

# Psycho-science: Where do we go from here?

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## Achievements to date

The last 25 years have seen a burgeoning of research and publications in the field of psychosocial oncology. For example, in 1998, the frequency of publication of *Psycho Oncology* (the official organ of the International Psycho Oncology Society) was increased from four issues per year to six issues per year, and by 2004 the frequency had increased to 12 issues per year (currently over 1200 pages per annum).

There have been a number of significant achievements during this time, notably (a) the universal realisation that the diagnosis and treatment of cancer commonly cause significant psychosocial and psychiatric morbidity, (b) the increasing recognition of the importance of good communication between health care professionals and their patients (and other family members) as well as the importance of providing appropriate information and support, and (c) the acceptance of the need to include measures of quality of life and related psychosocial parameters as outcomes in clinical trials of new oncological interventions. There has also been increasing recognition of the need for specialist palliative care services [1].

Unfortunately, too much recent research, both qualitative and quantitative, has been devoted to describing and quantifying *ad nauseam* the nature and prevalence of cancer-related distress, at the expense of developing and evaluating ways of preventing and treating such distress.

Despite this, a number of well-designed randomised controlled trials (RCTs) have shown that psychosocial interventions can be effective in reducing treatment-related distress (for example, treatment-related nausea and anxiety treated to medical investigations and procedures) as well as in treating clinically significant anxiety and depression [2]. Other RCTs have shown that various psychosocial interventions, for example, relaxation and guided imagery, can improve quality of life more generally following the diagnosis as well as during and after treatment [3].

## Quo vadis

Despite substantial investment in training and personnel, psychiatric and social morbidity remains high in the United Kingdom. For example, Hall and colleagues [4] reported that of 269 women with early breast cancer, 49.6% were clinically anxious and 37.2% were clinically depressed in the first 3 months, and Burgess and colleagues [5] found that, of 222 women with early breast cancer, 48% were clinically anxious and/or depressed in the first year. These figures are in marked contrast to those obtained in a study of women with locally advanced breast cancer who received their multimodality therapy within the context of an open access support centre that was fully integrated with chemotherapy, radiotherapy and surgery [3]. Following 18 weeks of neoadjuvant chemotherapy, the prevalence of anxiety and mood disorders assessed using standardised psychiatric interviews was only 6%. Subsequent studies have confirmed a low rate of morbidity in patients with early breast cancer and colorectal cancer receiving this type of integrated support. Future research, therefore, should focus on the optimal way to organise psychosocial support with a view to preventing morbidity, enhancing quality of life, and promoting post traumatic growth.

A related issue concerns the sociodemographics of patients who access psychosocial support centres. Most patients are typically white middle class women with breast cancer [2]. We have recently shown that, if provision is integrated physically, functionally, financially and managerially, men and women attend in almost equal numbers, and the number of patients with lung cancer and colorectal cancer is similar to that of breast cancer ([www.lgwalker.com](http://www.lgwalker.com) [OHS Audit]).

Although traditional psychiatric diagnoses are widely used in psychosocial oncology, some types of clinically significant distress are difficult to categorise using traditional taxonomies. For example, Kissane and colleagues have made the useful distinction both conceptually and empirically between “depression”

and “demoralisation” [6]. Demoralisation is characterised by hopelessness, helplessness and a loss of meaning in the absence of anhedonia or significant blunting of the pleasure response. Clinically, the distinction can be very useful, not least because the latter carries a relatively high risk of suicide. RCTs to evaluate the optimal management of depression and demoralisation are now needed.

Some early randomised controlled trials suggested that various psychosocial interventions could prolong survival in some patients. Most recent studies, however, have failed to find an effect on survival. Nevertheless, recent studies have shown that psychosocial factors may affect specific clinically relevant variables, for example, VEGF (e.g. [7]), and there may be considerable value in examining the effects of psychosocial and other related interventions on specific biological variables such as this rather than on survival which can be affected by a wide range of disease and treatment-related factors [8].

In the United Kingdom, attention has recently focused on the psychosocial needs of patients who have “survived” cancer. It is increasingly recognised that they may have long-term issues, for example, related to the side effects of treatment or to the fear that the cancer might return (the so-called syndrome of Damocles). Patients may feel “abandoned” by the cancer services following treatment, despite periodic follow-up appointments. There is a need to develop and evaluate how best services can be organised and staffed in order to address these issues. One approach is to provide an open access (“drop in”) service as described above.

Another area that is ripe for research is the development of interventions to prevent and to manage burnout in health care professionals. A number of studies have demonstrated that between a quarter and a third of oncologists, surgeons and clinical nurse specialists suffer from clinically significant anxiety and/or depression [9]. A similar proportion of clinicians are emotionally exhausted, withdraw emotionally from their patients, and report low personal accomplishment. This has a negative effect on their clinical work, their families, and their organisation (many intend to retire early). Although a number of studies have identified factors that contribute to work-related stress, there is an urgent need to develop and evaluate interventions to prevent burnout, and to treat burnout when prevention fails. Otherwise, the cost to patients, the health care system, and to society, not to mention the individuals concerned and their families, will be very high.

## Conclusions

Significant progress has been made in the last 25 years. However, a great deal remains to be done in terms of applying the knowledge already gained, particularly in terms of preventing distress; improving quality of life before, during and after treatment; supporting the workforce, and integrating psychosocial science conceptually and organisationally with other aspects of cancer.

## Conflict of interest statement

None declared.

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