

1.9 Psycho-Oncology

Summary

- Psycho-oncology addresses the psycho-pathological and psychosocial impact of cancer on patients and their relatives
- This discipline is integrated into oncology supportive care and fosters a global approach to the care of cancer patients
- Across countries, up to 50% of cancer patients have been reported with psychological distress, with rates depending on medical, individual, interpersonal or social factors
- Lack of attention to cancer patients' psychosocial needs or deficiencies in physician-cancer patient communication may exacerbate cancer patients' psychological distress
- Psycho-oncology offers evidence-based psycho-social interventions targeted at patients, families or their social milieu, or focusing on caregivers and healthcare professionals to address psychosocial concerns, foster adaptation to the disease and treatment course, and therefore improve healthcare outcomes

Psycho-oncology is a subspecialty of oncology that has developed rapidly over the past 30 years with the recognition of the psychosocial impact of cancer and its treatment and the need to foster global, holistic care of the person confronted with this disease. Global care refers to the consideration of the multidimensional aspects of health, i.e. the physical health, mental health, social well-being and role functioning. Human aspects of care have been underscored in the face of increasing emphasis on bio-technological aspects of medicine, especially in Western countries.

The global care approach is particularly relevant in the field of cancer. Cancer and its associated conditions may significantly damage patients' quality of life. Complementary to therapy for cancer, the care provided in oncology must include the management of disease symptoms, treatment side effects and sequelae, as well as psychosocial distress and needs that arise in that context.

A dimension of quality of life is psychological well-being, which may be considerably affected by the diagnosis of cancer and the therapeutic process. Patients as well as their family members are confronted with a number of distressing emotions and experiences, including fear of death and uncertainty about the nature, evolution and prognosis of the disease. Individuals affected by cancer have to face a reduced ability to control their life, increased dependency on others, and disequilibrium in familial, professional and social life. Untreated psychological conditions may further damage quality of life as well as increase medical costs by longer hospital stays or higher rates of utilisation of primary care medical services [1,2].

Psycho-oncology addresses the psychosocial needs of patients and their family members across the continuum of care, from prevention and early detection through treatment and survivorship to palliative and end-of-life care [3]. Psychosocial interventions in oncology include the facilitation of patients' and families' coping, relief of psychological distress and also address the wellbeing of oncology professionals. The psycho-oncology discipline also strives to contribute to World Health Organization efforts in cancer prevention and engaging community-based interventions to enhance health promotion (e.g. smoking cessation, sun protection, physical activity and healthy diet endorsement, early detection of cancer).

The psycho-oncology field promotes a multidisciplinary co-ordinated approach in the psychosocial care of cancer patients. As a component of supportive care, psycho-oncology concerns a number of health professions such as psychia-

try, psychology, social work, nursing, integrative medicine, allied health practitioners or spiritual/religious counsellors, who work in close collaboration with other supportive care professionals. Activities of psycho-oncology professionals are integrated into supportive care services that provide treatment to prevent, control or relieve complications and side effects of cancer treatment (e.g. pain, anaemia, fatigue, infections, nausea and emesis) in order to improve the patient's comfort and quality of life.

Although psycho-oncology has become an important part of cancer care in many countries, at present it has only been fully integrated in a few countries [4]. This is highlighted by the numerous unmet care needs in cancer patients, not only while under treatment across the entire spectrum of psychological needs, health system inadequacies, need for information, physical and daily living, patient care and support, and sexuality [5] but also in the survivorship phase, with regard to emotional, physical, treatment-related and home care, and social (insurance, employment) domains of life [6]. The use of mental health services is significantly higher in cancer survivors compared to the general population, although a significantly higher proportion of cancer survivors compared to those without such history reported needing mental health services but not having access to them because of cost [7].

On the other hand, various reports across countries have demonstrated patients' dissatisfaction with care in oncology, especially with regard to aspects of their interaction with providers (e.g. information provision, attention to psychosocial needs) [8], underscoring the need to improve the psychosocial care of cancer patients, provided not only by experts in psycho-oncology but also by first-line healthcare professionals (physicians, nurses, etc.).

