

# Cancer Care and the Role of Psychosocial Oncology: Where are We and Where are We Going?

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Cancer care is an evolving specialty, and nurses have been pivotal in that evolution. Often with the closest relationship with the patient, privy to the details of their anxieties, and personal journey, nurses are uniquely situated to assist in the provision of psychosocial care to patients and the multidisciplinary team with an overview of the patient's health status, including the level of multifactorial and complex distress.

Despite the advent of effective radiation oncology, surgery, and chemotherapy, we know that cancer still is often thought of as being synonymous with death, pain, and suffering.<sup>[1]</sup> As cancer became recognized as a disease, and in those early years, the predictions of survivorship or the extension of life was limited or guarded and often the sole focus of cancer care. More recently, cancer care programs have recognized the emotional pain and distress patients

and families experience with the diagnosis and treatment of cancer and now seek to provide support as a matter of compassion and comfort. This awareness has led to the creation of a new field of cancer care called Psychosocial Oncology or Psycho-Oncology. As this new discipline joined the cancer care team and supported the provision of good clinical care, research became the requisite addition to this discipline. Credible research demonstrated value and enabled practitioners to provide empirically based psychosocial oncology interventions. Early psychosocial studies focused broadly on many aspects of cancer including anticipatory nausea and vomiting,<sup>[2]</sup> expressive and supportive group therapy and extension of life,<sup>[3]</sup> existential therapies,<sup>[4]</sup> quality of life,<sup>[5]</sup> as well as issues around death and dying.<sup>[6]</sup>

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In recent years, attempting to better understand the nature and type of cancer-related distress encountered by patients has led to a better definition of distress,<sup>[7]</sup> with accompanying prevalence studies of most frequently encountered problems. These studies have qualitatively and quantitatively demonstrated that cancer is complex and multifactorial (physical, practical, emotional, and spiritual) affecting the quality of life of patients and their families<sup>[8-10]</sup> and that standardized screening for distress may be the most effective and efficient way of understanding the patient and the challenges they encounter from time of diagnosis through treatment, recurrent disease, and palliative care.<sup>[11-13]</sup> These findings have importantly highlighted key areas of patient concern where psychosocial interventions can be timely, targeted and evidence based.

Despite these findings, the inclusion of psychosocial oncology into mainstream cancer care remains varied and in many countries limited, with continued adherence to a predominantly biomedical approach to patient care in many areas of the world.

Research on the patient experience and the role psycho-oncology can play in the care of the cancer patient has been growing rapidly. The World Health Organization declaration that there can be no health without mental health<sup>[14]</sup> is seen as a driver in both endorsement and development of comprehensive whole patient care for many countries. Despite these comments, shifting from a biomedical model to a comprehensive biopsychosocial model of care remains a significant challenge.

## Cancer Care in Retrospect

Looking back over the past 30 years, we see that cancer care globally has evolved to a new standard of care. Thirty years ago, the word cancer was barely spoken when communicating with the patient. We were struggling with how to discuss a diagnosis with the patient and family. There was little discussion about informed consent or communication training. Thirty years ago, comprehensive cancer care meant surgery, chemotherapy, or radiation. Cancer was synonymous with death, pain, and suffering.

## Cancer Care Today

Today, cancer care at a global level is increasingly about multidisciplinary whole patient care with a model that now includes the psychosocial aspect of the patient experience. Thanks to diligence, perseverance, vision, and work of clinicians, researchers, patient advocates, pioneers, and leaders, we are aspiring to this new culture of cancer care.

Today, cancer care is increasingly comprehensive and integrated. The patient is central and the treatment is much more than about the tumor. Today, patient-centered care is the new dictum in Oncology! Multidisciplinary care is making a difference to all cancer patients. It is also making a difference to all medical disciplines, especially nurses and physicians, to our administrators, to insurance companies, to our accreditation bodies, and importantly, to national policy makers.

Despite the complex and cultural challenges as well as adherence to the traditions of a hierarchical medical model, multidisciplinary care, using the full range of skills of nurses and other professionals, is making a difference in our global cancer community.

Through the rapidly growing body of research, we have developed a strong evidence base to demonstrate that psychosocial oncology must be seen as necessary and an essential service. Today, our relatively new field of psychosocial oncology is growing into a core service in many regions of the world, helping to reduce the burden of cancer, and enhancing the quality of life from time of diagnosis through treatment, survivorship, and palliative care.

A clear sign of the appreciation for this area is the inclusion of psychosocial research papers into virtually every journal related to cancer care.

We also see this development through the creation of training academies, conferences, and workshops in every corner of the world.

