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Advances in Psychotherapy –
Evidence-Based Practice

Psychological Approaches to Cancer Care

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Contents

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Description

Many people think of cancer as a single disease, with multiple possible sites of impact. In truth, cancer is a family of disorders with varying degrees of severity, prognosis, life disruption, impact on appearance, etc. There are other common misunderstandings, or myths, about cancer and its treatment. These are reviewed in Appendix 1. Treatment can be acute and time-limited, or it can be chronic and lifelong. The length of survivorship after a cancer diagnosis is widely variable, including some patients who will live with the disease and some who will be cured. Of course, the impact of cancer on any individual's mental health and quality of life is also greatly variable. There is also growing recognition of the impact of a cancer diagnosis on the family caregivers of the person with the diagnosis.

Although cancer rates are declining year by year, cancer is still the second leading cause of death in the United States

While cancer remains the second leading cause of death in the US, the death rate associated with cancer dropped every year between 1999 and 2019 (Centers for Disease Control and Prevention (CDC), 2021). This is generally attributed to decreases in cigarette smoking, increased utilization of cancer screening tests, and advances in cancer treatment. As death rates have dropped, there are increasing numbers of cancer survivors and longer periods of survivorship.

Psycho-oncology is a subspecialty of oncology, focused on the psychosocial impact of cancer on patients and their families

Psycho-oncology is a subspecialty in oncology, focused on the psychosocial impact of cancer on patients at all stages of the disease, on their families, as well as on individuals determined to be at increased risk for cancer. Psychosocial care in oncology is most typically provided by psychologists, social workers, nurses, and physicians, but it can also be provided by chaplains, patient navigators, and counselors (Deshields et al., 2013). For the psychosocial clinician, it can be difficult to learn the "language" of cancer care. Basic cancer terms are defined in Appendix 2.

While psycho-oncology clinicians often address psychiatric disorders, they also have occasion to provide care for those suffering from cancer with subclinical coping difficulties. Some appropriate targets for intervention may not rise to the level of a disorder, such as questions about how to communicate about the cancer diagnosis at work or with children, or dealing with hair loss, or concerns about sexuality after cancer treatment. We provide strategies that can be used in the context of clinical disorders or the context of coping challenges. Some clinicians may be working in settings where there is no concern about billing, but in those settings where billing is a concern, health and behavior codes may be appropriate for patients without a psychiatric diagnosis. Some patients may be willing to self-pay for psychosocial services.

1.1 Common Psychiatric Diagnoses in the Context of Cancer

1.1.1 Major Depression

The prevalence of major depression in the oncology population is estimated to be up to 24%

The prevalence of major depression in the oncology population is estimated to range up to 24% (Krebber et al., 2014). There can be overlap among the vegetative symptoms of depression (change in appetite, weight gain or loss, anergia, and change in sleep whether insomnia or excessive sleep) and symptoms of cancer or side effects of treatment. There can also be overlap among the cognitive/emotional symptoms of depression (feelings of guilt, concentration difficulties, thoughts of death) and reactions to cancer or to cancer treatment. Because anhedonia is one of the diagnostic criteria for depression and is not a side effect of cancer treatment, it may help the clinician to distinguish major depression from a general reaction to cancer.

1.1.2 Adjustment Disorder

Adjustment disorder may be present in up to 19% of patients with cancer

Adjustment Disorder may be present in up to 19% of patients in this population (van Beek et al., 2019). Adjustment Disorder is most commonly further defined by “with depression,” “with anxiety,” or “with mixed anxiety and depression.” While Adjustment Disorder may be hard to distinguish from distress (described below), the diagnosis requires impairment in functioning.

1.1.3 Anxiety Disorders

The prevalence of anxiety disorders in patients with cancer is 11%

The prevalence of anxiety disorders in patients with cancer is estimated to be around 11% (Mehnert et al., 2014). Several types of anxiety disorders are more likely to be problematic in the cancer setting.

Generalized Anxiety Disorder (GAD)

GAD is characterized by persistent and pervasive worry. There is much to worry about in the cancer setting, including upcoming scans, the efficacy of treatment, the possibility of recurrence or progression of the disease, and the probability of death. Learning how to manage anxiety/worry is an important skill for those diagnosed with cancer and is addressed later.

Obsessive-Compulsive Disorder

In the cancer setting, obsessive concern about exposure to germs can become an issue, particularly for immunocompromised patients. Compulsive self-examination for the presence or progression of tumors can lead to irritation of relevant parts of the body, and the resulting swelling or tenderness can increase anxiety.