To this end, there are a large number of evidence-based interventions available for cancer patients and their families [9] as well as for healthcare providers [10,11] that may improve outcomes in cancer care.

Depending on the culture, economics and healthcare systems, psychosocial issues in oncology may vary widely across countries and thus call for different priorities of interventions. On one hand, low-resource countries should rather focus attention on cancer prevention and education to improve early detection of cancer, especially cervical cancer; and on palliative care, considering the limited opportunity for cancer treatment in these countries [3]. On the other hand, in high-resource countries, cancer care is confronted with complex decisions (e.g. treatment or surveillance in prostate cancer, prophylactic mastectomy or intensive surveillance in women at high risk for breast cancer, types of adjuvant hormone therapy in early stage breast cancer) while therapeutic alternatives present equivalent survival efficacy but different effects on quality of life. Physician-patient shared decision making has to have high priority, requiring superior physician communication skills to prevent exacerbation of patients' psychological distress.

This chapter presents the main psychosocial concerns patients and families face when confronted with cancer, and addresses health care providers' own difficulties in facing and dealing with these psychosocial cancer consequences. It also provides information about interventions that have proved useful and efficient to manage these problems.

Psychosocial issues in patients and relatives

Quality of life. An increase in attention to cancer patients' quality of life has been witnessed in the past few decades. The ultimate goal of medicine is not solely health or the prolongation of life but also the preservation or improvement of quality of life. Instruments have been developed and validated to measure this key concept in oncology with objectives such as describing and monitoring patients' symptoms, difficulties or needs, or assessing medical treatment or psychosocial interventions. The term "quality of life" is commonly

used in the cancer literature to mean health status, physical functioning, severity of symptoms, psychosocial adjustment, well-being or satisfaction with life. Broad quality of life domains have been described, comprising the physical, psychological, economic, spiritual and social domains.

Studies have shown how cancer and its treatment may entail problems along these different quality of life dimensions. At the psychological level, the cancer diagnosis in itself even if associated with a good prognosis and absence of aggressive therapy (e.g. a small cutaneous melanoma, or an intra-epithelial lesion of the uterine cervix), may be perceived as synonymous with death, pain and suffering, and cause significant psychological distress. Mood disturbance (depression, anxiety) or cognitive abnormalities (poor concentration, memory impairment) may be observed. At the physical functioning level, the principal means of treating cancer—surgery, chemotherapy and radiation—are powerful but often associated with significant sequelae. All these interventions, including hormonal therapy, have physical side-effects, which may be short-term or time-limited, or chronic and persistent, or develop after treatment has ended [12]. Decreased performance status and physical functioning may

lead to problems in carrying out daily activities; treatments may involve physical mutilations (e.g. disfigurement, creation of a stoma, hair loss) and symptoms (e.g. pain, nausea and vomiting, fatigue, sleep disturbance). At the social level, concerns with regard to relationships with a partner, family members or with the social network may be raised. Cancer patients may experience feelings of loneliness, abandonment or lack of support; financial or work problems may also emerge; in the survivorship phase, for example, patients may encounter problems in returning to work, feeling marginalised or even stigmatised as a result of having been affected by cancer.

Psychological distress and disorders. Psycho-oncology mainly addresses the psychopathological or psychosocial consequences that arise specifically as a result of cancer and its treatment. Usual diagnostic criteria, like those listed in the Diagnostic and Statistical Manual of Mental Disorders [13], do not necessarily adequately reflect the psychological disorders resulting from a somatic condition such as cancer. Psychological suffering may be perceived as a "normal" reaction to the traumatic event that represents a cancer diagnosis. To underline a continuous psychological phenomenon from "normal" feelings to psychological disturbance

