



Psychosocial problems secondary to cancer: an Italian multicentre survey of consultation-liaison psychiatry in oncology

L. Grassi^{a,*}, P. Gritti^b, M. Rigatelli^c, C. Gala^d
for the Italian Consultation-Liaison Group

^a*Dipartimento Discipline Comunicazione e Comportamento, Sezione di Psichiatria, Università di Ferrara, Corso Giovecca 203, 44100 Ferrara, Italy*

^b*Dipartimento Assistenziale di Psichiatria, Unità Operativa di Igiene Mentale, II Università di Napoli, Largo Madonna delle Grazie, 80138 Napoli, Italy*

^c*Dipartimento Patologie Neuropsicosensoriali, Sezione di Psichiatria, Università di Modena, Via Pozzo 1, 41100 Modena, Italy*

^d*Servizio di Psicologia Clinica, IRCSS, Ospedale Maggiore, Via Sforza 35, 20122 Milan, Italy*

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Abstract

Data relative to consultation-liaison psychiatry (C-L) in oncology are lacking. In order to examine this area, a multicentre investigation was conducted in 17 general hospitals in Italy. All psychiatric consultation requests for cancer patients referred to C-L during a 1-year period were evaluated. Only 5% ($n=217$ referred patients: 114 men and 103 women) of all C-L activity were for cancer patients. Most were 'routine' consultations (72%) for current psychiatric symptoms (69%) or coping/compliance problems (12%). Previous psychological or psychiatric disorders were shown in 32% of cases. Approximately 40% of patients were not informed of their referral to C-L. The most frequent ICD-10 psychiatric diagnoses were adjustment disorders (27%) and major affective disorders (23%). Transfer to psychiatric units was low (1%). These findings indicate the need for improvement of referral criteria to C-L and closer attention to continuity of psychosocial care of cancer patients during hospitalisation and post-discharge. © 2000 Elsevier Science Ltd. All rights reserved.

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1. Introduction

Although it is well recognised that the diagnosis of cancer and the subsequent treatment are an important source of stress and emotional burden for the patients, it is only in the last 15 years that the specific characteristics of psychosocial problems secondary to cancer have been examined in more detail, see [1–4] for reviews in this area. Since the US PSYCOG multicentre study, which showed that approximately half of 215 newly-diagnosed cancer outpatients met the criteria for a psychiatric disorder [5], a number of other investigations carried out in several European countries, such as the UK [6,7], Italy [8,9] and Belgium [10], have confirmed that 30–40% cancer patients, in any phase of illness, have symptoms suggesting a psychiatric diagnosis.

Although psychological morbidity tends to be higher immediately after the diagnosis and to decrease over time, it has been shown that 20–30% long-term survivors of cancer continue to report psychopathological symptoms, including anxiety, post-traumatic stress and mood disorders [11–15]. Furthermore, 20% of patients without psychological problems at the time of diagnosis develop major affective disorders within the following year [16].

The prevalence of psychiatric disorders is evidently higher in patients referred by oncologists to medical psychiatry services (consultation-liaison psychiatry, C-L) for suspected psychiatric disorders. A study by Levine and colleagues [17] of a consecutive series of a 100 psychiatric consultations requested by oncologists for hospitalised cancer patients, revealed that 56% had a diagnosis of depression and 40% an organic brain disorder. By using more reliable diagnostic criteria, namely the DSM-III-R, in 98 cancer patients referred to psychiatric consultation, Razavi and colleagues [6] were able

* Corresponding author. Tel.: +39-532-236-809; fax: +39-532-212-240.

E-mail address: l.grassi@dns.unife.it (L. Grassi).

to diagnose an adjustment disorder in 46% of the cases, major depressive disorders in 26% and mental organic disorders in 10%. More recently, Kissane and coworkers [18], showed that amongst 271 cancer patients referred to C-L 24% had a diagnosis of mood disorders, 16% of adjustment disorders and 10% organic disorders.