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Theories and Models

Psycho-oncology is a relatively young field. Dr. Jimmie Holland, the founding mother of psycho-oncology, established the first psychiatry clinical service in a cancer center, at Memorial Sloan-Kettering, in 1977. She was also involved in the founding of the International Psycho-Oncology Society in 1984 and the American Psychosocial Oncology Society in 1986. She published the first textbook *Psycho-Oncology* in 1989 and established the first journal devoted to the topic in 1992. Dr. Holland led the inaugural Distress Management Panel of the National Comprehensive Cancer Network in 1997; and this panel produced the first distress management guidelines in 1999. While relatively young, the field of psycho-oncology builds on traditions established in the fields of health psychology/behavioral medicine and consultation–liaison psychiatry.

2.1 Biopsychosocial Model of Cancer

Prior to the 1970s, many physicians avoided informing patients of their cancer diagnoses.

Discourse on cancer care has long incorporated psychological factors. Beginning in the 1800s and extending into the early 20th century, the psychology of cancer largely centered on issues of fear, guilt, and shame, owing to a combination of stigmatization and fatalism (Fabrega, 1990). Cancer and the associated symptoms – both physical and emotional – were typically not discussed with patients to avoid contributing to a pervasive sense of hopelessness. Psychological dysfunction was viewed only as a consequence of cancer, rather than a factor impacting clinical course and care. For example, a survey of physicians published in 1961 indicated that only 10% would tell their patients about a terminal cancer diagnosis (Oken, 1961). Overwhelming fatalism about a cancer diagnosis relegated care of cancer patients to religious groups, and providers and family members were discouraged from disclosing a cancer diagnosis to affected patients to maintain hope and minimize emotional distress (Holland, 2010). The survey about communication preferences was repeated in 1977, and a major cultural shift was highlighted, with 97% of physicians at that time favoring telling a patient about their cancer diagnosis. The dramatic reversal was thought to be attributable to updates in medical school and hospital training, more clinical experience with cancer, improvements in cancer treatments, an increase in public awareness, and more personal experiences with cancer (Novack et al., 1979). The patient rights movement of the 1970s also helped to spur this change (Annas, 2017).

2.2 Models of Cancer-Related Distress

Distress exists on a continuum from common feelings of sadness and fear to depression, anxiety, social isolation, and existential/spiritual crisis

Distress in the cancer setting extends along a continuum, ranging from common, normal feelings of vulnerability, sadness, and fear to problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis. In the Distress Management Guidelines, the NCCN (2021) also describes distress as arising from a combination of patient-level characteristics and periods of increased vulnerability (see Table 1).

The following sections offer an overview of models for the development of cancer-related distress.

Table 1
Risk Factors for Distress and Periods of Increased Vulnerability Contribute to the Development of Cancer-Related Distress

Risk factors for distress	Periods of increased vulnerability
• History of psychiatric disorder or SUD • History of depression/suicide attempt • Cognitive impairment • Communication barriers • Severe comorbid illness • Social issues: – Family/caregiver conflicts – Inadequate social support – Living alone – Financial problems – Limited access to medical care – Young or dependent children – Younger age – History of abuse • Spiritual/religious concerns • Uncontrolled symptoms • Cancer type associated with risk of depression • Diagnostic delay • Higher levels of preoperative anxiety and postoperative pain • Difficulty tolerating uncertainty	• Finding a suspicious symptom • During diagnostic workup • Finding out the diagnosis • Learning about genetic/familial cancer risk • Awaiting treatment • Change in treatment modality • Significant treatment-related complications • End of treatment • Admission to/discharge from hospital • Transition to survivorship • Surveillance • Treatment failure • Recurrence/progression • Advanced cancer • End of life

Adapted from National Comprehensive Cancer Network (NCCN), 2021.

2.2.1 Cancer-Related Distress as an Adjustment Disorder

Cancer-related distress has been conceptualized as an adjustment disorder

Li et al. (2010) offer a model of cancer-related distress as adjustment-related challenges which exist on a continuum from a normal stress response to an adjustment disorder. Consistent with the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association (APA), 2013) definition

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Diagnosis and Treatment Indications

3.1 Distress in Cancer

Distress is associated with reduced adherence to treatment, increased frequency of medical encounters (acute care, emergency room, office visits), increased length of hospital stays, poorer QoL, and reduced survival (NCCN, 2021). The etiology of distress in cancer is multifactorial and related to the significant life changes associated with a serious illness. Many patients experience changes to employment causing financial, familial, and housing distress. Other patients experience significant physical complications of their disease as well as side effects and long-term sequelae of cancer treatment. These symptoms can occur at any time during the cancer continuum, including upon diagnosis, during the planning and initiation of cancer treatment, during adjustments to the treatment plan, and during remission and survivorship.

