

Psychosocial Care for Cancer Patients—Too Little, Too Late?

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Abstract

Assessment of psychosocial and psychiatric needs is an increasingly important component of cancer care. Clinical experience with patients indicate that distress, anxiety and depression are prevalent from early stages of the illness. Strategies to enhance psychosocial care are presented and these include early identification through screening, training for healthcare staff working with cancer patients and support not only for patients but their caregivers as well.

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Cancer significantly impacts patients, families, the health system and society. Its incidence has grown steadily (9417 cases in 2006 to 11,069 cases in 2010) and it contributes to the second highest condition of hospitalisation (5.8%) in Singapore.¹ Twenty-eight people in Singapore are diagnosed with cancer each day.²

Cancer treatment has advanced significantly and mortality rates have reduced.² Some patients can expect a cure and some may survive with the illness as a chronic disease. This however does not reduce the substantial physical, psychological and social disability associated with the disease. Patients with cancer have a high incidence of emotional problems and psychiatric comorbidity. One study reported that 47% of cancer patients who suffered distress qualified for primary psychiatric disorders of anxiety and depression.³ The provision of psychosocial care however has not developed in tandem with the tremendous medical advances in cancer treatment.

While the epidemiology of cancer is closely tracked, we know little about the psychological issues and psychiatric sequelae amongst local cancer patients and survivors. Early work by Kua found that depressive illnesses accounted for 90% of psychiatric complications in breast cancer patients referred to the Department of Psychological Medicine, National University Hospital.⁴ More recent work on psychosocial needs of cancer patients at the National Cancer Centre Singapore found that 75% (n = 535) reported unmet needs, with the highest prevalence for disease information needs (61.5%) followed by financial (40.2%), social support (39.7%), psychological (27.3%) and physical (26.1%) needs.⁵

Under a Ministry of Health Quality Improvement and Innovation Fund Project (HQIIF), new patients (n = 99) at the Haematology Oncology Clinic of the National University Cancer Institute Singapore (NCIS) reported distress levels of 3.31 ($\pm$ 2.891) where 4 and above on the distress

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thermometer is the threshold for clinical suspicion.⁶ Anxiety and depression assessed using the ‘5 emotion’ thermometer ($n = 48$) was $3.31 (\pm 2.96)$ and $2.46 (\pm 2.54)$ respectively. On the hospital anxiety depression scale (HADS), anxiety levels were $5.01 (\pm 4.71)$ and depression was $5.05 (\pm 4.674)$. At the higher end, these levels fall within caseness for anxiety and depression. Patients’ quality of life determined using the EQ5D scale, was significantly negatively correlated with both anxiety ($P < 0.05$) and depression ($P < 0.001$; Mahendran R, Chua J, Kua EH. Emotional distress and psychiatric comorbidity in cancer patients at first consultation in a cancer center. Poster Presentation, 166th American Psychiatric Association Meeting, San Francisco, 21 May 2013). These preliminary first visit self-assessments reflect the need for early recognition and identification of concomitant psychological and psychiatric issues and the commitment of resources for psychosocial support.

Psychiatric issues related to cancers can appear at any point in the illness trajectory from the acute phase of the illness, the intermediate phase as treatment is progressing and in the long term when survivorship and having to deal with physical sequelae arise. There are also psychiatric illnesses that predate the cancer diagnosis which may be exacerbated during the course of cancer diagnosis and treatment. The ‘cancer journey’ is described as a life-cycle with different challenges in the different stages of the illness and the treatments. The acute phase is hallmarked by busy treatment schedules, dealing with side effects and fatigue, medical uncertainty and fears of disability, dependence and dying. Emotional issues complicate and impede coping. The survivorship phase involves different physical and emotional challenges such as body image issues, sexuality and fears of recurrence and social and financial matters.

The World Health Organization’s dictum that “there can be no health without mental health” led the International Federation of Psycho-Oncology Societies (IPOS) to recommend “specific investment in psychosocial oncology”.^{7,8} Clarke phrased it as “there can be no cancer health without mental health”.⁹ There is a need to develop psychosocial care for cancer patients in Singapore as an integral component in the continuum of cancer care.

Psychiatry has a role in taking an active collaborative lead in this development. Psycho-oncology as a sub-specialised area provides the avenue but unfortunately very few psychiatrists are trained in this area. Psychiatry residency training provides the opportunity for electives in psycho-oncology, a positive step in developing the interest. Secondly, the National Comprehensive Cancer Network recommends that distress is recognised as the 6th vital sign.¹⁰ Our HQUIF project supports instituting this as part of regular assessments for cancer patients.

Continuity of care from ambulatory to inpatient settings is an area that can be supported by consultation-liaison psychiatry services. A review of oncology inpatient referrals to a consultation-liaison psychiatry service over a 3-month period found that out of 11 referrals, 5 were terminally ill with 2 dying within a week; only 2 were in early stages of treatment. Six were depressed, 2 anxious and agitated, and the remaining 3 delirious (unpublished data, E Wuan, R Mahendran, Oncology referrals to a consultation-liaison psychiatry service, 2012). Addressing psychiatric and social needs at late stages is leaving psychosocial care till far too late.

Training for healthcare workers in oncology settings in recognising distress and providing patient support is another crucial step. Our research with medical oncology nurses found that their practice behaviours in caring for oncology patients changed significantly with training and that the gains in knowledge and practice was sustained over a period of time ($P < 0.001$; Tan L, Mahendran R, Chua J, Leong T, Chow YL, Ang ENK, Lim SE, Kua EH. Knowledge, attitudes and practice behaviors of psychological distress screening and management amongst oncology nurses in Singapore. Poster Presentation, 13th ASEAN Congress, AFPMH 16 to 17 November 2012). The majority of the nurses (76%) reported moderate to high levels of resilience despite the high emotional demands of their roles.

Jimmie Holland, the doyen of psycho-oncology highlights the disease, personal factors and the society and culture as factors that determine a patient’s psychological adaptation to cancer.¹¹ We add an additional factor, the family. Family members, whether parents of children with cancers, young family members with a parent or sibling with cancer or an elderly person with a child or spouse with the illness, all require support. A study with 150 family caregivers using the Caregiver Quality of Life Index-Cancer (CQOL-C) scale found lower overall levels of quality of life compared to overseas data and there were more areas of concerns amongst local families (psychological burden, life interference, caregiving trouble, financial concerns, helplessness and social support).

China, Japan, Korea and Taiwan have formed the East Asian Psycho-Oncology Network (EAPON) to collaborate in developing psychosocial oncology care in East Asian countries.¹² There is much we in Singapore can do to enhance the psychosocial aspects of cancer care.

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