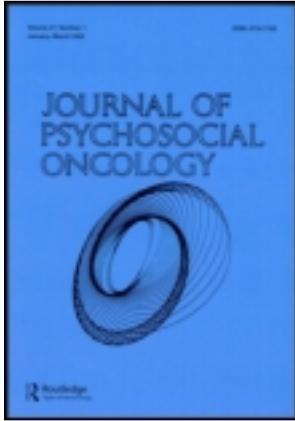


This article was downloaded by: [Bert Garssen]

On: 29 October 2011, At: 13:20

Publisher: Routledge

Informa Ltd Registered in England and Wales Registered Number: 1072954 Registered office: Mortimer House, 37-41 Mortimer Street, London W1T 3JH, UK



Journal of Psychosocial Oncology

Publication details, including instructions for authors and subscription information:

<http://www.tandfonline.com/loi/wjpo20>

Problems Addressed During Psycho-Oncological Therapy: A Pilot Study

Bert Garssen PhD^a & Marije van der Lee PhD^a

^a Helen Dowling Institute, Centre for Psycho-Oncology, Utrecht, The Netherlands

Available online: 28 Oct 2011

To cite this article: Bert Garssen PhD & Marije van der Lee PhD (2011): Problems Addressed During Psycho-Oncological Therapy: A Pilot Study, *Journal of Psychosocial Oncology*, 29:6, 657-663

To link to this article: <http://dx.doi.org/10.1080/07347332.2011.615379>

PLEASE SCROLL DOWN FOR ARTICLE

Full terms and conditions of use: <http://www.tandfonline.com/page/terms-and-conditions>

This article may be used for research, teaching, and private study purposes. Any substantial or systematic reproduction, redistribution, reselling, loan, sub-licensing, systematic supply, or distribution in any form to anyone is expressly forbidden.

The publisher does not give any warranty express or implied or make any representation that the contents will be complete or accurate or up to date. The accuracy of any instructions, formulae, and drug doses should be independently verified with primary sources. The publisher shall not be liable for any loss, actions, claims, proceedings, demand, or costs or damages whatsoever or howsoever caused arising directly or indirectly in connection with or arising out of the use of this material.

Problems Addressed During Psycho-Oncological Therapy: A Pilot Study

BERT GARSSSEN, PhD and MARIJE VAN DER LEE, PhD

Helen Dowling Institute, Centre for Psycho-Oncology, Utrecht, The Netherlands

Therapists working at the eight psycho-oncological centers in the Netherlands (N = 43) were presented a list of 15 problems often encountered during therapy with cancer patients. The therapists were asked to indicate the predominant psychological problems they had dealt with during their five most recently completed interventions. The authors received complete answers from 37 therapists (86%). Anxiety and depression were the two predominant problems most often encountered by therapists during therapy (31% and 29%, respectively). Other problems included relationship problems (23%) and saying farewell to life (21%). In about one half of the cancer patients anxiety and/or depression were not the focus during their therapy.

KEYWORDS *psychotherapy, distress, anxiety, depression, problems*

INTRODUCTION

Psychological symptoms develop often from the many demands cancer makes on the patient's resources and ability to adapt. One has to cope with the symptoms of the disease and their consequences, such as pain, fatigue, and functional impairments. One's short-term future is uncertain, and one's life has to be reorganized. Many patients fear the possibility of cancer recurrence, and for some patients the disease can be life-threatening. Returning to work is not always easy, if at all attainable. In countries with an inadequate health insurance system financial stress is in many cases unavoidable. Relationship problems often develop, particularly if the partner is unwilling or incapable of discussing cancer-related issues or emotions, or if

The authors report there are no financial conflicts of interest related to this project.

Address correspondence to Bert Garssen, PhD, Helen Dowling Institute, Centre for Psycho-Oncology, Rubenslaan 190, 3582 JJ Utrecht, The Netherlands. E-mail: bgarssen@hdi.nl

family and friends are uninterested in the patient's plight or they are uncomfortable, even negative, whenever the patient brings up his or her disease and its consequences. For those patients with few or no family or friends social isolation can also be very distressing.