The CoC accreditation standard is very general and leaves much room for institutional decision-making about screening. The American Psychosocial Oncology Society (APOS), the Association of Oncology Social Workers (AOSW), and the Oncology Nursing Society (ONS) published a joint consensus on guidelines for distress screening and distress management (Pirl et al., 2014). The consensus statement included these recommendations:

1. A universal definition of distress among CoC-accredited programs. The organizations favored the NCCN definition of distress.
2. Validated instruments for distress screening, using published threshold values and ranges.
3. Screening instruments that are broadly focused rather than unidimensional.
4. Repeated screening versus one-time only.
5. Timely review of screening results.
6. For positive screens, identification of the cause of distress and triage to an appropriate clinician.

Several tools can be utilized for distress screening. The NCCN Distress Thermometer (DT) and Problem List (PL) (NCCN, 2021) is the most widely used brief general screening tool. The most common cutoff score for a positive screen is a score of 4 or more on the DT; the PL can provide additional information about contributors to a patient's distress, but a more detailed assessment may be needed to triage a patient to relevant resources. One example of a comprehensive distress screener is the Coleman Foundation Supportive Care Screening Tool. Other potential screening tools are mentioned below. Once distress has been identified, a variety of psychosocial interventions has proved efficacious in relieving distress and improving QoL.

plete cessation of the relevant substance. Yet, the patient may have their own preferences about their current use and may not completely agree with recommendations to limit or stop use. In these instances, motivational interviewing is an evidence-based approach to evaluate the patient's interest in addressing the problem and to promote the consideration of behavior change (Smedslund et al. 2011).

3.8 Vulnerable Populations

Lower socioeconomic status has been associated with higher rates of distress primarily driven by financial distress (Meeker et al., 2016). Financial difficulties is often exacerbated because of limitations on a patient's ability to work while going through treatment. Many individuals do not have eligibility for short or long-term disability benefits through their employer; therefore, the inability to work can drastically reduce income, causing problems with housing, utilities, food, and transportation.

Lower socioeconomic status, rural setting, and pre-existing psychiatric diagnosis contribute to health disparities

Patients with cancer living in rural settings have greater disparities in the incidence of cancer, and in access to cancer diagnostics and cancer treatment, all of which likely explain poorer rates of survival (Atkins et al., 2017; Paskett et al., 2020). These disparities can arise because of a lack of access to the healthcare system or greater distance of travel to obtain subspecialty screening and treatment. Providing distress assessment and psychosocial treatments via telehealth (including telephone-based services) can reduce barriers to needed support. Telehealth became more widely available with the COVID-19 pandemic.

Historically, patients with pre-existing psychiatric diagnoses have had worse cancer outcomes

Individuals with pre-existing psychiatric diagnoses have worse overall survival and worse prognosis in the context of cancer, due in part to their decreased likelihood of getting timely cancer care consistent with established clinical guidelines (Kisely et al., 2013; Paredes et al., 2021). In fact, those diagnosed with schizophrenia have increased mortality from breast, colorectal, and lung cancer (Kisely et al., 2013). The intake interview should include questions about history of mental-health diagnoses or active mental-health symptoms. When possible, patients with such a history can be referred to specialty care. Some settings may present scant resources for mental-health treatment, in which case distress screening proves less useful; however, with increasing awareness of the problems that patients with cancer face, more resources are becoming available.

Adolescents and Young Adults (AYAs)

AYAs are confronted with unique issues because of their developmental stage and their extended cancer survivorship

The psychosocial needs of AYAs are often fundamentally different from those of older patients and pediatric patients. The combination of typical developmental transitions in early adulthood and the physical and emotional impact of cancer can place AYAs at heightened risk for cancer-related distress. In particular, processes of separation/individuation can be disrupted in families dealing with cancer in an adolescent or young adult. AYA patients can also experience significantly longer periods of survivorship than other groups, again pointing to the need for psychosocial support and intervention across the utilization of medical services (Kisely et al., 2013; Paredes et al., 2021). Collaborative care has been shown to improve each of these outcomes while reducing the wait time for access to mental-health treatment.

4.2 Effectiveness of Treatments

4.2.1 Psychosocial Interventions

A recent review of online interventions for individuals who had completed treatment for cancer demonstrated that CBT was the most common intervention utilized (Willems et al., 2020). CBT interventions were beneficial in terms of decreased fear of cancer recurrence, decreased insomnia, improved sleep quality, and decreased memory difficulties. Online interventions were determined to be accessible and acceptable to cancer survivors.

In a meta-analysis of mindfulness interventions with cancer patients, evidence was found for improvements in QoL, anxiety, depression, and some physical symptoms (fatigue, sleep) (Haller at al., 2017). In another review of studies with cancer patients, use of acceptance and commitment therapy was found to be associated with better mood and QoL (González-Fernández & Fernández-Rodríguez, 2019). Finally, in a review of interventions with colorectal cancer patients, emotional expression, progressive muscle relaxation training, and interventions focused on self-efficacy demonstrated a significant positive impact on mental health (Mosher et al., 2017).

