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The Psychiatrist's Perspective on Quality of Life and Quality of Care in Oncology: Concepts, Symptom Management, Communication Issues

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The important prevalence of psychosocial problems and psychiatric disturbances that have been reported in oncology, underlines the need for comprehensive psychosocial support for cancer patients and their families. Psychosocial support is designed to preserve, restore or enhance quality of life. Quality of life refers not only to psychosocial distress and adjustment-related problems but also to the management of cancer symptoms and treatment side-effects. Psychosocial interventions designed for this purpose should be divided into five categories: prevention, early detection, restoration, support and palliation. Firstly, preventive interventions are designed to avoid the development of predictable morbidity secondary to treatment and/or disease. Secondly, early detection of patients' needs or problems refers to the assumption that early interventions' could have therapeutic results superior to those of delayed support, both for quality of life and survival. Thirdly, restorative interventions refer to actions used when a cure is likely, the aim being the control or elimination of residual cancer disability. Fourthly, supportive rehabilitation is planned to lessen disability related to chronic disease, characterised by cancer illness remission and progression, and to active treatment. Fifthly, palliation is required when curative treatments are likely to no longer be effective, and when maintaining or improving comfort becomes the main goal. Psychological interventions are often multidisciplinary, with a variety of content. The type of psychological intervention ranges from information and education to more sophisticated support programmes including directive (behavioural or cognitive) therapies, or non-directive (dynamic or supportive) therapies. Social interventions usually include financial, household, equipment, and transport assistance depending on individual and family needs and resources. These interventions may be combined with the prescription of pharmacological (psychotropic, analgesic), physical, speech or occupational therapies, especially in rehabilitation programmes. Health care services devoted to delivery of these interventions are hospital, hospice or home-based and organised very differently depending on already available community resources and local practice.
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INTRODUCTION

AN IMPORTANT prevalence of psychiatric disturbances in cancer patients has been reported in many studies. In 1983, the Psychosocial Collaborative Oncology Group observed a prevalence rate of 47% for Diagnosis and Statistical Manual of Mental Disorders-III-defined psychiatric disorders in a cohort of cancer patients (inpatient and outpatient populations of three cancer centres). Most importantly, this rate was approximately twice that reported for psychiatric disorders in medical patients, and three times the modal estimate appearing in the literature for the general population. As a diagnostic category, adjustment disorders accounted for 68% of all diagnoses. Other diagnoses were major affective disorders (13%), organic mental disorders (8%), personality disorders (7%), and anxiety disorders (4%). In total, nearly 85% of patients with a positive psychiatric condition had depression or anxiety as the principal symptom.

Most of these conditions were judged by the authors to be highly treatable disorders [1]. In a 1987 study, approximately one in three oncology outpatients, assessed with the Brief Symptom Inventory, reported moderate-to-high levels of depression and anxiety [2]. In Sweden, all cases of cancer have been, by law, notified and recorded since 1958 and a 1989 Swedish study reported that cancer patients seem to have an increased suicide rate compared with that of the general population, particularly during the first year after diagnosis, when the rate is multiplied by 15 [3]. Last but not least, the high risk of medium- and long-term sequelae of cancer and its treatments has come to light, even if the exact prevalence of these problems remains to be assessed in future prospective research [4].

Therefore, the assumption that emotional distress was just a foreseeable and ordinary reaction to cancer had to be reviewed, and the need for comprehensive therapeutic models to care for patients who develop psychological disorders was recognised.

Before reviewing recent advances in treating the psychological

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conditions related to cancer, we must consider three concepts that have a major influence on the current literature: stress, rehabilitation, and quality of life.

