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Editorial Comment

Managing psychological morbidity in cancer patients

P. Maguire *

CRC Psychological Medicine Group, Stanley House, Christie NHS Trust, Wilmslow Road (off Cotton Lane), Withington, Manchester M20 4BX, UK

For over 20 years it has been known that the diagnosis and treatment of cancer in adults is associated with a substantial psychological and social morbidity [1]. Up to a third of patients will develop a major depressive disorder, generalised anxiety disorder or adjustment disorder. This represents an increased relative risk of three times the prevalence of affective disorders in a general population. Body image problems occur in up to 25% of patients whose treatment involves the loss of an important body part or function. Commonly, such patients will present complaining that they are feeling less than whole, increasingly self-conscious, and/or experiencing a loss of femininity or masculinity. Sexual difficulties are also found more commonly in cancer patients [2]. As many as 10% of cancer patients suffer from organic confusional states. Given these data one would have thought that progress would have been made in trying to reduce the prevalence of this psychological morbidity. Unfortunately, this is not the case. For example, Zabora and colleagues [3] found that 35% of a sample of 386 adult cancer patients selected at random from 12 oncology departments across the US obtained scores on the Brief Symptom Inventory consistent with their having developed a psychiatric disorder.

The paper by Grassi and coworkers [4] in this issue of the journal (pp. 579–585) is, therefore, very relevant since it determined how many cancer patients are referred to a consultation liaison psychiatry service. They conducted a multicentre investigation in 17 general hospitals in Italy. All psychiatric consultation requests for cancer patients referred to these services during a 1-year period were evaluated. They found that only a small proportion of patients with psychological morbidity were referred to these services and an even smaller number were offered any follow-up thereafter by the liaison service. Over one third of patients so referred were not informed that they had been referred to a psychiatric service. Thus, it must be concluded that only a minority of cancer patients who develop psychological morbidity are offered appropriate help and there is still a reluctance to be honest about such referral.

It might be hoped that such patients would recover spontaneously from their psychiatric disorder, but it has been established that few do so because the problems that provoke the onset of their disorder and maintain it (for example, worries about recurrence and the nature of the treatment offered) remain unresolved. It is important to consider, therefore, why so few cancer patients are offered appropriate psychological help.

Since the 1970s it has been evident that health professionals involved in cancer care are able to recognise less than half of those patients who need help. For example, Hardman and colleagues [5] assessed the prevalence of psychiatric morbidity in 126 medical oncology patients using the Standardised Psychiatric Interview. Doctors and nurses looking after these patients were then asked to make a judgement about whether they thought these patients had any clinical anxiety and/or depression. Less than half of those patients with a depressive disorder were detected by the medical or nursing staff. While anxiety was diagnosed correctly in 79% of patients this was only achieved at the cost of labelling 40% of patients who were normal as morbidly anxious. More recently, oncologists working in out-patient clinics [6] showed a poor ability to recognise which of their patients were highly distressed. Both patients and healthcare professionals are responsible for this low recognition of psychological morbidity.

Patients are reluctant to be honest about any psychological problems they have developed because they believe they are an inevitable consequence of diagnosis and treatment and believe that nothing can be done to resolve them. Moreover, they do not want to burden health professionals who they have come to like and respect or distract them from the key task of ensuring their physical survival. They worry that if they admit they are not coping they might be considered pathetic, inadequate and neurotic. Their belief that it is not

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* Tel.: +44 (0)161-446-3680; fax: +44 (0)161-448-1655.
E-mail address: mdbpsgpm@man.ac.uk (P. Maguire).

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appropriate to disclose any emotional problems is reinforced by their perceptions that few doctors and nurses involved in cancer care ask about the impact of diagnosis, illness and treatment on their mood state and daily lives, or respond appropriately to relevant questions and cues. Objective scrutiny of consultations has confirmed that they tend to be doctor-led, focused on physical issues and ignore psychosocial aspects.