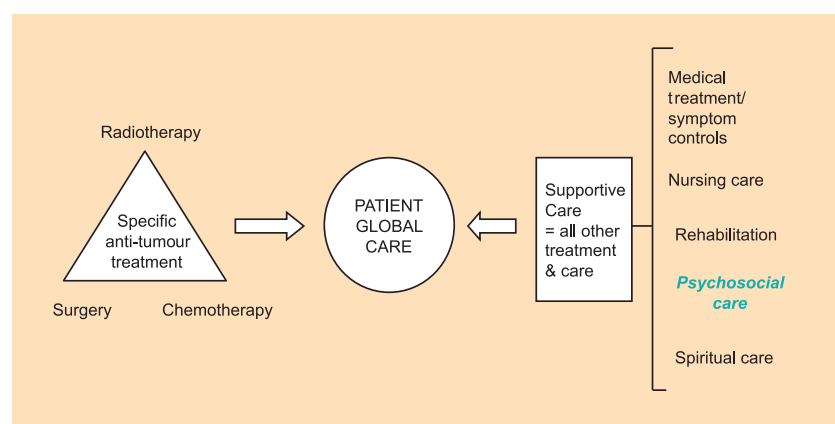


Fig. 1.9.1 Specific anti-tumour treatment and supportive care including psychosocial care for the global care of the cancer patient

requiring specialized intervention and to avoid psychopathological stigmatisation, Holland and colleagues [14] has proposed the word “distress” to account for the psychological experience of oncology patients. They defined this term as a “multifactorial unpleasant emotional experience of a psychological (cognitive, behavioural, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fears, to problems that can become disa-

bling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis”.

Faced with a diagnosis of cancer, most people react initially with numbed shock and disbelief, followed by anxiety, anger or depression. In most cases, this stress reaction subsides within a few weeks as patients learn to come to terms with their disease. Nonetheless, a significant number of cancer patients may develop persistent psychological disorders that call for professional attention.

Studies conducted in recent decades have revealed that pathological levels of distress were more prevalent in patients with cancer than in the general population [15]. One third of all cancer patients experience prolonged high levels of distress that contribute to ongoing adjustment difficulties and can potentially interfere with treatment compliance [16].

As presented in Table 1.9.1, among mood and anxiety disorders, figures range from 6.3% and 47.2% for anxiety, 7.8% and 57% for depression and 7.1% and 48% for general distress and are found in North America [1,17] as well as in

Author, country, year	Sample size assessment mode	General distress	Anxiety	Depression
Berard, South Africa, 1998[26]	N=456 HAD-S, BSI, Psychiatric interview	-	-	14%
Brédart, Italy, 1999[19]	N=190 HAD-S	-	16%	
Pascoe, Australia, 2000[18]	N=504 HAD-S		11.5%	7.1%
Zabora, US, 2001[17]	N=4496 BSI	35.1%	-	-
Uchitomi, Japan, 2003[28]	N=212 DSM-III SCID, POMS	-	-	4.7-8% within 1 year post-surgery
Carlson, Canada, 2004[1]	N=3095 BSI-18	37.8%	-	-
Grassi, Mediterranean countries, 2004[21]	N=277 HAD-S	-	34%	24.9%
Burgess, UK, 2005[20]	N=222 DSM SCID	48% first year/ 15% fifth year post-diagnosis	-	-
Santos, Brazil, 2006[27]	N=107 HAD-S, IES		20.5%	16.8%
Mehnert, Germany, 2007[22]	N=127 DSM SCID	7.1% adjustment disorder	6.3% generalised anxiety disorder	7.8% major depression + dysthymic disorder
Strong, UK, 2007[23]	N=3071 HAD-S	22%	-	-
Tavoli, Iran, 2007[25]	N=142 HADS	-	47.2%	57%
Ozalp, Turkey, 2008[24]	N=204 HAD-S	37.3%	-	-

Table 1.9.1 Prevalence figures for anxiety or depressive disorders in cancer patients across countries
HAD-S = Hospital Anxiety and Depression Scale, BSI = Brief Symptom Inventory, DSM SCID = structured clinical interview for the Diagnostic and Statistical Manual of Mental Disorders, POMS=Profile of Mood Scale, IES= Impact of Event Scale

Australia [18], European countries [19-23], the middle East [24,25], South Africa [26]; South America [27] and Asia [28]; and across the trajectory of the illness—from the time of the diagnosis of treatment to termination of treatment, survivorship, or recurrence and palliation [20,29].

