *et al.* 1980). Equally, there is much work that needs to be done in teaching undergraduate medical students the skills that, up until recently, have

been conspicuous by their absence. Seminars using role play and video playback, covering such topics as 'breaking bad news', 'obtaining informed consent', 'information sharing' and 'patient-led interview techniques', could be incorporated into medical school curricula to cover these much neglected areas. Cantwell & Ramirez (1997), looking at the effectiveness of undergraduate communication skills training in a London teaching hospital, have well illustrated some of the problems associated with such a programme.

A psychosocial educational forum on a regular basis in the shape of a journal club is an important way in which the team creates a shared understanding and approach to developments in the field and where collaboration over research can occur.

Support groups for staff

These have been found to be effective in preventing demoralisation and 'burn-out' and in enhancing job satisfaction (Roberts, 1997). Burn-out among oncology staff has been related to work overload, low satisfaction in relationships with patients and feeling insufficiently trained in communication skills (Ramirez *et al.*, 1996). Staff support groups provide a space where the staff's own feelings can be aired, where a different understanding of difficult patients can be brought to bear and where interdisciplinary problems can be resolved. The psycho-oncologist's role is crucial in, if not facilitating such groups, helping to maintain their place within the working week.

Bereavement outreach

Linking with community workers, community psychiatric nurses and community-based hospice nurses is an important part of the psycho-oncologist's role. Anticipatory grief is often present when working with families and, where appropriate, can be encouraged along with realistic planning for the future. Those relatives at risk of developing abnormal grief reactions can be identified at such meetings and offered extra support through their subsequent bereavement. Some services advocate a more proactive approach and in the weeks post-bereavement they routinely contact all the families that they have been involved with, to offer support.

Group therapy

There is tremendous scope to harness the therapeutic potential of groups for cancer patients. However, the majority of patients do not choose to attend group support programmes when they are available. The liaison-consultation psychiatrist needs to be skilled in creating a positive group culture to facilitate this. One

approach, advocated by Cunningham & Edmonds (1996), is to introduce a type of intervention that is arranged as a hierarchy based on the extent of active participation required by the patient. An information-sharing-based group that requires little active participation is the starting point and this can evolve into a support group focusing on training in coping skills that makes more demands on patient's voluntary activity. Once barriers have been loosened and a sense of communality established, patients are more likely to opt to continue onto the next level of intervention, which is a more intensive psychotherapy group. Such groups have been shown to be effective in improving emotional adjustment through encouraging a more open expression of feelings and a more active assertiveness in assuming control over the course of treatment, of life decisions and of relationships (Cunningham *et al.*, 1995).

Research and audit

With the development of 'quality of life' instruments, it is possible to integrate the biological research of the cancer unit with the psychosocial perspective. In addition, some randomised studies have found that patients who have received a psychosocial intervention show not only improved quality-of-life scores but tend to live longer (Spiegel *et al.*, 1989; Richardson *et al.*, 1990; Fawzy *et al.*, 1993; Ratcliffe *et al.*, 1995); there is an urgent need for further studies to confirm these findings. Developments in the field of psychoneuroimmunology suggest that the complex but profound effects that the mind has upon the body, and the immune system in particular, will provide exciting and challenging findings for the psycho-oncologist well into the 21st century.

The future

The future development of psycho-oncology as a specialist consultation-liaison discipline hinges upon advancement in two areas: the implementation of established research findings and the development of training. Firstly, with the weight of evidence clearly showing the benefits of psychological therapy and with their lack of harmful side-effects, this form of intervention should be advocated and provided for all patients who will accept it. The time lag between researchers establishing the effectiveness of an intervention and its routine clinical use should not be extended unnecessarily; efforts now need to be focused on the creation of practical working arrangements that allow for the incorporation of psycho-social interventions within hospitals. It has been recommended that psychosocial modalities need to be placed on the same footing as

other adjunctive medical treatments, with the principle guiding our recommendations to patients being the likelihood of benefit, not whether there is overt distress and not simply whether the patient asks for help (Cunningham *et al*, 1995). Indeed, it has been argued convincingly elsewhere that it is unethical not to introduce psychological interventions whose benefits to patients have been established (Holmes, 1994). The value of restricted emergency-based liaison services has been called into question but this should not blind managers to the proven efficacy of specific psycho-social interventions for this patient group. There is a need to establish their cost effectiveness because, although there is evidence showing that psychiatric morbidity in the medically ill in general leads to increased health care costs (House, 1995), the converse (i.e. a lowering of psychiatric morbidity, resulting in lowered health care costs) in oncology patients, although expected, has not been proven.

It has been recommended that liaison posts be funded as part of its medical directorate; imaginative managerial structures need to be established in order for the psychiatrist to maintain close links with his or her professional peer group (Royal College of Physicians and Royal College of Psychiatrists, 1995). The psycho-oncologist, in straddling two disciplines, and very often two trusts, is attempting the badly needed re-integration of a psychotherapeutically informed psychiatry with medicine.

Given the rapid growth in this field, there is an increasing need to develop guidelines and standards for psychiatrists who want to specialise in the psychosocial care of cancer patients (Die Trill & Holland, 1995). An attachment in generic liaison psychiatry will not accomplish this. Training fellowships are available through the Cancer Research Campaign at large cancer centres for specialist registrar-grade trainees; there is an opportunity at these centres to develop a curriculum based on didactic and skills development components that could be applied in other centres. With increasing numbers of patients with cancer experiencing longer survival, with the thrust of the Calman report (1995) proposing more patient-led services and with the clinical usefulness and therapeutic durability of psychosocial interventions established, there will be a growing demand for appropriately trained psychiatrists to guide future developments in psycho-oncology.

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