

Psycho-social Oncology: Where have we come from and where are we going?



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- Psychosocial care provided by:
 - **Front-line staff**
 - doctors, nurses, allied health in oncology and palliative care
 - **Specialist psychosocial staff**
 - psychiatrists, social workers and psychologists
- Front-line psychosocial care - present since medicine began
- Social work - a significant and ongoing role since early 20th century*
- Psycho-Oncology – a more recent development (1970s)

* Pat Fobair. Historical Threads in the Development of Oncology Social Work. J Psychosoc Oncol. 2009;27(2):155–215





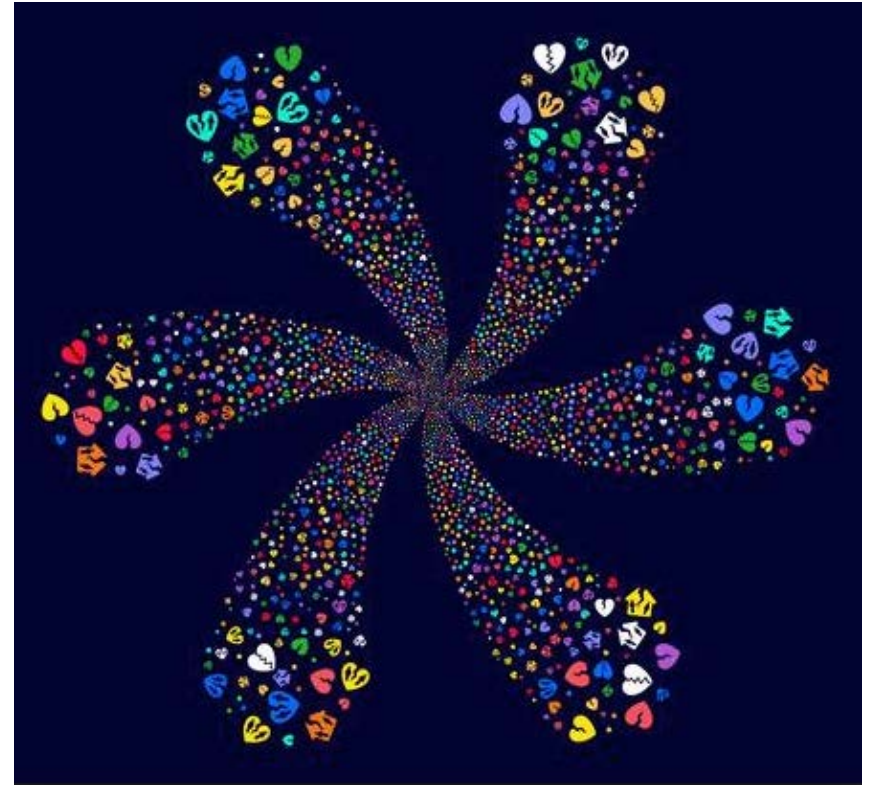
Date	Events
1930s	Psycho-analysts began investigating emotional causes of cancer
1940s	First scientific study of acute grief (Lindemann, 1944)
	First paper on social work in cancer * Clark E. A Red Cross medical social worker's role in patient's adjustment to cancer diagnosis. <i>Med Woman's J</i> 1947; 54(6):24-31
	Emerging recognition of patient as a person * Cockerill EE. The cancer patients as a person. <i>Public Health Nursing</i> 1948; 40(2):78-83.
	Loma Feigenberg, psychiatrist at the Karolinska Institute in Stockholm * First known psychotherapy for cancer patients * Formed International Group for Study of Death, Dying and Grief
1950s	First papers on psychological care of cancer patients, and their responses * Kline NS, Sobin J. The psychological management of cancer cases <i>JAMA</i> 1951; 146(17):1547-51, 1951
	First papers on disclosure of cancer diagnosis * Maloney FG. Should a patient be told he has cancer? <i>Wisconsin Medical Journal</i> . 1954; 53(10):541-4.



Date	Events
1960s	First epidemiological studies of emotional factors and cancer outcome * Leshan L. Cancer mortality rate. Some statistical evidence of the effect of psychological factors. <i>Archives of General Psychiatry</i> 1962; 6:333-5.
1970s	EORTC established quality of life outcome measures Project Omega in Massachusetts Hospital screened for distress in cancer patients. * Wiseman AD, Worden JW. The existential plight in cancer – significance of the first 100 days. <i>Int J Psychiatry Med</i> 1976; 7(1): 1-15
	Paper on impact of fighting spirit on survival published. * Greer S, Morris T, Pettingale KW. Psychological response to breast cancer: effect on outcome. <i>Lancet</i> 1979 Oct 13;2(8146):785-7.
1980s	British, American and International Psychosocial Oncology Societies formed. Handbook of Psycho-Oncology published in 1989 – first text in the field Mental Adjustment to Cancer Scale created (Maggie Watson & Colleagues)



- And then:
- An explosion of activity!