Post-traumatic stress disorders as a result of the stress event that represents confrontation with a life-threatening illness such as cancer are also found in the cancer setting, with prevalence rates of 19% in breast cancer patients post-surgery and 16% at 6 months [22].

In advanced cancer, about half of patients express some level of suffering, with physical symptoms, psychological distress and existential concerns contributing to the prediction of this experience [30].

Acute confusional states are less common in patients with cancer overall but develop frequently in advanced cancer, and are a leading source of distress for family caregivers [31]. Patients become restless, suspicious and confused, with impaired concentration, memory and orientation in time and space. Opioid analgesics essentially, but also chemotherapy agents, cerebral tumours or encephalopathy are common causes.

Predictors of psychological disturbance in cancer patients have been highlighted including medical (staging of disease, physical or psychological symptoms), individual (age, gender, past history of psychiatric disorder, personality) or interpersonal and social factors (marital status, social network, education, current concerns) [1,17,20,32]. Potential predictors are not very useful clinically as they only partly explain the development of psychological disturbances. There is meanwhile a consensus to consider the systematic screening of these disturbances as useful in order to allow early treatments of these conditions [33,34].

Couple and family issues. Cancer is a family affair and not the patient's problem alone [35].

The effect of cancer on family members, in turn, may affect the patient's adjustment to illness. The well-being of close relatives is of concern especially since contexts of scarce psychosocial resources lead to reliance of this only source of support to patients.

Marital relationships may be altered, especially in the case of pre-existing problems whereas good marital relationship may buffer the stress of cancer, and are associated with less distress in the patient.

An insufficiently recognised complication of cancer is sexual functioning [36]. Sexual problems can be a consequence of cancer-related anxiety and depression or result from psychological and physical damage following certain treatment such as disfiguring surgery, ostomies, surgically induced nerve damage, radical pelvic irradiation, side-effects of chemotherapy or hormone treatment. Treatment for prostate cancer such as prostatectomy or hormone therapy can diminish a man's self-esteem as a sexual partner [37]. Body image and sexual problems were experienced by a substantial proportion of women in the early months after diagnosis of breast cancer and were associated with mastectomy and possible reconstruction, hair loss from chemotherapy, concern about weight gain or loss, poorer mental health, vaginal dryness and partner's difficulty in understanding patients' feelings [38].

Less well recognised than marital problems is the effect that breast cancer may have on the mother-daughter relationship. Daughters' distress levels have been found to be significantly related to mothers' distress levels [35]. Considering children/adolescents more generally, the family characteristics such as the family's communication or expressiveness are associated with children/adolescents psychosocial outcomes; a particular risk factor may be maternal depression which can affect the parenting role [39].

Specific issue: breast cancer genetic risk. Development of medical knowledge and technol-

ogy brings definite benefit to the health of individuals; however, new associated psychosocial problems may be elicited, which the psycho-oncology field must address. One of these is related to the psychosocial issues associated with breast cancer genetic testing and subsequent health care management, in terms of intensive medical surveillance or prophylactic interventions. The familial breast cancer syndrome associated with a BRCA1 or BRCA2 mutation is thought to confer in a woman a lifetime risk of breast cancer of between 50 and 85% [40]. Since the discovery of these mutations a decade ago, familial cancer services have been set up in many countries (e.g. Australia, Canada, France, Germany, Netherlands, UK and the USA) to respond to the increasing demand for breast cancer genetic counselling and testing [41].

Breast cancer susceptibility testing offers the potential for early detection of breast cancer, since a positive test result points to the need for increased surveillance, i.e. regular mammography or magnetic resonance imaging (MRI) or indicates the possibility of reducing cancer risk through chemoprevention and risk-reducing surgery. A positive test may also present psychological benefits in reducing the individual's uncertainty and doubts. However, cancer-susceptibility testing also encompasses limitations and potential risks, depending on the test result. The test result may be: 1) positive in an unaffected, at-risk individual when a disease-related mutation has been identified in the family, 2) positive in an individual who is the first identified mutation carrier in a family, 3) negative when a disease-related mutation has been identified in the family or, 4) uninformative or of uncertain significance.

