Cancer

The 3rd cause of death worldwide, considering severity and prevalence.
- chronic progressive symptoms, with a steady decrease in quality of life

- changes in self image and in performing familial and professional roles
Public stereotypes

Cancer is considered in certain cultural environments as a traumatic irreversible event, that almost always guarantees death.
Survival Rates of Children and Young Adults Suffering from Cancer

- Acute lymphoblastic leukaemia
- Acute myeloid leukaemia
- Hodgkin lymphomas
- Non-Hodgkin lymphomas
- Nephroblastoma
- Osteosarcomas
- Ewing sarcomas
- Rhabdomyosarcomas
- Brain tumours
- Germ cell tumours
- Neuroblastoma and ganglioneuroblastoma
Psychological reactions to cancer

Distress, in its various forms: feelings of impotence, vulnerability, fear, sadness, depression, anxiety, social isolation.
Coping strategies

- denial (+/- confusion, impaired awareness and attention, depersonalization): more frequent in first hours and days;

- doubt, anxiety, need of reality testing;

- acceptance:
  - adaptative (problem-centered coping: in curable phases; emotion-centered coping: in advanced phases).
  - maladaptative (reversed).
Dysfunctional variants of acceptance

- rebellion;
- projection;
- exaggerated reflection (focusing on the past);
- anxiety / panic (< 50%);
- depression (< 50%)
  (most noxious = hopelessness-helplessness syndrome).
Consequences

- bad doctor-patient relationship (negative transference and countertransference, lack of trust and hope);

- non-compliance;

- bad prognosis (in terms of life expectancy).
The "difficult" cancer patient - reasons

1. Patient variables:

- biographic:
  - age (stereotype age-illness)
  - personality type (e.g. A, C) (anxious, paranoid, obsessional);
  - dysfunctional coping strategies.

- are you paranoid?
  - [ ] yes
  - [ ] no

- who
- is
- this???
2. Medical variables:

- (a) related to perception of critical symptoms

E.g. pain (70%):

- is associated with objective events (invasion of nerves, metastases, or invasive treatments - surgery, chemo-therapy, radiotherapy).
  ... can be perceived higher in anxious and depressive individuals.

It is problematic when chronic, progressive and unpredictable.
- (b) related to the trajectory of the patient, throughout the disease.

Many times it is unclear to which specialist the cancer patient should refer, when, why, for what time.

There is a high need of clear and well-defined protocols / decision algorithms.
Castration - resistant prostate cancer patient pathway

HT = hormone therapy;
SRE = skeletal - related events;
Dx Proc = diagnostic procedures;
EBRT = external beam radiation therapy;
PC = palliative care.
- (c) related to the perceived effects of the treatment

HBM: balance gains - losses should be tested throughout the therapy, because in several procedures (such as surgical interventions or chemotherapy) a certain patient ambivalence can occur and increase.

This ambivalence is later responsible for non-compliance and a worse prognosis.
3. Psychosocial variables:

- low education;
- dysfunctional family (not necessary violent, but also hyperprotective).

“WHEN SOMEONE HAS CANCER, THE WHOLE FAMILY AND EVERYONE WHO LOVES THEM DOES, TOO.”
4. Variables related to the physician / medical institution:

- „good samaritan” vs. cynicism;
- emotional / relational problems (e.g. empathy fatigue / bad communication skills);
- physician's personality type (e.g. A);
- rustout / burnout syndromes;
- lack of organizational support (e.g. the physician has to solve all the problems related to a patient, feels harassed by the family, pressed by staying efficient, has no psychological assistance / support groups).
"Case manager"

Aimed to offer a better coordination of care;

Without being the patient's primary physician, the CM knows in all moments patient's needs, the problems that have occurred, thereby being able to prioritize and orient in a logical way the resources and persons caring for the patient;

Appreciated by families;

More used in advanced cancer (Palliative Care).
Giving

BAD NEWS
SPIKES—A Six-Step Protocol for Delivering Bad News: Application to the Patient with Cancer

WALTER F. BAILE, a ROBERT BUCKMAN, b RENATO LENZI, a GARY GLOBER, a 
ESTELA A. BEALE, a ANDRZEJ P. KUDELKA b

aThe University of Texas MD Anderson Cancer Center, Houston, Texas, USA; 
bThe Toronto-Sunnybrook Regional Cancer Centre, Toronto, Ontario, Canada