Firstly, physicians now widely accept the view that cancer and its treatments constitute a stress imposed on a previously healthy individual, involving adjustment efforts (or coping) and possibly adjustment disorders. This stress concept treats psychological disturbances as the consequence of a sustained stressful situation. Several recent articles evaluated the psychosocial disorders associated with cancers in terms of adaptation [5], or adjustment [6]. Moreover, an association between severe life stressors and the recurrence of cancers has been suggested in a retrospective study [7], although larger prospective studies are needed for confirmation. However, results of studies on the possible relationships between psychosocial factors, stress, immune and endocrine function, and cancers remain contradictory [8–10].

Secondly, improvement in cancer treatments and prognosis means that a diagnosis of cancer can no longer be equated with a death sentence. Survival, especially in patients with cured haematological malignancies [11], has increased, and with it the need for achieving and maintaining optimal quality of life has become apparent for these patients. Consequently, oncologists are increasingly aware of the patient's needs regarding the return to a normal and useful life, and they, therefore, feel more concerned not only about the short-term psychological effects of their treatments [12], but also about their long-term outcomes in terms of a patient's quality of life [13] and rehabilitation [14]. In particular, the psychological distress after surgical treatment of breast cancer is still the centre of a controversial debate on partial versus total mastectomy [15, 16]. At the same time, surgical and medical treatment decision-makers increasingly consider the psychosocial factors predictive of a treatment's success or failure [17].

Rehabilitation of the cancer patient, which seems to be the current leading concept, includes specific support by a multidisciplinary team. From this perspective, psychosocial and psychopharmacological interventions will become a part of large programmes oriented toward the rehabilitation and quality of life of cancer patients.

Although most recent articles are related to these promising topics, only a minority have investigated the ways to make them operational, i.e. the two types of interventions known to be effective for common psychiatric or psychological disorders, which are psychological support and psychotropic medications. Past literature has had to be reviewed to provide a valid picture of the current situation in this very new area.

PSYCHOLOGICAL SUPPORT

In this article, the term psychological support includes all the psychosocial interventions relevant to oncology. Psychological support may thus range from the information provided by the general practitioner who suspects a diagnosis of cancer to the use of sophisticated techniques performed by well-trained oncologists and psychiatrists.

Evidence has been found that psychologically cancer affects not only the patients, but also their relatives and the health professionals dealing with them [18]. Family interventions and psychological training or support for health professionals should thus also be included in psychological support programmes [19].

Not surprisingly, therefore, the literature includes various techniques, more or less explicitly described, dealing with this question: what can we do, without medications, to help the cancer patient cope? Despite the multiplicity of approaches and the objectives they openly declare (i.e. to reduce psychological morbidity, enhance quality of life, improve communication, provide information, and teach skills) their purpose can be summarised as optimisation of the patient's adaptation to the consequences of the disease. Although techniques constantly overlap in clinical practice, they can be divided schematically according to (1) their degree of directivity, e.g. non-directive versus directive and (2) their form, e.g. individual, family, or group (Table 1).

Directive techniques

Behavioural therapies are based on conditioning theories. They involve precise observation of behaviour and use directive methods to achieve determined goals. Their results can be observed directly by the disappearance or persistence of the symptom. The positive effects of the behavioural techniques in treating adverse reactions are rather well documented by controlled studies. These techniques are especially effective for anticipatory nausea and vomiting related to cancer chemotherapy [20]. They are also proposed for controlling and treating psychological reactions secondary to painful procedures and acute pain, and adverse reactions to surgery, radiotherapy, and hyperthermia treatment. Recently, they have been proposed for treating post prostatectomy urinary incontinence [21] and also for anxiety and depression in patients with early breast cancer [22]. These uses would represent a considerable and promising increase in indications for the use of behavioural techniques.

Cognitive therapy deals with present problems and tries to identify maladaptive thoughts, irrational beliefs, and inner factors that are responsible for psychological or somatic symptoms. Once identified, these thoughts are confronted with reason and reality. Self-monitoring automatic thoughts, restructuring and learning coping strategies are commonly used with cancer patients. No recent article related to this topic was found.

