

CHAPTER 18 PSYCHOSOCIAL CARE

The diagnosis and treatment of cancer presents a major and stressful life event that necessitates an adaptive adjustment to sustain quality of life. A fundamental goal is to enhance quality while striving to prolong life. Quality of life has been reported to predict survival in patients with advanced Colorectal Cancer.¹ Attention to psychosocial aspects is vital to achieve an appropriate level of quality of life.

The importance of psychosocial care is recognised by the recent publication of *Clinical practice guidelines for the psychosocial care of adults with cancer (2003)*,² which are a useful evidence-based source for practising clinicians.

Sprangers et al³ reviewed nine studies assessing psychological dysfunction in patients with Colorectal Cancer. Prevalence estimates for depression ranged from 7% to 50%, with significantly higher rates for ostomates than nonostomates.^{4,5} Anxiety was problematic in 25%.^{6,7} Psychological functioning was more impaired in younger female patients.^{8,9} Further evidence indicates that 31.6% of colon cancer patients experience psychological distress.¹⁰

In general, people with a stoma reported greater impairment of social functioning, including problems with work, frequency of social contacts, and quality of relationships, including marriages.³

There is also evidence that families of colon cancer patients experience adjustment problems.¹⁰ In a large Australian study of patients with advanced cancer in the palliative care setting, up to half of the patients (20% of whom had Colorectal Cancer), one third of their spouses and one quarter of their offspring showed evidence of substantial psychological distress warranting specific support.¹¹ The distress reverberates through the family in the setting of palliative care in such a way that both patient and family-centred models of care need to be adopted.

Prevalence estimates of sexual dysfunction after surgery for Colorectal Cancer range from 62% to 88% when pelvic autonomic nerves have been damaged, and include problems with erectile function and ejaculation in men.^{3,12} Sexual problems experienced by women after surgery include dyspareunia, vaginal dryness and pain interfering with sexual pleasure.¹³ Age may play an important role in impairment of sexual functioning.

A range of physical symptoms also interfere with the quality of life of colorectal patients: one third of patients report more than five bowel movements per day, half have problems with flatus, odour, diet, diarrhoea or constipation, and stoma-related problems remain substantial. Spillage and accidents in the 1960s ranged from 50% to 86% and, despite technical advances in ostomy equipment, more recent studies also report significant problems with leakage, odour and late complications.^{5,14}

Systematic studies of patients with cancer have shown that clinicians frequently fail to identify psychological problems. There are generic factors related to poor adjustment to diagnosis and treatment applicable to all patients with cancer, as well as specific factors in the setting of Colorectal Cancer. The latter have been identified as:

- younger patients^{4,8,15}
- women^{4,8,9}
- ostomates³ (refer 12.1)
- patients who have experienced cumulative losses
- those who are socially isolated
- those who have been widowed, separated or divorced

- those with a history of psychiatric disorder
- those in financial difficulty
- those with social deprivation.

Surveys of patients with cancer repeatedly identify information provision as a major unmet need.¹⁶ Research has shown that the provision of adequate information is related to increased psychological wellbeing.¹⁷ Effective communication skills ensure that this information is clearly explained and understood.^{18,19}

Relevant principles about information provision for Colorectal Cancer patients are that:

- treatment options should be explained clearly, with realistic information about potential effectiveness and adverse effects
- patients should be invited to guide the clinician over the level of detail they wish and over their desire for active involvement in decision making;²⁰
- clinicians should review both the understanding of and reaction to the information as a means of increasing integration and providing emotional support
- written materials should be provided and consideration given to offering tape recording of key consultations.²¹ Provision of a specialist nurse or counsellor, a follow up letter and psycho educational programs may also assist in recall of information.²²
- information should be made available over time and if desired, review appointments that allow time for further integration of information should be scheduled
- patients' carers and families should also be kept well informed
- well-informed patients feel more in control and achieve a better psychological adjustment over time, although many are concerned if they perceive a delay in active treatment.

18.1 Psychological treatments

Surveys of patients with cancer identify psychological support as a major unmet need.¹⁶ There is incontrovertible evidence from three meta-analyses of the benefits of psychological interventions in patients with cancer. Such interventions improve emotional adjustment (including anxiety and depression, sense of control, self-esteem), functional status (including daily living activities, social and role functioning, and vocational activities), knowledge of the disease and its treatment, treatment and disease-related symptoms (e.g. nausea, vomiting, pain, etc.) and overall quality of life.^{17,23,24} Intensive psychotherapy, consisting of weekly supportive group therapy with self-hypnosis for pain over a 12-month period, has also shown significant survival benefits in women with metastatic breast cancer.²⁵

There are wide benefits from relaxation-based therapies in reducing anxiety, treatment-related phobias, conditioned nausea and vomiting, and insomnias.¹⁷ Both cognitive-behavioural and supportive-expressive therapies are effective in countering existential fears of dying, aloneness, meaninglessness and unrealistic fears about processes of treatment.^{17,23,24} Early referral for specialist support from a clinical psychologist or liaison psychiatrist is worthwhile when symptoms of distress or high risk become evident.

Randomised controlled studies of early versus late referral to palliative care services show strong evidence of the benefits of early referral in reducing time spent in hospital, enhancing symptom control, increasing family satisfaction, and permitting death to occur in the desired location.²⁶⁻²⁸ Early

referral to community-based domiciliary palliative care services support and information, where available, may have several benefits and enhance quality of life. Support can be provided by various health disciplines with appropriate training.

Guideline — Psychological interventions	Level of evidence	Practice recommendation	Refs
Psychosocial care is important. Psychological interventions should be a component of care as they can improve the quality of life for patients with cancer.	I	Strongly recommend	17, 22

References

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