There is a tendency to group these various specific symptoms under the single heading of *distress*, which would be warranted if high levels of anxiety or depression were the predominant psychological symptom experienced by the majority of cancer patients. Most studies evaluating the efficacy of psycho-oncological interventions have used distress as the main outcome variable (Jacobsen & Jim, 2008; Naaman, Radwan, Fergusson, & Johnson, 2009; Osborn, Demoncada, & Feuerstein, 2006); and the focus of screening lists, aimed to detect cancer patients who are in need for psycho-oncological care, is also often on anxiety and/or depression. However, studies that have investigated the problems and needs of cancer patients showed that other problems are considered no less important. An Australian study surveyed unmet needs among 888 cancer patients (Sanson-Fisher et al., 2000), indicating that the five needs that were most often unfulfilled were fear about the cancer spreading, fear of recurrence, family concerns, access to information on what to do to help oneself get well, and lack of energy and tiredness. The needs assessment instrument used in this Australian study was also applied in another more recent Australian study among 802 patients. The five unmet needs ranked highest included needing help with fear of cancer spreading, concerns about the worries of those close to you, uncertainty about the future, lack of energy/tiredness, and not being able to do things one used to do (Beesley et al., 2008). In a British study among 380 patients, the five emotional and spiritual needs ranked most important were hope for the future, help with any fears, help in dealing with the unpredictability of the future, time for myself, and help with finding a sense of purpose and meaning (McIllmurray et al., 2001). In another British study, the five most prominent symptoms among 480 patients were feeling weak/tired/lacking energy, worries or concerns about the future, not being able to do the things one usually does, feeling tense/worried/fearful, and pain (Lidstone et al., 2003). In an American study among 2,071 cancer patients, the top five problems were fatigue, sleeping problems, financial problems, pain and controlling one's fear, and worry about the future (Loscalzo & Clark, 2007). These findings show that cancer patients consider specific problems at least as important as anxiety or depression.

The focus on anxiety and depression in screening lists and in the choice of outcome measures in evaluating psycho-oncological interventions is problematic as cancer patients frequently report other problems as their main concern. The inadequate match is illustrated by the findings of Tiller (2006). In this study, 343 new patients were screened for high distress levels at an oncology centre in Sydney, Australia, during a period of 16 months. Approximately 25% of these patients met the cutoff criterion set by the Hospital

Anxiety and Depression Scale (HADS), of which only 30% actually consulted a clinical psychologist. During the same period, 103 patients were referred to a clinical psychologist for reasons other than a sufficiently high HADS score, such as adjustment problems, flat affect, relationship problems, and hereditary cancer issues.

This study identifies the predominant psychological problems psycho-oncological therapists focus on when treating their patients. The needs assessment studies mentioned above are directed at patients who are asked about the fulfilment of their needs by a variety of medical and psychosocial care providers, whereas psychotherapists are questioned in this study. There are reasons to assume that the outcome of both types of studies will not be similar: (1) there is a difference in focus, namely between various types of care providers and psychotherapists; (2) not all patients who express a psychosocial need actually seek therapeutic help; and (3) the psychotherapist's view of what important problems are may differ from the patient's view. So, we expect that this study will provide new information. A better insight into the main psychological symptoms dealt with during psycho-oncological treatments could help to choose more relevant outcomes in effect studies.

METHOD

This study included only therapists working at independent psycho-oncological centers, not therapists affiliated with hospital departments. Therapists working at these centers represent the majority of all psycho-oncological therapists in the Netherlands. There are eight of such centers in the Netherlands, whose patients are referred by medical specialists or nurses, or who are self-referred. As only therapists were involved in this study approval by an ethical committee was not necessary.

A questionnaire was created in collaboration with three therapists, who had at least 5 years of experience in psycho-oncological therapy. They compiled a list of 15 possible psychological problems based on what they had frequently encountered during therapy. There are no established criteria for developing such a questionnaire. The collaboration with experienced therapists seemed to provide sufficient guarantee for obtaining our objective, namely to have a list that was not too long but included most problems regularly dealt with during psycho-oncological therapy.