A positive test result may lead to heightened anxiety about being a mutation carrier or induce guilt about possible transmission of genetic risk to children. Mutation carriers may be confronted with the medical and psychological risks of increased screening or surgical prophylactic interventions or of potential insurance, employment or social discrimination. When the genetic test result is uninforma-

tive or of uncertain significance, continuing anxiety, depression or confusion considering the lack of evidence-based guidance regarding prevention or surveillance strategies may appear. A negative test result may offer reassurance and reduction of anxiety about personal cancer risk due to heredity; however, it may result in strained family relationships or guilt, and potential inappropriate routine surveillance.

Research results to date do not indicate harmful psychological consequences following a positive test result [41-44]; however, most studies have been undertaken in settings devoted to clinical research and care by specialists in hereditary cancer and have addressed individuals of prevailing cultures. These studies do not provide long-term information on the emotional and health behavioural effects of this new technology. Although counselees seem to improve their knowledge about genetic aspects after genetic counselling, their risk perception remains incorrect [42], suggesting the need for professional support in helping individuals make informed decisions when considering the option of performing genetic tests or managing their high risk of cancer.

Studies on the psychological consequences of intensive screening or prophylactic interventions require careful attention. In the general population, if mammography screening does not appear to have a negative psychological impact on the majority of women, those who are recalled for further investigations after screening are subject to significant adverse consequences which may remain in the long term [45]. Additionally, regarding prophylactic mastectomy in particular, although the literature indicates a high level of satisfaction among women overall, a subset may report regret post surgery and are likely to experience high levels of psychological distress, sexual dysfunction and concern with body image [44].

Psychosocial issues in oncology professionals

In the context of cancer care, the relationship between patients and healthcare providers and the standards of communication are of the utmost importance. Inadequate explanations may lead to patients being confused about their diagnosis, prognosis and potential therapeutic options, thereby promoting dissatisfaction and psychological distress. This can affect attitudes towards treatment and care, difficulty adhering to medical recommendations, and may result in poorer outcomes. However, the information that must be conveyed to patients—disclosing a cancer diagnosis or explaining aggressive treatments—often has ‘threatening’ content, making the task of healthcare providers particularly difficult.

The care of patients with cancer may be particularly stressful. In particular, dealing with cancer patients’ psychosocial issues entails an emotional burden that can lead to burnout [46]. A high level of morbidity and mortality, confronting death, treatments with limited efficacy that are powerful but toxic or mutilating, difficult therapeutic decisions, medical or nursing staff conflicts, patients’ or family emotional or behavioural reactions may all contribute to the stress associated with cancer care. For example, healthcare professionals may report feelings of helplessness, anger, or occasional identification with the patient. In communicating with cancer patients, doctors are often confronted with a number of difficult issues for which they are usually unprepared, such as communicating bad news, preparing for aversive procedures, exploring treatment options, enrolling in clinical trials, discussing prognosis, or switching from curative treatment to supportive care [47]. In cancer care, professionals need to accept that care can be of good quality and effective without necessarily leading to a cure; this may challenge their original motivation in entering the medical profession.

Management of psychosocial issues

Interventions targeted at health care professionals.

Lack of skills and training in the detection of cancer patients’ and families’ psychosocial needs has been identified as a substantial barrier to the provision of evidence-based psychosocial care in oncology [2]. Studies suggest that clinicians do not identify patients with high levels of anxiety or depression [48-50] and need for psychosocial counselling [50]. Physical symptoms are more frequently addressed by the treatment team than are psychological concerns, although patients expect clinicians to initiate discussions about psychosocial issues [51].

Oncologists play an important role not only in identifying psychological distress but also in preventing it by providing adequate information and basic emotional support to patients and their relatives. Adequate communication skills are required to deal with issues that regularly arise in the cancer setting (e.g. complex treatment decision-making, treatment refusals, euthanasia requests).