Doctors and nurses admit readily that they are reluctant to enquire about the psychological impact of the diagnosis and treatment of cancer. They fear it might cause more harm than good and create psychological problems. They worry that they may not be able to deal with any problems that they elicit and that it may take so much time that they cannot cope with their work load. They worry that they might get too close to patient's suffering and identify with them. All this could jeopardise their personal survival. Such concern is realistic when it is remembered that Ramirez and colleagues [7] found that the level of 'burnout' in British cancer specialists was very high in at least 25% of those surveyed. So, doctors and nurses use interviewing strategies designed to keep the interview in neutral emotionally instead of asking more appropriate questions about a patient's psychological adaptation or lack of it. The use of these distancing tactics has been found to be common in both doctors and nurses [8,9]. For example, experienced cancer nurses used distancing in over half of their utterances when assessing cancer patients' problems. Progress in improving psychological care will only be made when doctors and nurses relinquish these distancing tactics and acquire the behaviours known to promote disclosure.

Doctors and nurses involved in cancer care need to be trained to recognise those patients and partners that need referral to a consultation psychiatric liaison service and distinguish them from those who would benefit from support and counselling by specialist nurses. Consultation psychiatric liaison services should only be expected to deal with patients who have developed actual morbidity or assess those patients where the referrer is uncertain as to whether true morbidity exists.

If consultation psychiatric liaison services are to be effective they must be able to respond promptly to requests for referral. They can only do this if they are staffed adequately. Unfortunately, there are few such centres attached to cancer hospitals and few general hospitals have psychiatrists specialising in cancer care. Currently, if the disorders of all patients who needed referral were recognised there would be no way that liaison psychiatric services could cope. Nor, it is likely that general psychiatric services would do so. They have moved out into the community and away from general and cancer hospitals. There are so many demands on their resources that they have to restrict their interest to severely mentally ill patients suffering from psychoses. Their threshold for referral and admission is, therefore, so high that they would be unable to take on cancer patients and partners with psychological and psychiatric morbidity. What alternatives are available?

General practitioners (GPs) ought to be able to deal with the affective disorders that develop in cancer patients by the use of appropriate antidepressant medication in therapeutic levels and counselling. Patients would only need to be referred to psychiatric consultation liaison services if they failed to respond to this first line treatment. Oncologists should also be able to learn to manage simple affective disorders and refer on only those cases that are more complicated. How achievable is this in practice?

A recent project conducted in Hampshire in the UK was designed to train GPs to recognise and manage depression [10]. 26 out of 55 practice teams were given 4 hours teaching followed by material tailored to their needs. It was well enough designed to be confident of the results. There was no increase in the ability of the GPs to recognise depression or in the patient recovery rates. In contrast, a more intensive approach involving small group learning showed that an improvement in recognition and treatment of depression could be achieved [11]. Further research is needed to develop and evaluate optimal training methods that will allow GPs, oncologists and specialist nurses to become more able to recognise and deal with affective disorders in cancer patients and determine which cases are complicated enough to refer on to a consultation psychiatric service.

Experience in my own cancer hospital, in working with cancer specialists and specialist nurses has shown that many of them are willing to offer first line treatment to patients who develop affective disorders. Only when they fail to respond to initial antidepressant medication are patients referred for further assessment. They are also more able to recognise patients with body image problems, sexual difficulties and confusional states that need psychiatric help. However, it cannot be assumed that specialist nurses in general have the necessary assessment skills to recognise those patients who need more intensive psychological help. Many specialist nurses are still appointed without much training in assessment and communication skills. It would also be unwise to leave psychological care to specialist nurses since they could not be expected to cope with all the patients who need psychological assessment. It will be necessary to train ward nurses in assessment skills so that the chances of any patient with psychological morbidity being recognised will be maximised and the burden of psychological assessment shared.

The way forward, therefore, is to train all health professionals involved in cancer care in basic communication and assessment skills to maximise the chances of anybody who develops psychiatric and psychological morbidity being recognised. Guidelines should then be provided about the optimal pathways of care whether it is the GP, oncologist, specialist nurse or psychiatrist. This will require additional resources at a time when it is recognised already, particularly in Britain, that resources needed for treatment of the disease itself are inadequate. Over 20 years ago it was found that training specialist nurses to recognise and refer patients who developed psychiatric problems after mastectomy led to effective psychiatric treatment and a substantial reduction in psychological morbidity [12]. But, this relied on extra training inputs and a backup psychiatric service. The paper by Grassi and colleagues is especially important since it draws our attention to continuing deficiencies in the psychological and psychiatric care of cancer patients and their partners. This problem clearly needs urgent attention.

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