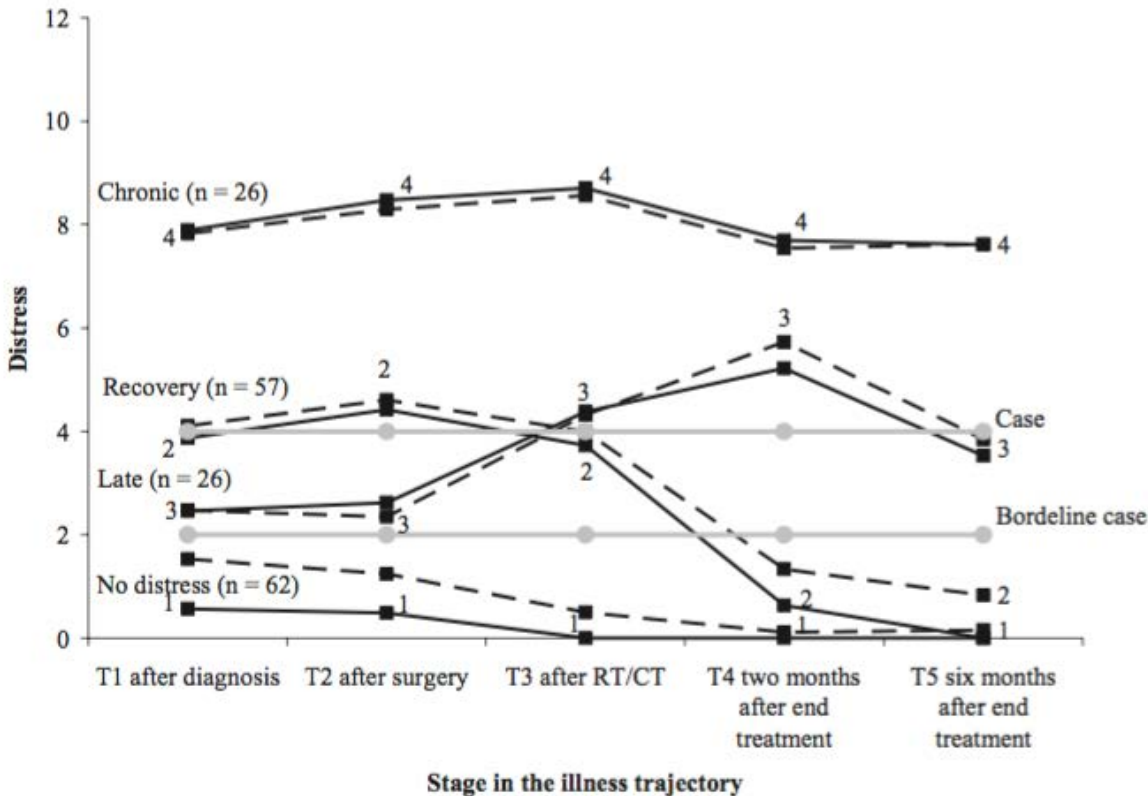
- Is there a problem?
- What causes distress?
- What increases distress?
- Does it matter?
- Do people want/need help?
- Can we help?
- How much does our help cost?
- Can we get psychosocial care into routine care?





Prevalence and trajectory of distress

DISTRESS AFTER A BREAST CANCER DIAGNOSIS



Henselmans et al,
2010
Health Psychology
29 (2):160-8



Prevalence of mental disorder

- Population-based study in Germany of in- and out-patients
- 4020 patients (68% response rate)
- Patients scoring above 9 on PHQ interviewed with CIDI-O

