

# Psycho-Oncology Training Empowers Therapists

BY CAROLINE HELWICK

NEW ORLEANS — Psychiatrists and other mental health professionals often lack sufficient background in oncology to effectively provide psychosocial care to cancer patients.

The Henry Ford Health System (HFHS) in Detroit has designed a program to fill this need, resulting in improved access to specialized care for their large patient base.

The program was described by Wendy Goldberg, a nurse practitioner at the Josephine Ford Cancer Center (JFCC) of the HFHS, at the annual conference of the American Psychosocial Oncology Society.

A review of the literature showed that one-third to one-half of all cancer patients experience significant psychosocial distress, and that psychological interventions are effective in remediating distress (Psychooncology 2004;13:837-49), Ms. Goldberg and colleagues noted in their poster.

"We have 7,000 cancer patients in our health care system . . . in southeast Michigan. We know that providing psychosocial care to this cancer population is important, but our psycho-oncology program consists of only a psycho-oncology nurse practitioner (myself) and a health psychology fellow," she said.

Because of the volume of this population, the patients' disease states, and issues of transportation, many patients requiring psychosocial services now see counselors within their communities who lack expertise in cancer care. The patients who were seen in the community have been highly dissatisfied with such care, Ms. Goldberg explained in an interview.

"Patients complained to their oncologists that their therapists did not understand their situation or were not helpful," she noted.

Envisioning a program that would prepare psychotherapy generalists in the community to deliver specialized psycho-oncology services, Ms. Goldberg and colleagues designed an intensive, specialized, mastery-based training program that covered cancer "basics" as well as the psychological and behavioral dimensions of cancer. (See box.)

The program was attended by 91 men-

tal health care providers, including psychiatrists, psychologists, social workers, and nurse practitioners from within the HFHS and the southeast Michigan region. Faculty included a psychologist, health psychology fellow, psychiatric nurse practitioner, psychiatric social worker, and oncology nurse practitioner, all with advanced training in the field.

The content for the 8-hour course included cancer biology and treatment issues, psychiatric comorbidity, psychological and psychopharmacologic interventions, ethics, and genetic testing in cancer populations. Interactive lectures, case presentations, and panel discussions with patients and family members focused on the mastery of essential knowledge, attitudes, and skill development in psycho-oncology care. Enrollees from the HFHS were invited to participate in the next two phases of the program, which entailed ongoing, small-

group, peer supervision via telephone conferences and a 1-day clinical observation.

At the conclusion of the seminar, participants reported high satisfaction with the course. On a quality-rating scale of 0-5, mean ratings were 4.5 or higher on all content and organizational categories. Virtually all respondents said that the program was highly applicable to their profession and yielded information that would be professionally useful.

"The response was unbelievably positive," Ms. Goldberg reported. "We were optimistic that the program would be appreciated, but many participants said it was the best course they had ever taken, and they did not realize how much they didn't know."

Ms. Goldberg and her colleagues are now formalizing the course and training model for implementation by others. ■

## Case Histories Show Impact of Program on Patients

Therapists reported a gain in knowledge that helped them counsel cancer patients. These are some of their "before and after" stories, as described by Teresa Lynch, Ph.D., a psychologist at the JFCC, and Ms. Goldberg.

► **Case No. 1.** The therapist could not understand why his very ill patient resisted discussions about end-of-life issues. But after reviewing the patient's clinical status, he learned the patient was midway through his initial treatment, was ill from the side effects of surgery and radiation rather than from disease, and—most importantly—had an excellent chance of cure. The therapist then understood that exploring fears about death and dying was not relevant, and he redirected the focus of therapy toward emotional resiliency during treatment.

► **Case No. 2.** The patient did not understand her oncologists' insistence that she needed both chemotherapy and radiation therapy. The therapist was able to use her fundamental knowledge of cancer biology to

probe the patient's understanding of these issues. She combined psychoeducation techniques with anxiety management to help the patient face an unpleasant reality. This interaction increased the patient's confidence in the therapist, which ultimately helped the patient receive optimal care.