All 43 therapists working at the eight centers were sent an e-mail with the following question: "What are the predominant psychological problems you deal with during therapy with your patient?" requesting participating therapists to answer this question for the five most recently completed treatments. So, each therapist contributed scores from five patients (scores from 185 patients in total). They were asked to indicate no more than three of the main psychological problems for each patient by checking problems in

TABLE 1 Problems that Are Predominant Among Cancer Patients Undergoing Psycho-Oncological Therapy According to the Therapists (Scores from Five Patients of Each of the 37 Therapists = Scores from 185 Patients in Total)

	Percentage
1. Anxiety	31
2. Depression	29
3. Partner relationship problems	23
4. Saying farewell to life	21
5. Processing cancer-related traumatic events	17
6. Dealing with boundaries	16
7. Returning to work/work-related problems	14
8. Fatigue	13
9. Helping children to deal with the patient's disease and the potential death of their parent	13
10. Support with getting through medical treatment	12
11. Self-acceptance	11
12. Processing loss of a partner	9
13. Processing other traumatic events	6
14. Confusion, loss of concentration	4
15. Genetic counselling	1
Depression and/or anxiety	53
Trauma-related (5, 6, and/or 8)	38

the list of 15 items. The therapist could also fill in a problem not mentioned in the list. The problems are displayed in Table 1. All these therapists had a masters' degree in psychology or medicine and had received additional therapeutic training, most often in cognitive-behavioural therapy.

Therapists who did not respond received up to two reminders. We received completed questionnaires from 37 of the 43 therapists we had approached (response rate 86%).

For each participating therapist, we tallied the number of patients for whom a specific psychological problem was indicated to be a main focus during their psycho-oncological treatment. This score was divided by 5 (as each therapist produced data for five patients) and multiplied by 100%, and then averaged for all therapists. The outcome represents the percentage of clients for whom—according to their therapists—a specific problem was the focus during therapy.

RESULTS

The frequencies of the main problems are presented in Table 1. Anxiety and depression were mentioned by therapists as predominant symptoms they had worked through with approximately 30% of their patients (31% and 29%, respectively). Other high scores were relationship problems (23%), saying farewell to life (21%), processing cancer-related traumatic events (17%),

returning to work/work-related problems (14%), and dealing with boundaries (16%).

The combination of anxiety and/or depression was a predominant symptom for 53% of the patients (53% is less than the sum of anxiety and depression, because patients who had anxiety and depression were only counted once). Obviously, a combination of categories yields a relatively high percentage. To compare, we also combined trauma-related problems—problems 5, 6, and 8—which yielded a frequency of 38% (see Table 1).

DISCUSSION

Cancer patients experience various challenging psychological symptoms, predominantly anxiety and depression. However, other specific problems that are experienced by patients at least as often include relationship problems, saying farewell to life, processing cancer-related traumatic events, returning to work/work-related problems, and dealing with boundaries. Although many cancer patients cope successfully with these problems and do not want or require support from professional care providers, there are patients who ask for professional help, often because they are incapable of coping adequately with their specific problems.

The psycho-oncological therapists we surveyed indicated that in 53% of their patients anxiety and/or depression were predominant symptoms they helped their patients cope with. The other side of the picture is that in 47% of their patients other problems were the focus during therapy. This implies that about one half of the patients would not have received professional psychological support if referral would be based on screening for anxiety, depression, or distress, whereas the patient and the therapist found it necessary and useful to work on these various specific problems. Nearly all frequently used screening instruments assess level of anxiety, depression or distress, such as the Hospital Anxiety and Depression Scale (HADS), Center for Epidemiological Studies–Depression Scale (CES-D), State-Trait Anxiety Inventory (STAI), General Health Questionnaire-12 (GHQ-12), Zung Self-Rating Depression Scale, or Beck Depression Inventory (BDI)—short form (ZSDS). Our finding also implies that using anxiety and depression questionnaires for the evaluation of therapy success would be inappropriate for about one half of the patients.

In this study, we only included therapists who were working at psycho-oncological centers. However, there is no reason to suspect that therapists affiliated with hospital departments treat patients with other types of problems. Another weakness is that there are no data from other studies available with which to compare our data. Our findings are based on responses from 37 psycho-oncological therapists, which may seem a few, but these 37 therapists represent the majority of all psycho-oncological therapists in the Netherlands.