Recently, psychosocial academies have been conducted in India, Russia, Korea, China, Italy, Slovenia, Taiwan, Africa, and many other locations. In addition, training programs are being developed in Eastern Europe in collaboration with the European Partnership for Action in Cancer.<sup>[15]</sup> In collaboration with the NCD Alliance, policies on lifestyle and behavioral factors in cancer control are being developed. In 2013, the International Union for Cancer Control (UICC) accepted the International Psycho-Oncology Society recommendations to call for universally available distress management services in Target 8 of the World Cancer Declaration.<sup>[16]</sup>

All of these activities demonstrate clearly that Psychosocial Oncology is becoming mainstream in the care of cancer patients worldwide.

Proponents of multidisciplinary care have a major influence in the realignment of oncology to whole patient cancer care. Psychosocial oncology has a stronger voice and we

as dedicated health care providers need to work together to give our patients a voice through our disciplines.

Looking forward to the future, we need to set lofty goals in the care of our cancer patients. The evolution of psychosocial oncology as a discipline and the implementation of international standards<sup>[17]</sup> of cancer care will take much hard and sustained work as well as both human and financial resources. Cancer care professionals need to work with all professional, political, and business communities to conduct research and disseminate the benefits of psychosocial care to patients, institutions, and governments.

We are creating a cultural shift in delivery of care to the cancer patient. The profession of nursing is essential to this change. Nurses moving to practice the full potential of their discipline will be critical in driving the agenda. Dedication to nursing's commitment to whole patient care will expedite the inclusion of psychosocial oncology in the best practice of comprehensive cancer care.

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### Conflicts of interest

There are no conflicts of interest.

## References

1. Sontag S. *Illness as a Metaphor*. USA: Farrar, Straus and Giroux; 1978.
2. Morrow GR, Dobkin PL. Anticipatory nausea and vomiting in cancer patients undergoing chemotherapy treatment: Prevalence, etiology, and behavioral interventions. *Clin Psychol Rev* 1988;8:517-56.
3. Spiegel D, Bloom JR, Kraemer HC, Gottheil E. Effect of psychosocial treatment on survival of patients with metastatic breast cancer. *Lancet* 1989;2:888-91.
4. Frankl V. *Man's Search for Meaning*. Boston, MA: Beacon Press 1959.
5. Aaronson NK. Quality of life: What is it? How should it be measured? *Oncology (Williston Park)* 1988;2:69-76.
6. Kübler-Ross E. *On Death and Dying*. New York, NY: Routledge 1969.
7. NCCN practice guidelines for the management of psychosocial distress. National Comprehensive Cancer Network. *Oncology (Williston Park)* 1999;13:113-47.
8. Cella D. Factors influencing quality of life in cancer patients: Anemia and fatigue. *Semin Oncol* 1998;25 3 Suppl 7:43-6.
9. Zabora J, BrintzenhofeSzoc K, Curbow B, Hooker C, Piantadosi S. The prevalence of psychological distress by cancer site. *Psychooncology* 2001;10:19-28.
10. Carlson LE, Angen M, Cullum J, Goodey E, Koopmans J, Lamont L, *et al*. High levels of untreated distress and fatigue in cancer patients. *Br J Cancer* 2004;90:2297-304.
11. Bultz BD, Carlson LE. Emotional distress: The sixth vital sign — Future directions in cancer care. *Psychooncology* 2006;15:93-5.
12. Bultz BD, Loscalzo MJ, Clark KL. Screening for distress, the 6<sup>th</sup> vital sign, as the connective tissue of health care systems: A roadmap to integrated interdisciplinary person-centred care. In: Grassi L, Riba M, editors. *Clinical Psycho-Oncology: An International Perspective*. Oxford, UK: John Wiley & Sons, Ltd.; 2012. p. 83-96.
13. Bultz BD, Loscalzo M, Holland JC. Distress as the 6<sup>th</sup> vital sign, an emerging international symbol for improving psychosocial care. In: Holland JC, Breitbart WS, Jacobsen PB, Loscalzo MJ, McCorkle R, Butow PN, editors. *Psycho-Oncology*. 3<sup>rd</sup> ed. New York: Oxford University Press; 2015.
14. Chisholm B, World Health Organization. *Br Med J* 1950;1: 1021-6.
15. European Partnership Action Against Cancer Consensus Group, Borrás JM, Albrecht T, Audisio R, Briers E, Casali P, *et al*. Policy statement on multidisciplinary cancer care. *Eur J Cancer* 2014;50:475-80.
16. Target 8: World Cancer Declaration; 2013. Available from: <http://www.uicc.org/world-cancer-declaration>.
17. Travado L, Reis JC, Watson M, Borrás J. Psychosocial oncology care resources in Europe: A study under the European Partnership for Action Against Cancer (EPAAC). *Psychooncology*. 2015 Dec 21. doi: 10.1002/pon.4044. [Epub ahead of print].