► **Case No. 3.** The patient approached the program's psychiatrist about her difficulty in proceeding with treatment recommendations until she could better manage her anxiety, attend to important personal business, and think more about her treatment options. The psychiatrist and nurse practitioner discussed the case together, and concluded that further delays in initiating cancer treatment could jeopardize the patient's chance for a good response, including cure. The team strategized ways to shift the focus of therapy to concerns about the risks of delay, rather than the patient's need to be "perfectly ready" before beginning treatment. The psychiatrist adjusted her treatment approach from reflective listening to a psychoeducational/

problem-solving strategy that helped the patient overcome a dangerous state of paralysis and avoidance. The patient later directly expressed her gratitude for this intervention to the oncology team.

► **Case No. 4.** A therapist who was working with a breast cancer patient wanted a greater appreciation of what her patient would face after completing chemotherapy. The therapist had no knowledge of tumor biology, including the meaning of estrogen receptor positivity. Therapists do have access to patients' electronic medical records (EMRs) in the health care system—the aim being to promote integrated care—but most therapists do not know what information to look for or where to find it in the EMR. To address this need, the psychosocial educational program devoted a telephone supervisory session to teaching therapists how to navigate the relevant aspects of the patient's EMR. At the same time, the teaching team reinforced some of the didactic information presented during the psycho-oncology seminar.

## U.S. Cancer Incidence, Death Rates Continue to Decline

BY JOYCE FRIEDEN

Overall cancer incidence and mortality are declining in the United States, according to a report issued by the National Cancer Institute.

These reductions are attributed mostly to decreases in both incidence and mortality for lung, prostate, and colorectal cancer in men, and breast and colorectal cancer in women. For all types of cancers combined, new diagnoses dropped an average of almost 1% per year from 1999 to 2006, and deaths from cancer declined an average of 1.6% per year from 2001 to 2006.

In terms of gender, cancer rates overall are still higher for men than for women, although cancer incidence and mortality decreased more in men. In

particular, for colorectal cancer—the second-leading cause of cancer deaths in the United States—overall rates are declining, but the rising incidence in men and women under age 50 years is worrisome, the report said.

The researchers also found that incidence rates in men have declined for cancers of the oral cavity, stomach, and brain, but rose for kidney/renal, liver, and esophageal cancers, as well as for leukemia, myeloma, and melanoma. In women, incidence rates decreased for uterine, ovarian, cervical, and oral-cavity cancers, but increased for lung, thyroid, pancreatic, bladder, and kidney cancers, as well as for non-Hodgkin's lymphoma, melanoma, and leukemia.

Among racial and ethnic groups, cancer mortality was highest in blacks and

lowest among Asian/Pacific Islanders. In addition, death rates from pancreatic cancer increased among whites but decreased among blacks.

The authors modeled projections of colorectal cancer rates and found that by getting more patients to adopt lifestyle changes such as quitting smoking and by increasing the use of colonoscopy and other screening techniques, overall colorectal cancer mortality could be cut in half by 2020.

The report was written by researchers from the NCI, the Centers for Disease Control and Prevention, the American Cancer Society, and the North American Association of Central Cancer Registries (Cancer 2010;116:544-73).

Information on newly diagnosed invasive cancers was obtained from popu-

lation-based cancer registries that participate in the NCI's Surveillance, Epidemiology, and End Results program and/or the CDC's National Program of Cancer Registries.

For most states, population estimates as of July 1 of each year were used to calculate annual incidence and death rates; these estimates are presumed to reflect the average population of a defined geographic area for a calendar year, the authors noted.

"The continued decline in overall cancer rates documents the success we have had with our aggressive efforts to reduce risk in large populations, to provide for early detection, and to develop new therapies that have been successfully applied in this past decade," Dr. John E. Niederhuber, NCI director, said in a statement. ■