Interventions have been designed to facilitate the detection of physical and psychological problems through the use of quality of life questionnaires in routine oncology practice [52], the provision of assessment tools [16] and guidelines for psychosocial management [14], as well as to train healthcare professionals in psychosocial issues [53] and in communication skills [54,55].

Psychological distress screening tools and psychosocial guidelines. Oncologists’ estimation of whether and how severe a patient is distressed is often complicated by patients’ denial [50]; besides, common somatic symptoms found in cancer, such as pain, fatigue, weakness, reduced energy and appetite/weight changes, are also common psychopathological symptoms: breathlessness, muscle pain, dizziness and palpitation for anxiety and panic attack; fatigue or appetite/weight for depression.

These somatic signs create difficulty in diagnosing depression and anxiety in cancer patients, and lead to highlighting more reliable symptoms such as, for depression, anhedonia, guilt, suicidal thinking and hopelessness [49].

In the United States, through the National Comprehensive Cancer Network (NCCN) (www.nccn.org), specific tools and procedures have been tested to trigger referral by the oncology staff to the psychosocial services. Similar to the pain management guide-

lines, a rapid psychological screen measure, the Distress Thermometer coupled with a Problem List to identify sources of distress (psychological, family, social, spiritual, practical, physical), are provided to patients in the ambulatory setting to identify those at risk for psychosocial problems and facilitate appropriate interventions.

Clinical practice guidelines based on comprehensive review of evidence-based psychosocial interventions have been produced in different countries as benchmarks against which the quality of psychosocial care in cancer can be assessed. In Canada, such guidelines allow regional and federal governments in planning and budgeting psychosocial care in cancer (www.capo.ca); in Australia, the implementation of the guidelines has been performed through demonstration projects, doctor communication skills training and forming partnerships with patient advocacy groups (<http://www.nhmrc.gov.au/>); in the United Kingdom, the National Institute for Health and Clinical Excellence also offers clinical guidance from a critical and comprehensive appraisal of studies assessing the effectiveness of psychosocial, supportive and palliative care services for cancer patients (<http://guidance.nice.org.uk/csgsp>). Other countries with guidelines in use are Germany, Hungary, Italy, Israel, Spain and Japan; in still others, guidelines are at different stages of development. Figure 1.9.2 illustrates the steps of interventions and skills needed to optimize the care of emotional distress [57].

Communication skills training. Good doctor-patient communication is essential, since it increases patients' coping and satisfaction with care, enhances informed consent and cooperation with care, reduces the probability of malpractice litigation and decreases professionals' burnout. Doctor-patient communication encompasses: 1) creating a good interpersonal relationship (a clear, warm and reassuring setting); 2) exchanging information (eliciting patients' information on their difficulties, prefer-

ences and expectations as well as providing complex medical information); and 3) making treatment-related decisions (which require an adequate understanding of the medical and psychosocial stakes associated with possible therapeutic options) [56].

Communication skills training is aimed at improving health care providers' ability to elicit patients' concerns and needs as well as to offer emotional support. Facilitating (e.g. use of open questions, expressions of empathy, appropriately responding to patients' cues) or blocking (e.g. exclusive focus on physical symptoms) communication behaviours have been described; these are promoted in training programmes [11].

A patient-centred care approach is encouraged; this entails the following specific features:

- an individualized, bio-psycho-social attention to the patient confronting the difficulties the disease imposes in his/her daily life;
- the consideration of a patient who is no longer a passive recipient of care, but perceived as possessing resources to deal with his/her condition, such as the capacity to understand medical information and share medical decision making; and
- a non-judgmental, genuine and comprehensive caring attitude.

Cancer patients generally prefer a collaborative role in deciding on a treatment plan; however a significant number prefer to remain passive, deferring to their physicians on treatment decisions [58]. Physicians are not necessarily attuned to patients' wishes regarding their involvement in shared decision-making. An uneven balance of power in treatment decision-making (either making all the decision or leaving it all to the patients) may affect patients' well-being and satisfaction with care.