Non-directive techniques

Providing information is the first step in helping patients cope with cancer. Information on diagnosis, prognosis, treatments, and long-term sequelae is given by oncologists and general practitioners in the first line, but can be further delivered by other medical staff members and completed by members of self-help groups, either alone or in groups. Information can be

Table 1. Common psychological support techniques in oncology

Non-directive techniques	Directive techniques
Individual	Individual
Information	Behaviour therapy
Counselling	Hypnosis
Psychotherapy (supportive or psychodynamic)	Relaxation
	Progressive muscle relaxation training
Group	Electromyographic biofeedback
Self-help	Guide imagery
Supportive psychotherapy	Systematic desensitisation
	Cognitive therapy
Family	
Supportive psychotherapy	Group
	Behaviour therapy
	Hypnosis
	Relaxation
	Cognitive therapy

provided to the patient alone, to the patient in the presence of family members, or even to family members apart from the patient. As reported recently, perception of information by the patient or his family may be distorted by intellectual and psychological factors, especially in the case of negative information [23]. Another bias can be the patient's inability or unwillingness to attend to all presented information.

Counselling is a special form of help performed by generally trained persons whose purpose is to listen to the patients, help them express and understand their feelings about cancer and encourage them to cope with their current situation. Counsellors can be specialised nurses, veteran patients, or even volunteers [24]. Counselling is a rather ubiquitous term, but this technique is an attempt to provide cancer patients with first-line support and continuity when no other more specialised help is available. Psychotherapy is the development of a trusting relationship that allows free communication between patient and specialised therapist. Two models of psychotherapy are used with the cancer patient: supportive and dynamic. Supportive psychotherapy is based on a short-term, crisis-intervention model. This technique is useful in restoring or maintaining the *status quo* in crisis situations, which are numerous in oncology. Individuals, families, or groups can be treated. However, a recent article concluded that although group support was effective in providing information and new friends, it did not help patients cope better with cancer [25]. Dynamic psychotherapy, based on the psychoanalytic model, is useful when patients desire to explore further their reactions and feelings to promote personality changes. Because its duration can be long, it is indicated for cancer patients with good prognoses.

Recent literature indicates that non-directive therapies achieve their supposed wide field of action at great cost: no definite conclusion can be drawn on their efficiency due to methodological deficiencies such as terms that are too broad and include different techniques, lack of fully completed interventional descriptions, the vague determination of which patients could benefit from these interventions, the non-homogeneous constitution of the patient groups studied, and the absence of control groups or randomisation in most studies. One author counted only seven randomised controlled trials in the field of psychotherapy [26]. Another author, considering the benefits of counselling, noted that such interventions have failed to provide unequivocally positive results in oncology [24]. Not so surprisingly, despite the unanimous regrets of these authors regarding methodology, general agreement still exists, supported by clinical experience, on the effectiveness of non-directive therapies and their feasibility in a cancer setting. Recent studies have provided empirical data on the effectiveness of psychotherapy, both group and individual [27, 28].

Directions for future research

Firstly, it is important to recall that a precise and comprehensive assessment of the psychological and psychiatric problems and a good understanding of the social situation are of the utmost importance for any reasonable therapeutic intervention. Developing specific assessment methods is still necessary, as are simple, reliable, and valid tools for the early screening of psychological disturbances in an oncology population [29]. Early detection of mild psychological distress may identify patients who could be helped with psychosocial interventions. Moreover, even if no data are available demonstrating that early treatment could have therapeutic results superior to those of delayed treatment, early treatment obviously has a positive effect on quality of life. In addition, early recognition of distress among family members and carers is another promising area of research that could improve the quality of support.

Secondly, the diversity of, and lack of precise description for most psychological interventions remains an obstacle to any progress in this field. Especially for non-directive techniques, the indications for and purposes of psychological support remain unclear. The type of cancer and treatment; the time in the illness course; the patient's personality, gender, and age; and the quality of social support are all factors that should be taken into account to increase the relevance and validity of research in this area. Most interestingly, the question as to whether or not appropriate psychological support has a positive influence on cancer patient survival has recently come to the fore. This topic requires careful examination and further controlled studies [30].