They presented their opinions on important themes in psycho-oncological therapy based on their recent experiences with 185 patients in total. A limitation of this study is the use of a nonvalidated questionnaire. The choice of the 15 types of problems and the wording of the 15 items were based on the input of several experienced psycho-oncological therapists. However, we do not know to what extent the therapists' scores correspond to what independent observers would have rated as important therapy themes.

The finding of this study that in approximately one half of the patients psycho-oncological treatment was targeted at specific problems other than anxiety or depression adds to the doubts about the usefulness of screening for psychological problems in its present form (Garssen & Kok, 2008). However, whether one considers this finding as a problem depends on one's preference for what we will label here as the medical or the therapeutical model. In the medical model a disorder, such as an anxiety or mood disorder, should be diagnosed before it is considered useful and appropriate to start psychotherapeutical activities. In this model the application of a screening tool focusing on depression and/or anxiety fits well as a first step toward a psychiatric diagnosis and possible psychotherapeutical support. In this model, psycho-oncological therapy for problems unrelated to anxiety and/or depression can only be considered as inappropriate. The therapeutical model implies that patients with a wish to be helped with any psychological problem should be helped, assuming that a problem analysis during intake indicates—to the patient and the therapist—that working on this problem is useful. In this model, screening for anxiety and depression is not considered very efficient. In view of unfulfilled needs for psychological support among cancer patients, more benefit is to be expected from promoting broader familiarity of psycho-oncological support facilities among patients, nurses and medical doctors.

Many studies that have evaluated the efficacy of psycho-oncological interventions focused on anxiety and depression (Jacobsen & Jim, 2008; Naaman et al., 2009; Osborn et al., 2006), and some studies included only cancer patients scoring high on distress. This design is suitable in some scientific aspects but does not represent clinical practice. Researchers who want to evaluate the effectiveness of the regular professional psycho-oncological care should include more outcome measures than anxiety and depression among their instruments and preferably choose for each patient the outcome measure that corresponds to his or her main problem.

REFERENCES

- Beesley, V., Eakin, E., Steginga, S., Aitken, J., Dunn, J., & Battistutta, D. (2008). Unmet needs of gynaecological cancer survivors: Implications for developing community support services. *Psycho-Oncology*, *17*, 392–400.

- Garsen, B., & Kok, E. d. (2008). How useful is a screening instrument. *Psycho-Oncology*, *17*, 726–728.
- Jacobsen, P. B., & Jim, H. S. (2008). Psychosocial interventions for anxiety and depression in adult cancer patients: Achievements and challenges. *CA-A Cancer Journal for Clinicians*, *58*, 214–230.
- Lidstone, V., Butters, E., Seed, P. T., Sinnott, C., Beynon, T., & Richards, M. (2003). Symptoms and concerns amongst cancer outpatients: Identifying the need for specialist palliative care. *Palliative Medicine*, *17*, 588–595.
- Loscalzo, M. J., & Clark, K. L. (2007). Problem-related distress in cancer patients drives requests for help: A prospective study. *Oncology-New York*, *21*, 1133–1138.
- McIlmurray, M. B., Thomas, C., Francis, B., Morris, S., Soothill, K., & Al Hamad, A. (2001). The psychosocial needs of cancer patients: Findings from an observational study. *European Journal of Cancer Care*, *10*, 261–269.
- Naaman, S., Radwan, K., Fergusson, D., & Johnson, S. (2009). Status of psychological trials in breast cancer patients: A report of three meta-analyses. *Psychiatry - Interpersonal and Biological Processes*, *72*, 50–69.
- Osborn, R. L., Demoncada, A. C., & Feuerstein, M. (2006). Psychosocial interventions for depression, anxiety, and quality of life in cancer survivors: Meta-analyses. *International Journal of Psychiatry in Medicine*, *36*, 13–34.
- Sanson-Fisher, R., Girgis, A., Boyes, A., Bonevski, B., Burton, L., & Cook, P. (2000). The unmet supportive care needs of patients with cancer. *Cancer*, *88*, 226–237.
- Tiller, K. (2006). Psychological screening and referral: A snapshot of a medical oncology department. *Psycho-Oncology*, *15*, S430–S431.