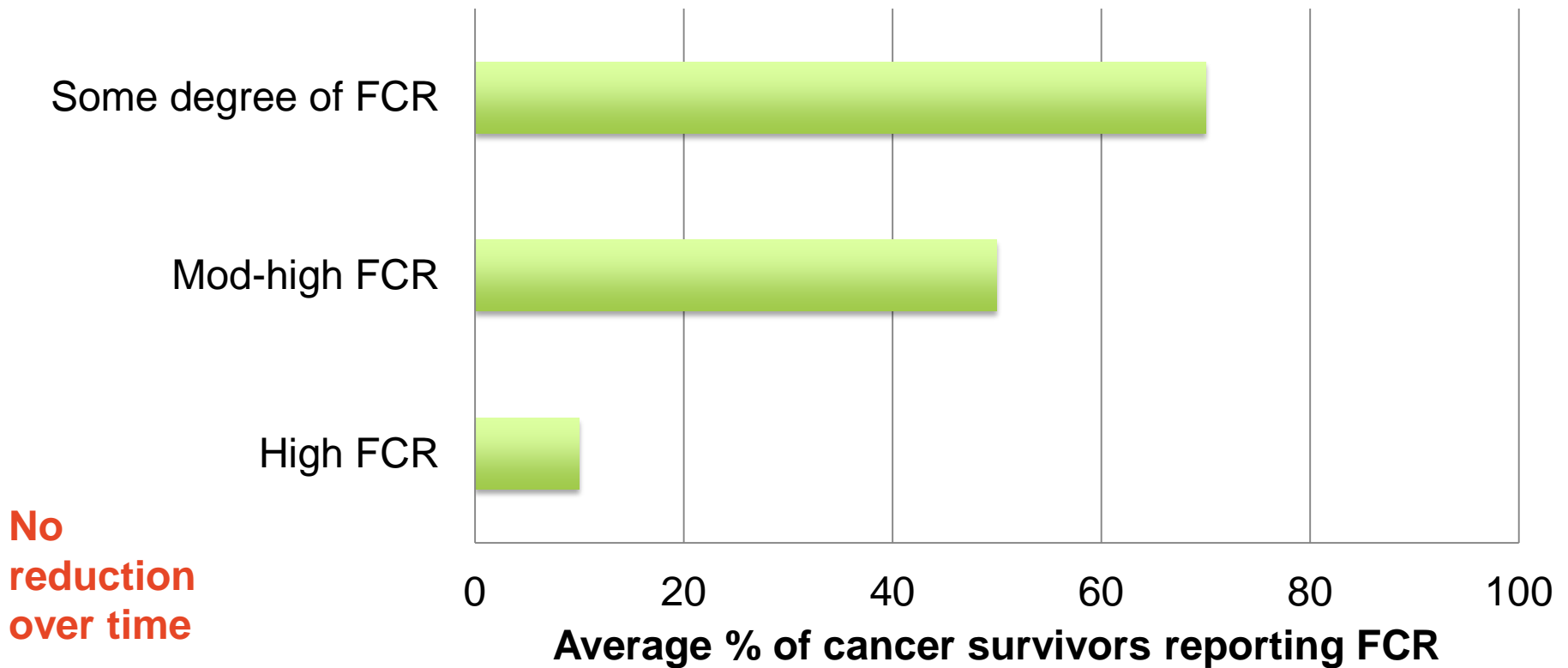
Mehnert A et al. JCO 2014; 32: 3540-3551



4-week prevalence of mental disorder

Disorder	Prevalence (%)	95% CI (%)
Mental disorder	32	29 - 34
Anxiety	12	10 - 13
Mood disorder	7	6 -8
Adjustment disorder	11	10 -12

Prevalence of fear of cancer recurrence (FCR): Systematic Review





- Some countries may still need to document local levels of distress and mental disorder
- Still unclear when distress becomes an adjustment disorder
- Detection of distress/disorder still poor in the clinic...





Syrowatka A; et al. Predictors of distress in female breast cancer survivors: a systematic review *Breast Cancer Research & Treatment*. 165(2):229-245, 2017

- 42 studies
- **Disease predictors :**
 - more advanced cancer at diagnosis, treatment with chemotherapy, longer primary treatment duration, more recent survivorship, recurrence, comorbidities
- **Modifiable treatment–related system predictors :**
 - menopausal/vasomotor symptoms, pain, fatigue, sleep disturbance
- **Socio-demographic predictors :**
 - younger age, non-Caucasian ethnicity, being unmarried, lower socioeconomic status, history of mental health problems, perceived functioning limitations
- **Modifiable socio-demographic predictors :**
 - lower physical activity, lower social support, and cigarette smoking.