Recent systematic reviews have provided evidence for the effectiveness of communication

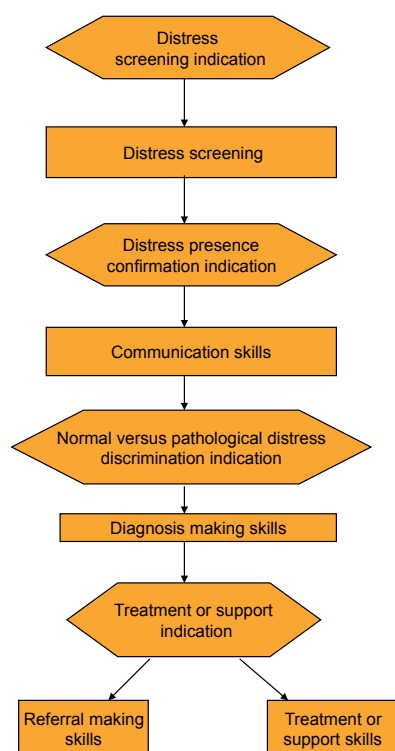


Fig. 1.9.2 Optimisation of distress treatment : importance of screening. Reprinted and translated from Razavi et al., (2008) *Précis de psycho-oncologie de l'adulte*, p. 311, Copyright with permission from Elsevier-Masson

training in improving basic communication skills in the cancer setting [10]. These must comprise the following specific features: learner-centered, skills-focused, and practice-oriented, organised in small groups and lasting at least 20 hours. Communication skills training courses should be proposed during academic training and pursued in continuing education programmes.

Interventions targeted at patients or relatives *Improving quality of life*. There is now a considerable body of evidence concerning the effectiveness of psychosocial interventions for individuals or families confronted with cancer [9]. Because of the various individuals' needs and contexts, different types of professional psychosocial interventions have been developed and tested. These comprise individual interventions such as education, counselling (crisis-oriented or psychodynamic), cognitive (cognitive reframing, problem solving) therapy or mind-body techniques (relaxation, hypnosis, meditation), group interventions (expressive-existential, cognitive-behavioural, psycho-educational) and couple or family interventions. They are usually targeted to specific episodes of the illness trajectory: diagnosis/pre-treatment, immediately post-treatment or during extended treatment (chemotherapy or radiotherapy), and advanced disease or death, through the bereavement period when addressed to relatives [1]. More specific interventions have also been designed for particular problems (e.g. sexual dysfunction, sleep disturbance). Careful psychosocial assessment at appropriate time points in the patient's journey may channel to specific interventions.

Cancer patients' psychological adjustment results from the interaction between their appraisals of the stresses associated with the disease and their internal or external resources, in terms of their coping style, personality traits or available support resources. Psychological therapy in people with cancer strives at facilitating coping in favour of improved patient well-being. For example, cancer patients with a hopeless/helpless or anxious preoccupied adjustment style perceive the disease as a

major threat, loss or defeat, which may lead to depressive or anxious mood disorders. During psychological therapy, these negative thoughts may be challenged, new ways of thinking about the disease and its impact on life explored and new methods to cope with the illness experimented [59].

In group therapy, expressing feelings and fear about the illness and encouraging mutual support is emphasised [60]. Emotional expression helps adjust to the stressful experience of cancer through the opportunity to identify one's feelings and to process them at a deep level.

Recently, the importance of finding meaning in life to the preservation of positive effects has been underlined in face of the catastrophic event of experiencing cancer. Additionally, a posttraumatic growth phenomenon, or positive changes has been reported as a result of this experience. These observations have triggered the development of new forms of psychological therapy for advanced cancer patients [61].

Considering the effects of psychological therapy in oncology, research evidence suggests that it does not promote survival but may affect this outcome in addressing patients' depression, hopelessness/helplessness and promoting improved adherence to anti-cancer treatments. The relevant outcomes are indicators of quality of life such as anxiety and depression or adjustment to the disease, as well as aspects of interpersonal and social functioning.