Thirdly, it is unfortunate that the qualifications of the person performing the therapy are not well defined. Should a general practitioner, an oncologist, a nursing staff member, a mental health professional (e.g. psychiatrist, psychologist, or trained therapist), or a non-professional (e.g. veteran patient or voluntary organisation member) intervene? What should be the basic communication skills of care professionals? Specific training should be designed and organised for each of these categories of therapist [19, 31, 32]. More research comparing the efficacy of the same treatments performed by differently trained persons must be carried out, not only to provide patients with the most effective therapy, but also to take into account its cost and feasibility in a cancer setting.

Fourthly, there is more and more evidence that psychosocial and behavioural techniques may prevent and manage the adverse symptoms associated with cancer and its treatment [33]. Symptom control will be, therefore, another end-point for psychosocial interventions in the future.

In conclusion, without rigorous research and controlled studies, psychological support will continue to be suspected of empiricism, although its efficacy as adjuvant therapy in oncology can no longer be questioned [34].

PSYCHOTROPIC MEDICATIONS

Clinical experience supported the need and usefulness of psychotropic medications in oncological settings. However, because psychotropic medications have been too rarely tested rigorously in oncology, any advances in the treatment of psychological disturbances remain dependent on progress in the clinical psychiatric research. With the exception of treatments for pain, which are discussed elsewhere, very few psychotropic medications have been tested in oncology: mianserin [35] and methylphenidate [36] have been tested for treating depression, and alprazolam [37] and lorazepam [38] have been tested for treating phobic nausea and vomiting related to chemotherapy.

In 1988, an uncontrolled pilot study in which imipramine "or its equivalent" was used suggested the efficacy of antidepressants in treating major depression in cancer patients [39]. A recent double-blind placebo-controlled study has shown that patients receiving fluoxetine reported significantly less psychological distress at the end of the study than patients receiving the placebo [40]. The small number of controlled studies on psychotropic compounds in oncology is explained in part by the lack of recognition of psychiatric disturbances in oncology. Another factor is the relatively small number of psychiatrists specialising in this field. The assumption that trials are difficult to conduct because of possible drug interactions and altered pharmacokinetics due to medications prescribed for the malignancy is irrele-

vant, especially in the case of psychotropic drugs, which are generally well tolerated.

Directions for future research

Firstly, because the psychiatric conditions found in cancer patients are reported to be quite different from those encountered in the general population and in other medically ill patients, further development of specific tools is needed to assess psychiatric morbidity in oncology. Secondly, controlled studies have to test the usefulness of psychotropic agents for major depressive disorders, chronic pain, delirium and insomnia. The complete lack of controlled studies in the field of adjustment disorders must be addressed without delay. Thirdly, the feasibility and effectiveness of using specific classes of psychotropic medications for preventing psychological and psychiatric disorders in cancer patients should be evaluated in prospective studies at each phase of the course of the illness [41].

CONCLUSION

Despite recognition of the high prevalence of psychiatric and psychosocial disturbances associated with cancer and its treatments, and inclusion of the psychosocial factors in quality of life assessments and rehabilitation programmes, very few articles rigorously investigate what can actually be done to prevent and alleviate these disturbances. In particular, research should be encouraged in the newly identified class of adjustment disorders that occur so frequently in oncology; new concepts to understand and treat them are urgently needed. The respective indications of psychological support, psychotropic medications, or both, are based on clinical experience and rarely controlled in large prospective studies. The first step should be to recognise the respective usefulness of single psychological intervention and psychotropic medication in specific situations (in chronic pain, for example) along with the best supportive care of the patients. The second step should be to compare different techniques for their efficacy, cost and feasibility in a cancer setting. The third step should be to test for the possible superior effectiveness of combinations, e.g. non-directive technique with directive technique, individual psychological support with family support, psychological support with psychotropic medication.

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