CONCLUSION: We understand predictors of distress pretty well





- **Dr-pt communication: 3 strong reviews**
- Rodin G et al. Support Care Cancer Clinician-patient communication: a systematic review. 2009;17(6):627-44.
- Lelorain S et al. A systematic review of the associations between empathy measures and patient outcomes in cancer care. *Psycho-Oncology* 2012; 21(12):1255-64
- Uitterhoeve RJ et al. The effect of communication skills training on patient outcomes in cancer care: a systematic review of the literature. *Eur J Cancer Care* 2010; 19(4):442-57
- **CONCLUSIONS:** Evidence that **discussing prognosis and end of life issues** reduces anxiety, **empathy** reduces distress.
- **BUT** quality of studies poor, pathways lacking, measurement diverse, culture not considered: **MORE WORK TO BE DONE**





Does distress impact survival / QOL?





- Early research linking “**fighting spirit**” with cancer outcome (Greer & Watson)
- **not supported** in later research





- Global **quality of life**, **functioning**, and **symptoms** individually or in combination, predict **survival** times
- Montazeri, A. *Health & Quality of Life Outcomes*. 7:102, 2009



- 77,173 English women with breast cancer (2000-2009)
131 had bipolar affective disorder, 955 depression
-
- A record of depression predicted worse overall survival (adjusted HR = **1.33**, 95% CI: **1.20-1.48**, $p < 0.001$)
- **Kanani R; et al, *Psycho-Oncology* 2016; 25(1):19-27**

- Probably room for more research here...
- Regardless, depression, stress and distress
NOT GOOD FOR QUALITY OF LIFE!

- Intervention trials to reduce distress/morbidity
- Many meta-analyses – mostly small to medium effect sizes, short f/u, small samples
- Park J; Bae S. *J Korean Academy Nursing*. 47(2):143-163, 2017
- Explored interventions for **survivors**
 - 35 papers identified
 - Effect sizes range from 0.23 to 0.68 for QOL, coping and self-efficacy, anxiety, depression and psychological distress.
 - **Counseling** most effective intervention for QOL
 - **CBT** effective for all outcomes

- Matthews H. et al. *Psycho-Oncology*. 26(5):593-607, 2017
- Explored interventions **after br ca surgery**
- **CBT** most effective intervention for anxiety, depression distress
- Effect sizes range from 0.27 to 0.67 for all outcomes
- **CONCLUSION:**
 - CBT best - moderately effective – can we increase efficacy?
 - **We still need high quality intervention studies of psychosocial interventions in cancer**



- Dieng M et al. Economic evaluations of psychosocial interventions in cancer: a systematic review. *Psycho-Oncology*. 25(12):1380-1392, 2016
- 8 studies involving 1668 patients (4 reported cost per QALY)
- 6/8 studies reported positive cost-effectiveness for:
 - HRQOL, mood, pain, distress or FOP, compared with usual care
 - Of these 6:
 - 3 = CBT, 2 = nurse-delivered telephone f/u + education/support, 1 = group-based exercise/psychosocial intervention
 - **Quality of studies good overall; however, some studies were limited by their choice of outcome measure and omission of important categories of costs**





- **CONCLUSIONS:**
 - Psychosocial interventions, particularly **CBT**, represent good value for money in cancer care
 - **Future research should include:**
 - clear definition of the economic question
 - inclusion of all relevant costs
 - consideration of utility-based quality of life measures for QALY estimation



- Few studies, often lacking theoretical framework
- Walker J et al. Screening Medical Patients for Depression: Lessons From a National Program in Cancer Clinics. *Psychosomatics*, 2017-05-01, 58 (3), 274-280.
 - Ensure engagement of staff and patients
 - Implement efficient 2-stage screening processes
 - Effectively manage workflow and quality assurance

- Geerlig E et al, The value of real-world testing: lessons learned from pilot implementation of a clinical pathway for the management of anxiety and depression in patients with cancer. Under review.
- Issues influencing uptake:
 - **evidence** (staff perceptions)
 - **context** (culture and external influences)
 - **facilitation** (intervention fit, familiarisation, engagement and burden)

- **We have:**
 - demonstrated psychosocial suffering and needs
 - produced evidence (albeit still weak) of intervention effectiveness
 - Started to explore translation into routine care

- **BUT:**
 - We need more, better conducted RCTs, demonstrating cost-efficacy, and a focus on translating evidence into practice



- **Define distress/adjustment disorder:** protocolize interventions
- **Investigate communication with rigor:** document pathways
- **Do better intervention trials:** Hi quality RCTs
 - Use active controls
 - Theory-based, empirically based interventions
 - Assess fidelity, moderators, mediators and cost
 - Have front-line staff as therapists to increase sustainability
 - PoCoG Conquer Fear: 24 local psychologists delivered intervention – still using
 - Conduct real-world trials and assess strategy efficacy