The importance of appropriate referral of cancer patients to C-L services is determined by the remarkable consequences of psychiatric disorders secondary to cancer at both the patient and the family levels. It has been demonstrated that cancer patients with psychiatric comorbidity present a reduced quality of life [19], a higher prevalence of pain [5,20], abnormal illness behaviour and problems in interpersonal relationships, including doctor–patient relationships [21] and a higher risk of suicide [22]. Furthermore, the rate of emotional burden of cancer patients' family, which is reportedly between 25 and 40%, tends to increase when their ill member shows symptoms of psychological stress [23,24]. Despite these data, it seems that only a minority of cancer patients receive psychological attention. Ford and colleagues [25] showed that doctors detected psychopathological symptoms in only 25% of cancer patients. Similar data were reported by other authors who found that, on average, oncologists recognise 1/2 cancer patients with a diagnosis of depression [4], whilst only 13% of those with severe depressive symptoms are correctly detected by oncologists [26]. Likewise, physicians tend to overrate anxiety of non-anxious or mildly anxious cancer patients, whilst they underestimate moderate and strong anxiety [27]. Furthermore, amongst cancer patients judged by oncologists as not needing psychological referral, 23% met the criteria for a possible mood disorder and 30% for a possible anxiety disorder [28]. An indirect confirmation of the frequent under-evaluation of psychosocial problems in cancer patients is the fact that oncology accounted for only 5% of the C-L service delivered to all hospitalised physically ill patients, corresponding to less than 2% of all admissions of cancer patients [17,29].

Since no study is available in Italy about C-L activity in oncology settings, the purpose of this investigation was to examine in more detail patterns of referral, psychiatric disorders and psychosocial interventions amongst hospitalised cancer patients.

2. Patients and methods

2.1. Study design

The data presented in this study were extrapolated from a more general multicentre investigation of C-L psychiatry conducted on a nationwide level in Italy between 1993 and 1994 [30]. 12 provinces were involved in the study, six in North Italy, three in Central Italy

and three in South Italy, for a total of 17 hospitals and 17 corresponding C-L psychiatric services. Bigger hospitals ($n=9$) had medical and surgery oncology departments or cancer units within specialist departments (e.g. haematology, gynaecology), whilst smaller hospitals ($n=8$) tended to admit cancer patients in internal medicine or general surgery wards.

All the patients admitted to the hospital and referred to C-L psychiatry during a period of 1 year were assessed by using a short-version of the Patient Registration Form (PRF-SF), recently developed by the European C-L Working Group (ECLWG) [31–33]. The PRF-SF consists of 60 items evaluating characteristics of C-L activity through five main domains: (1) patient's domain (e.g. sociodemographic data, psychiatric history); (2) hospitalisation domain (e.g. date of admission and discharge, total time spent on consultation, primary reason of referral); (3) diagnostic domain (e.g. patient's health-care status before admission, somatic diagnosis at admission, psychiatric diagnosis at consultation); (4) intervention domain (e.g. psychological intervention, pharmacological intervention, transfer to psychiatry); and (5) outcome domain (e.g. formulation of post-discharge plan or death). Cancer diagnosis was assessed through the WHO ICD-9 system, whilst psychiatric diagnosis was assessed according to the ICD-10 system [34].

In agreement with the ECLWG protocol [33], all the raters in the Italian investigation participated in a reliability phase which consisted of completing the PRF-SF for 13 vignette pre-coded cases which were sent and evaluated by the main centre (Milan). 85 consultants out of 87 (98%) fulfilled the reliability criteria (average $\kappa \geq 0.70$) and took part in the study.

2.2. Statistical analysis

Statistical procedures included descriptive statistics, assessment of response distribution (frequency counts) and cross-tabulation. Differences between groups were tested by means of the Student's *t*-test and chi-square test, where appropriate. Statistical significance was set at the 5% level. Analyses were conducted using the SPSS 6.1 package [35].