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ABSTRACT

We describe a protocol for disclosing unfavorable information—“breaking bad news”—to cancer patients about their illness. Straightforward and practical, the protocol meets the requirements defined by published research on this topic. The protocol (SPIKES) consists of six steps. The goal is to enable the clinician to fulfill the four most important objectives of the interview disclosing bad news: gathering information from the patient, transmitting the medical information, providing support to the patient, and eliciting the patient’s collaboration in developing a strategy or treatment plan for the future. Oncologists, oncology trainees, and medical students who have been taught the protocol have reported increased confidence in their ability to disclose unfavorable medical information to patients. Directions for continuing assessment of the protocol are suggested. The Oncologist 2000;5:302-311

BACKGROUND

Surveys conducted from 1950 to 1970, when treatment two-day period, 500 received a transponder allowing them to respond in “real time” to questions that were presented on a
S:

SETTING
SETTING

- location;

- mental setting of the Dr. (reflection to what is about to happen; implications of information disclosure, such as opening new treatment possibilities).
How?

- separate room;
- no mobile phone / pager;
- availability (sit down);
- patient in a comfortable position/dressed;
- not done when patient in pain (or reporting other uncomfortable symptom);
- family members possibly present (at patient's choice);
- nonverbal messages of openness (eye contact; body orientation towards patient; touching patient's arm / forearm).
How?

Open-ended questions, aimed to find out what the patient knows about the symptoms / their current trend.

"What do you know about your current symptoms?"

"What do you know about the purpose of the blood tests / IRM?"

These questions = useful to identify patients in wishful thinking, denial, repression.
How?

- one...more open questions, aiming to test the patient's need to find out more;

- "What would you want to know about the results of the tests?"

- "Would you want to know all the details or just the essential information?"

- "Would you like to inform you more about the tests results or about the future therapy plans?"
K:

GIVING KNOWLEDGE
How?

- introductory phrase ("I am afraid I have to give you some news which are not so good as we expected");
- Dr should use terms that are understood by the patient ("the cancer has extended", and not "has disseminated");
- small chunks, followed by waiting patient's feedback (cognitive: e.g. asks more information; affective: e.g. cries etc.);
- never give radical messages ("your cancer spread so much that nothing can be done"); in fact, always there is smth. to be done (e.g. controlling critical symptoms).
EMOTIONS EMPATHY
EMOTIONS, EMPATHY

- emotional reactions can be very diverse (cry, silence, distrust, ....);

- the Dr should always let the space for the Pt to express his / her emotions;

- only after, the Dr should give empathic messages (NV, then V).
<table>
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<th>Empathic statements</th>
<th>Exploratory questions</th>
<th>Validating responses</th>
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<tr>
<td>'I can see how upsetting this is to you.’</td>
<td>'How do you mean?’</td>
<td>'I can understand how you felt that way.’</td>
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<td>'I can tell you weren’t expecting to hear this.’</td>
<td>'Tell me more about it.’</td>
<td>'I guess anyone might have that same reaction.</td>
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<tr>
<td>'I know this is not good news for you.’</td>
<td>'Could you explain what you mean?’</td>
<td>'You were perfectly correct to think that way.’</td>
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<tr>
<td>'I’m sorry to have to tell you this.’</td>
<td>'You said it frightened you?’</td>
<td>'Yes, your understanding of the reason for the tests is very good.’</td>
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<tr>
<td>'This is very difficult for me also.’</td>
<td>'Could you tell me what you’re worried about?’</td>
<td>'It appears that you’ve thought things through very well.’</td>
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<tr>
<td>'I was also hoping for a better result.’</td>
<td>'Now, you said you were concerned about your children. Tell me more.’</td>
<td>'Many other patients have had a similar experience.’</td>
</tr>
</tbody>
</table>
How?

- should be done only after E;

- the Pt is asked about being available to discuss available options;

- key messages (should be given ALWAYS)
  1. continuity of care;
  2. control of critical symptoms (pain);
  3. patient's wishes will be respected.
Psychotherapeutic intervention
Targets:

- acute stress produced by revealing the diagnosis and prognosis;

- improvement of compliance and trust;

- address obstacles / side effects of therapy (ex. pre / post-surgery).
Tools:

1. education
   (e.g. about the connection stress – malfunctioning of the immune system);

2. direct intervention on dysfunctional emotions and thoughts: relaxation (Schultz training), hypnosis;
3. CBT

- cognitive restructuring (e.g. fight against dysfunctional thoughts, focus of coping strategies on realistic goals, acquiring new coping strategies)

- behavior to support cognitive restructuring (e.g. giving up abandonment, passivity; improvement of the abilities to find and use resources of social support).
4. group therapy
(e.g. “supportive-expressive group th.”)

Benefits:
- provides hope;
- perception of solidarity;
- provides information;
- selflessness (focus on other's pb. can offer the opportunity to escape one's own pb.);
- interpersonal learning (re: pathway through the disease course);
- catharsis;
- offering a meaning.