Following a critical review of 329 trials in cancer psychological therapy and considering various aspects of quality of life, Newell et al. [9] concluded that group therapy, education, structured and unstructured counselling, and cognitive behavioural therapy offer promise for many of the psychosocial outcomes explored (e.g. depression, anxiety, overall quality of life and physical symptoms such as fatigue or conditioned nausea).

Further studies need to address the appropriateness of existing forms of psychological therapy for subgroups of patients so as to design or

adapt interventions accordingly (e.g. patients from rural areas, with psychopathological antecedents or from varying cultural backgrounds). For example, these may rather attract patients belonging to higher socioeconomic classes [62], although cancer patients from lower socioeconomic status have been shown to present greater morbidity and poorer perseverance with anti-tumour treatment. Psychosocial factors, like optimism, unmitigated communion, or negative social interaction have been shown to moderate the effect of psycho-oncological interventions, highlighting a specific group of participants more susceptible to benefit from currently proposed interventions [63]. Henceforth, it would also be useful to determine the optimal time to offer psychological interventions to patients for they may not be open to address their distress at any time, especially as long as a treatment decision has not yet been made [64].

Conclusions and recommendations

Cancer and its treatment may considerably affect patients' physical and psychosocial functioning, hence overall quality of life. The psycho-oncology discipline has been developed and implemented in an increasing number of countries to respond to the psychosocial needs raised in oncology at the different phases of the cancer journey, including prevention and early detection, diagnosis and first treatments, survivorship, recurrence, terminal stages and bereavement.

Evidence-based psychosocial interventions addressing patients, families or their social milieu, or focusing on caregivers and healthcare professionals have been designed and tested, and are presently available in many settings to address psychosocial concerns, foster adaptation to the disease and treatment course, and therefore improve healthcare outcomes.

However, at an international level, the integration of psychosocial oncology within oncological care is still deficient. Clinical and educational recommendations based on current scientific knowledge have been provided [3,65]; these

should be more largely endorsed. The psychosocial components of oncological care should be included in every national cancer care plan and psycho-oncology services made available in every cancer care service. Cancer patients and close relatives should be offered psycho-oncology consultations and a range of psychosocial services during and after the treatment course; they should be provided with clear, free-of-charge information on their condition, respecting their needs and preferences. Healthcare professionals should be provided with validated psychosocial assessment tools, training and continuous supervision to be supported in addressing and adequately responding to the psychosocial needs of patients and relatives, engaging good communication and shared medical decision making.

The International Psycho-Oncology Society (IPOS) was implemented in 1984 to bring together investigators and clinicians dedicated to the clinical, educational and research aspects of psycho-oncology, in order to spread knowledge and practice in the psychosocial care of cancer patients worldwide while taking into account the diversity of problems and needs according to the cultural, economical or healthcare system background. Thanks to an initiative from the Psycho-Oncology Co-operative Research Group in Australia, a world map showing psycho-Oncology research groups is now available (<http://www.ipos-society.org/professionals/tools-resources/research-centers.htm>)

Cross-national psycho-oncology research is now possible thanks to the international development and validation of psychosocial instruments allowing monitoring of patients' difficulties and assess interventions effectiveness [66, 67] or evaluate the quality of cancer care provided [68].

The further mission of the IPOS is to assist the WHO in shaping priorities of action regarding the psychosocial element of national cancer control programmes [3].

Psychosocial oncological care is an essential component of high-quality cancer care that should be made available across countries to improve cancer patients' and relatives' health outcomes, their quality of life and satisfaction with care, and to ensure healthcare providers' well-being while carrying out the activities of their caring profession.



Fig. 1.9.3 Communication skill training is aimed at improving health care providers' ability to elicit patients' concerns and needs as well as to offer emotional support

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3. Australian Practice Guidelines for the Psychosocial Care of Adults with Cancer: <http://www.nhmrc.gov.au/>
4. The National Institute for Health and Clinical Excellence guidance: <http://guidance.nice.org.uk/>
5. The National Comprehensive Cancer Network (NCCN), guidelines for supportive care, distress management: www.nccn.org
6. World map of psycho-oncology research groups: <http://www.ipos-society.org/professionals/tools-resources/research-centers.htm>