3. Results

3.1. Characteristics of the sample

During the study period a total amount of 4182 psychiatric consultations were performed. Of these 217 involved cancer patients (5.2% of the total number of consultations, range across centres: 1–7%). 114 were men (53%) and 103 women (47%). Age ranged from 18 to 89 years (mean: 62.32 ± 14.54). Most patients were

admitted to medical departments ($n=159$, 73%, e.g. oncology, haematology, gastroenterology, internal medicine) and 58 (27%) were in surgery departments (e.g. oncology surgery, general surgery, gynaecology). Seven consultations regarded day-hospitalised patients (3%) and 2 home-hospitalised patients (1%). Sites of cancer were as follows: gastrointestinal tract 26% ($n=56$), blood 25% ($n=55$), genito-urinary tract 13% ($n=28$), breast 12% ($n=25$), respiratory 12% ($n=25$), skin 2% ($n=4$) and other sites 11% ($n=24$). Socio-demographic and clinical characteristics of cancer patients are summarised in Table 1.

3.2. Characteristics of consultation requests

Characteristics of consultation requests are shown in Table 2. Mean time in days between admission and consultation request by the consultee (lag-time 1) was

Table 1
Socio-demographic and clinical data of the patients

	<i>n</i> (%)
Sex	
Male	114 (53)
Female	103 (47)
Age \pm SEM (range) (years)	62.32 \pm 14.54 (18–89)
Education	
< 8 Years	81 (37)
8 Years	76 (35)
13 Years	28 (13)
18 Years	8 (4)
No information	24 (11)
Marital status	
Never married	30 (14)
Separated/divorced	6 (3)
Married	133 (61)
Widowed	48 (22)
Occupation	
Employed	21 (10)
Unemployed	6 (3)
Disability pension	7 (3)
Housewives	40 (18)
Retired	138 (64)
Students	1 (0.5)
Unknown	4 (2)
Cancer site	
Gastrointestinal	56 (26)
Blood	55 (25)
Genito-urinary	28 (13)
Breast	25 (12)
Respiratory	25 (12)
Skin	4 (2)
Other	24 (11)
Stage	
Local disease	35 (16)
Locoregional	79 (36)
Metastatic	92 (42)
Unknown	11 (5)

8.65 (± 12.04) days. Most consultations were requested as routine requests (i.e. consultation to be performed within 48 h or to be programmed) ($n=156$, 72%), 49 (23%) were 'urgent' (within 24 h) and a minority ($n=12$, 6%) were 'emergency' requests (within 1 h). Main reasons of referral, as filled out by the consultee, were current psychiatric symptoms ($n=150$, 69%), coping/compliance problems ($n=26$, 12%), suicide risk/suicide attempt ($n=10$, 5%), previous psychiatric problems ($n=9$, 4%), patient requesting psychological help ($n=5$, 2%), unexplained physical symptoms ($n=5$, 2%), staff problems in dealing with the patient ($n=4$, 2%), substance abuse ($n=1$, 0.5%) and other reasons ($n=7$, 3%) (Table 2).

3.3. Psychiatric consultation

Data concerning results of psychiatric consultation are indicated in Table 3. Mean time between consultation request and first consultation (lag-time 2) was 1.63 (± 3.10) days, with 37% consultations carried out within the same day, 31% within the following 24 h and 14% within the following 48 h. More than one-third of the patients ($n=86$, 40%) were not informed of their referral to C-L.

Patients' psychiatric history indicated that 68% of subjects ($n=148$) had never had psychological or psychiatric disorders in the past, whilst 32% ($n=69$) had a lifetime history of psychiatric disorders for which they received psychiatric care ($n=26$ from community psychiatry services, $n=21$ from their GPs, $n=14$ from private mental health professionals and $n=7$ from other services). A minority of referred patients ($n=21$, 10%) were already known by the C-L service because of psychiatric consultations during previous hospital admissions.