A recent review of psychosocial interventions for patients with advanced cancer included these interventions: CBT, meaning-centered therapy, dignity therapy, supportive counseling, psychoeducation, and integrative therapies (e.g., music, writing) (Teo et al., 2019). CBT was determined to benefit QoL, relevant symptoms (pain, fatigue, shortness of breath), and self-efficacy. Meaning-centered therapies were also found to be effective, with benefits in QoL and spiritual well-being. Dignity therapy was found to be effective in terms of decreased distress.

4.2.2 Psychotropic Medications

With all psychiatric medications, the goal of treatment is full remission of symptoms. Not all patients, however, achieve full remission, therefore ongoing assessment and management are required.

Effectiveness of Antidepressants for Depression

In the general population, antidepressants significantly improve depressive symptoms of major depressive disorder compared to placebo as early as 4 weeks after treatment initiation (Cipriani et al., 2011). Treatment response rates to a single antidepressant (measured as a 50% reduction in depressive symptoms on validated scales) are estimated to be as high as 60% by 12 weeks compared to a 41% response rate for placebo (Cipriani et al.). When a patient has a clinical response to an antidepressant, they demonstrate a reduction in

Antidepressants are effective in reducing overall severity of depression symptoms

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Appendix: Tools and Resources

The materials reproduced on the following pages can also be downloaded free of charge from the Hogrefe website after registration.

Appendix 1: ASCO Answers: Myths & Facts About Cancer
Appendix 2: Basic Cancer Terms
Appendix 3: NCCN Distress Thermometer and Problem List
Appendix 4: Patient Screening Questions for Supportive Care

Appendix 1: ASCO Answers: Myths & Facts About Cancer

There is a lot of information about cancer available, but some of it is misleading or wrong. Here are the facts behind some of the most common cancer myths and misconceptions. Your health care team is also a good resource if you have any questions about the accuracy of anything you hear or read.

MYTH: Cancer is contagious.

FACT: Cancer is not contagious. However, some cancers are caused by viruses and bacteria that can be spread from person to person. Certain types of the human papillomavirus (HPV) have been known to cause cervical, anal, and some kinds of head and neck cancers. Hepatitis B and hepatitis C are viruses that increase the risk of developing liver cancer. Bacteria like H. pylori can cause stomach cancer. It is important to remember that while the viruses and bacteria that cause some cancers can be spread from person to person, the cancers they cause cannot be spread from person to person.

MYTH: If you have a family history of cancer, you will get it too.

FACT: Although having a family history of cancer increases your risk of developing the disease, it is not a complete prediction of your future health. An estimated 4 out of 10 cancers can be prevented by making simple lifestyle changes, such as forming healthy eating habits, maintaining a healthy weight, exercising, limiting alcoholic beverages, practicing sun safety, and avoiding tobacco products. If you have inherited certain cancer genes that put you at high risk for cancer, your doctor may recommend surgery or medications to reduce the chance that cancer will develop.

MYTH: Cancer thrives on sugar.

FACT: There is no conclusive evidence that proves eating sugar will make cancer grow and spread more quickly. All cells in the body, both healthy cells and cancer cells, depend on sugar to grow and function. However, there is no proof that eating sugar will speed up the growth of cancer or that cutting out sugar completely will slow down its growth. This doesn't mean you should eat a high-sugar diet, though. Consuming too many calories from sugar has been linked to weight gain, obesity, and diabetes, which increase the risk of developing cancer and other health problems.

MYTH: Cancer treatment is usually worse than the disease.

FACT: Although cancer treatments, such as chemotherapy and radiation therapy, can cause unpleasant and sometimes serious side effects, recent advances have resulted in many drugs and radiation treatments that have more manageable side effects. As a result, symptoms like severe nausea and vomiting, hair loss, and tissue damage are much less common. However, managing side effects, also called supportive care or palliative care, remains an important part of cancer care. Supportive care can help a person feel more comfortable at any stage of illness. People who receive treatment for cancer and treatment to ease side effects at the same time often have less severe symptoms, better quality of life, and report that they are more satisfied with treatment.

MYTH: It is easier to remain unaware you have cancer.

FACT: You should not ignore the symptoms or signs of cancer, such as a breast lump or an abnormal-looking mole. Although the thought of having cancer is frightening, talking with your doctor and getting a diagnosis will give you the power to make informed choices and seek the best possible care. Because treatment is usually more effective during the early stages of cancer, an early diagnosis often improves a person's chance of survival.

MYTH: My attitude will have an effect on my cancer.

FACT: There is no scientific evidence that a positive attitude will prevent cancer, help people with cancer live longer, or keep cancer from coming back. However, things that promote positive thinking, such as relaxation techniques, support groups, and a support network of family and friends, may improve a person's quality of life and outlook. It is important to remember that placing such an importance on attitude may lead to unnecessary guilt and disappointment if, for reasons beyond your control, your health does not improve.