Scientific Symposium (Tue, 22 Sep, 14:45−16:45)
Managing emotional concerns

150 INVITED

Management of anxiety and depression for people with cancer

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The diagnosis and treatment of cancer have been shown repeatedly to be associated with high levels of psychiatric morbidity. In the United Kingdom, despite substantial investment by the National Health Service, and others, morbidity has remained very high. Indeed, for breast cancer, the prevalence of morbidity appears to have increased.

The most commonly used classification schemes are ICD-10 and DSM-IV, although these have limitations in the context of cancer. For example, it is useful to distinguish between depression and demoralisation, and the latter is not recognised in either taxonomy. Also, the interpretation of the significance of some symptoms such as fatigue and weight loss can be difficult in patients receiving cancer treatment or with advanced disease, and there is merit in substituting other symptoms in some situations.

The most common manifestations of significant anxiety and depression in patients with cancer include major depression, adjustment reactions, demoralisation, the Damocles' syndrome, phobias (especially claustrophobia), procedural distress and post traumatic stress disorder.

Reviewing the evidence in 2006, Rodin and colleagues concluded that "Antidepressant medications should be considered for the treatment of moderate-to-severe major depression in cancer patients. Current evidence does not support the relative superiority of one pharmacologic treatment over another, nor the superiority of pharmacologic treatment over psychosocial interventions".

Several psychosocial interventions, for example adjunctive psychological therapy, have been shown to have a beneficial effect on patients with clinically significant anxiety.

A number of RCTs have found that psychosocial interventions can prevent psychiatric morbidity. For example, one study found that supportive expressive therapy prevented clinically significant depression, and another showed that a brief three-session intervention prevented clinically significant anxiety and depression in patients at high risk of these disorders.

Many patients with cancer do not have clinically significant anxiety or depression. A number of RCTs have shown in this population that interventions such as relaxation, guided imagery, psycho-education, cognitive existential group therapy, reflexology, massage and exercise can improve mood and/or reduce anxiety.

There is evidence that the provision of an open-access psychosocial support service that is fully integrated physically, functionally and managerially with other aspects of cancer provision prevents a substantial amount of psychiatric morbidity. For example, we have consistently shown very low levels of morbidity in the control (treatment as usual) arms of our RCTs with patients who have locally advanced breast cancer, early breast cancer or colorectal cancer.

It is now clear that a great deal can be done to prevent the development of clinically significant anxiety and depression, as well as to treat these disorders effectively when they occur.

Future studies should try to establish which intervention (psychological, interpersonal, pharmacological) is most appropriate for which patients (type of cancer, stage of disease, personality and coping characteristics, level of distress) in which setting (individual, group, hospital, community) delivered by which therapist (profession, personal characteristics, training, experience).

References

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Clinical communication skills and coping, the keys to helping patients

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When health care professionals use communication skills effectively, both they and their patients benefit. Communication within oncology is a core clinical skill but one in which some oncologists or specialist cancer nurses have received formal training, other's haven't got a training. Inadequate communication may cause much distress for patients and their families, who often want considerably more information than is usually provided. Many patients leave consultations and hospital unsure about the diagnosis and prognosis, confused about the meaning of – and need for – further diagnostic tests, unclear about the management plan and uncertain about the true therapeutic intent of treatment. Additionally, communication difficulties may impede the recruitment of patients to clinical trials, delaying the introduction of efficacious new treatments into clinics. Lack of effective communication between specialists and departments can also cause confusion and a loss of confidence amongst the team. Oncologists themselves acknowledge that insufficient training in communication and management skills is a major factor contributing to their own stress, lack of job satisfaction and emotional burnout. Consequently, over the past few years there have been several initiatives aimed at improving basic communication skills training for healthcare professionals in the cancer field. When healthcare providers have received training in communication then they will identify their patients' problems more accurately. Their patients will be more satisfied with their care and can better understand their problems, investigations, and treatment options. Patients are more likely to adhere to treatment and to follow advice on behaviour change. Finally patients' distress and their vulnerability to anxiety and depression are lessened. I will try to present evidence that doctors and nurses do not communicate with their patients as well as they should, and the possible reasons for this.

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Therapeutic decision-making in adolescents with cancer

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It is fundamental to the care of young people with cancer to maintain open lines of communication and to treat them as equals in an environment of mutual trust and honesty. This translates into a need to involve them in all decision-making and discussions. For this to be successful young people need to be involved as active agents in the partnership of care, that involves young people, professionals and in many cases other significant carers. They need to understand the implications of what is happening to them and the implications of the decisions they make (Rodwell, 1996). They need to be given enough responsibility to be able to take control: seen as a vital element of the coping strategies used by young people. Young people also need to know what options are available to them so that they can make choices and seek the information that they require, when they require it. An individualised approach to care is required to account for the fact that they may want to make decisions on some occasions but not others.

One key element to address these fluctuating needs is the requirement for clear, appropriate and comprehensive information at all stages. This allows for participation and a level of control in decision-making (Fallowfield, 2001). Only when information has been shared and digested, and trust has been established can the process of patients making choices for themselves commence, only then can they 'find their voices' (Falk-Rafael, 2001). Choices can then be made based on their knowledge and skills: they can be purposeful and pro-active, rather than re-active. It is essential that professionals who care for this population understand their needs and are able to facilitate them in making decisions and choices.

The aim of this presentation is to draw on published work, on recent research completed and ongoing, in the field of teenagers and young adult cancer care in the United Kingdom to illuminate the unique challenges associated with providing appropriate care and support (Kelly, 2008), that places partnership and involvement at its core.

References

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