Table 2
Consultation data

	<i>n</i> (%)
Primary reason of referral	
Current psychiatric symptoms	150 (69)
Compliance/coping problems	26 (12)
Previous psychiatric problems	9 (4)
Suicide risk	6 (3)
Suicide attempt	4 (2)
Unexplained physical symptoms	5 (2)
Request from the patient	5 (2)
Staff problems with the patient	4 (2)
Substance abuse	1 (0.5)
Other	7 (3)
Urgency	
Routine	156 (72)
Today	49 (23)
Within 1 h	12 (6)
Lag-time 1:	8.65 \pm 12.04 days
Lag-time 2:	1.63 \pm 3.10 days

93 subjects (43%) reported using psychotropic drugs at home in the week before admission to the hospital, mainly benzodiazepines ($n=40$, 43%), antidepressants ($n=28$, 30%) and neuroleptics ($n=23$, 25%). Mental health professionals prescribed these drugs in most cases ($n=43$, 46%), in 34 cases (37%) psychotropic drugs were prescribed by the patient's GPs, whilst the source of prescription was unknown in 17 cases (18%).

Most patients ($n=185$, 85%) met the criteria for an ICD-10 psychiatric diagnosis, whilst 32 patients (15%) had symptoms which did not allow the consultant psychiatrist to diagnose any mental disorder. Principal psychiatric diagnoses consisted of adjustment disorders ($n=59$, 27%), major affective disorders ($n=50$, 23%), organic mental disorders ($n=41$, 19%), anxiety disorders ($n=17$, 8%), schizophrenia and delusional syndromes ($n=9$, 4%), substance abuse ($n=2$, 1%) and personality disorders ($n=4$, 2%) (Table 3).

Psychosocial problems or concerns were reported by 47% of the patients ($n=102$), mainly as a consequence

of the current illness, $n=66$, but also interpersonal relationships ($n=10$), parent-child relationships ($n=7$), marital relationships ($n=5$) and non-compliance with medical treatment ($n=4$) (Table 3).

3.4. Psychiatric intervention

Table 4 shows psychiatric intervention as made by the consultant. Psychotropic drugs were prescribed in most consultations ($n=151$, 70%), specifically benzodiazepines ($n=32$), antidepressants ($n=26$) and neuroleptics ($n=31$) alone or, more frequently in combination (benzodiazepines + antidepressants $n=30$; benzodiazepines + neuroleptics $n=14$; benzodiazepines + antidepressants + neuroleptics $n=11$). Psychological intervention (unstructured counselling) was performed in 76% of the consultations ($n=164$) and was given mostly to patients ($n=150$) but in a minority of the cases, to the family ($n=4$) or staff ($n=10$).

After initial consultation, 70 patients (32%) were given further psychiatric consultations during hospitalisation (mean: 1.77 ± 1.72 , range: 1–15 follow-up visits).

3.5. Outcome

16 patients (7%) died during admission. A small number of patients ($n=3$, 1%) were transferred to psychiatric units and 7 patients (3%) to another hospital. Of the remaining 191 patients, post-discharge plan was formulated for 86 patients (45%) as follows: referral to community mental health services ($n=35$, 18%), referral to C-L outpatient service/psycho-oncology services ($n=24$, 13%), referral to GPs ($n=24$, 13%), and referral to other services (e.g. social services) ($n=3$, 2%) (Table 4). Globally, no significant difference was shown between general hospitals with and without specialist cancer units as far as the consultation data and psychosocial variables were concerned.

Table 3
Psychiatric history and ICD-10 psychiatric diagnosis

	<i>n</i> (%)
Psychiatric history	
Previous psychiatric contacts	
Yes	69 (32)
No	148 (68)
Current psychosocial problems	
Yes	102 (47)
No	115 (53)
ICD-10 diagnosis	
No psychiatric diagnosis	32 (15)
Psychiatric diagnosis	185 (85)
F00–F09: Organic mental disorders	41 (19)
Delirium	24 (11)
Other psychiatric disorders	17 (8)
F10–19: Mental and behavioural disorders due to psychoactive substance abuse	2 (1)
F20–29: Schizophrenia, schizotypal and delusional disorders	9 (4)
F30–39: Affective disorders	50 (23)
Bipolar disorder (depressive episode)	1 (0.5)
Major depression (single/recurrent)	40 (18)
Persistent depression	7 (3)
Other depressive syndromes	1 (0.5)
F40–49: Neurotic, stress-related, somatoform	76 (35)
Phobic anxiety disorders	13 (6)
Other anxiety disorders	2 (1)
Reaction to severe stress/adjustment	59 (27)
Somatoform disorder	2 (1)
F50–59: Behavioural syndromes associated with physiological/physical factors	1 (0.5)
F60–69: Personality disorders	4 (2)
Other disturbances	2 (1)

Table 4
Psychiatric intervention and outcome

	<i>n</i> (%)
Psychiatric intervention (multiple response)	
Psychotropic medication	151 (70)
Psychological intervention	164 (76)
Number of consultations mean \pm SEM (range)	1.77 ± 1.72 (1–15)
Psychiatric aftercare recommendations ($n=191$)	
No	105 (55)
Yes	86 (45)
Outpatient mental health service	35 (18)
Outpatient C-L/psycho-oncology service	24 (13)
GPs	24 (13)
Other (e.g. social services)	3 (2)

4. Discussion

This is the first detailed nationwide Italian study investigating the patterns of referral and characteristics of psychiatry consultation for patients with cancer.

Only a very low percentage of C-L activity in the hospital concerned patients with cancer. In fact, C-L in oncology accounted for only 5.2% of all the C-L services' clinical activity. This seems to corroborate previous reports indicating that in general hospital cancer patients are rarely referred for psychiatric consultation [17,29]. Thus, the establishing of specific liaison units within the oncology setting is urgently needed in order to improve recognition of patients' emotional problems and prompt referral or intervention [36,37]. To this end, a specific liaison programme aimed at prompting oncologists to refer cancer patients to C-L services determined, over a 3-year period, an increase in consultation rate from 4 to 9% in a study carried out in England [29]. In Australia, a history of 15 years of liaison activity between a specific C-L service and an oncology unit resulted in a referral rate of 10% [18]. Nevertheless, this rate still seems low considering the 25–40% prevalence of psychological disturbances among patients with cancer. Since it was not possible in our study to evaluate the proportion of referred cancer patients with respect to the total number of cancer patients admitted to the hospital during the study period, more research is needed to draw definite conclusions about this issue.

Furthermore, consultees frequently needed psychiatric consultation within a short timeframe: 23% were urgent requests (within 24 h) and another 6% emergency requests (within 1 h). Most patients were referred because of current psychiatric symptoms (69%) and coping/compliance problems (12%). Other reasons, such as suicide risk/suicide attempt, patient requesting psychological help or staff problems in dealing with the patient were rare. These data confirm previous studies [18] and point out the specific characteristics of the C-L service in oncology. In fact, unexplained physical symptoms, suicide risk and history of psychiatric disorders, which are important reasons for psychiatric referral of hospitalised physically ill patients in non-cancer settings [30,38], were scarcely represented in this study.

Interestingly, 40% cancer patients were not informed about their referral to psychiatry consultation. After excluding the 11% of patients with acute confusional states, which may have prevented referring doctors from explaining to these patients about the need for psychiatric consultation or intervention, the rate of non-informed patients remains high in comparison with the data reported in studies of non-cancer patients [30]. A possible explanation may be connected with the tendency amongst Italian physicians to not completely inform patients about the diagnosis of cancer and therapeutic strategies [39,40], particularly if they are in an advanced stage of

illness [41]. This might be extended to psychiatric intervention for a variety of reasons, such as fear of stigmatising the patient, cultural barriers about psychiatry and difficulty in involving the patients in decision making about diagnostic and therapeutic needs and options.

The study showed that adjustment disorders were the most frequent diagnosis affecting approximately 27% of the referred population. Despite the fact that adjustment disorders seem common and 'benign' psychological consequences of cancer, more attention should be paid to this diagnosis without dismissing it as 'physiologically reactive' and 'reasonable given the circumstances'.

In fact, recent reports have shown that a high proportion of underestimated and untreated adjustment disorders tend to become more chronic over time, favouring the development of persistent affective disturbances [13]. Affective disorders, particularly major depression, were the second most frequent diagnosis amongst cancer patients referred to C-L. The problem of the prevalence of depression amongst cancer patients and the need for proper assessment has been repeatedly underscored over the last few years [42,43]. Although it has been reported that depression secondary to cancer is associated with suicide risk, poor quality of life, abnormal illness behaviour and interpersonal problems [19–21], a high percentage of cancer patients with depression go unrecognised by oncologists [26]. Organic psychiatric disturbances were the next most prevalent category, with 11% of patients receiving a diagnosis of delirium. As reported by a number of authors, the diagnosis of delirium is much higher amongst cancer patients, particularly in the advanced phase of illness [44]. Because of the nature of this study, it is not possible to know if this low rate of referral is due to staff's inability to recognise confusional states or to the tendency to refer only the most difficult clinical situations. However, the rate reported in our study is similar to findings of other C-L studies in oncology [18]. Taken together, however, these data indicate the need for improving the staff's ability in screening and recognising psychological and psychiatric symptoms of cancer patients and in appropriate referring when necessary [45–47]. As far as the quality of C-L is concerned, most consultations were carried out on the day of the request or the following day, indicating a comparable standard with C-L services in European general hospitals (ECLW study, data not shown). Nevertheless, only a minority of cancer patients (32%) received further consultations after the first contact. This seems to indicate a strong need for improvement in the quality of Italian C-L activity in oncology, given the importance of follow-up in reinforcing the continuity of psychological care amongst referred patients. Psychotropic drugs were frequently used by consultants as a treatment of choice, with 70% of patients receiving psychopharmacological prescriptions. However, unstructured psychological counselling was also frequently

performed (76% of cases). As far as outcome is concerned, a few patients were transferred to psychiatric units ($n=3$, 1%), indicating that psychiatric disorders secondary to cancer are usually manageable in the oncological setting, without any need for a more structured intervention. At discharge, approximately half (45%) were recommended for psychiatric/psychological follow-up, with approximately 18% of patients referred to mental health services, 13% to their GPs and another 13% referred to C-L/psycho-oncology outpatient facilities. These figures indicate that continuity of care by using C-L/psycho-oncology outpatient services is rarely allowed in the Italian healthcare system, whilst several studies have demonstrated the importance of setting up specific facilities which take care of the patients and the families throughout the process of illness [48].

Certain caveats should be added when examining this data. The study was conducted in general and teaching hospitals, limiting the generalisability of the results. It is possible that highly specialised cancer hospitals have specific psychological services which provide routine psychological assessment and earlier referral to psychiatry of patients showing emotional problems. However, given the very limited number of such centres in Italy and the lack of data indicating the exact rate of psychological and psychiatric referrals, it is reasonable to hypothesise that the vast majority of cancer patients receiving care in medical or surgery departments of general and/or university hospitals (where specific psycho-oncology units do not necessarily exist) are not properly assessed as far as psychosocial needs are concerned. Another limitation is given by the lack of assessment of important psychological aspects, such as psychosocial support, coping styles and quality of life on which psycho-oncology literature has focused attention in the last 10 years. Furthermore, the cross-sectional nature of the study cannot allow us to draw any conclusions about the outcome of the patients over time, e.g. how many patients followed psychiatric suggestions for post-discharge follow-up, what benefit they received from consultation in terms of reduction of symptoms and impact on the family system. Moreover, it has to be pointed out that the problem of the outcome of C-L intervention in the general hospital setting is far from solved.

Despite these limitations, this study strongly suggests the need for more specific attention to be paid to cancer patients' problems and a larger diffusion of psychosocial oncology programmes within the healthcare services in Italy.

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Appendix 1

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