Psychological Treatment

Thomas B. Strouse, MD[a,*], Brenda Bursch, PhD[b]

KEYWORDS

• Cancer • Pain • Psychological • Cognitive behavioral • Hypnosis • Relaxation

KEY POINTS

- Pain, coping challenges, psychological distress, and psychiatric disorders are highly prevalent during cancer treatment and its sequelae.
- Cognitive behavioral approaches that include relaxation skills and/or hypnotherapy have strong research support for pain reduction among cancer patients.
- Research results support the value of integrating behavioral health interventions into cancer treatment settings.

INTRODUCTION

Psychological distress and pain associated with cancer and its treatment can create a toxic dyad, with each potentially exacerbating the other in a cyclical manner. The biopsychosocial model defines symptoms as the product of biological, psychological, and social subsystems interacting at multiple levels.[1] Psychological factors shown to contribute to pain range from personality traits (eg, passive and dependent coping styles, low self-efficacy, attentional control, and the tendency to catastrophize in response to stressors) to emotional state factors (such as anxiety, depression, trauma symptoms, uncertainty, helplessness, hopelessness, and anger). Beliefs about the cause or consequences of pain can also contribute to the pain experience. Such factors can represent longstanding, precancer patterns, or can emerge for the first time during the stresses of diagnosis, treatment, and survivorship.

Pain, coping challenges, psychological distress, and psychiatric disorders are highly prevalent during cancer treatment and its sequelae. Research has revealed that 53% of patients will report significant pain symptoms at some point during or after cancer treatment.[2] Mood disorders are found in 20% to 30% of patients engaged in active disease-modifying treatment and in up to 40% of those in survivorship.[3] It is likely that treatments

Disclosure Statement: Neither author has a conflict to disclose.

[a] Resnick Neuropsychiatric Hospital, UCLA Department of Psychiatry, David Geffen School of Medicine, 757 Westwood Plaza, Room 4230B, Los Angeles, CA 90095, USA; [b] Pediatric Psychiatry Consultation Liaison Service, David Geffen School of Medicine at UCLA, 760 Westwood Plaza, Semel 48-241, Los Angeles, CA 90024-1759, USA
* Corresponding author:
E-mail address: TStrouse@mednet.ucla.edu

Hematol Oncol Clin N Am ■ (2018) ■–■
https://doi.org/10.1016/j.hoc.2018.01.010 **hemonc.theclinics.com**

that improve depression symptoms have a greater impact on cancer-related pain that the converse, although this is a complicated interplay.[4] Patients whose mental health screener results exceed routine distress screening thresholds should be referred for a diagnostic evaluation by a social worker, psychologist, or psychiatrist with the aim of facilitating access to evidence-based treatment for any diagnosed disorders. Recent work indicates significantly higher rates of opioid prescriptions in cancer survivors compared with age-matched controls, providing another perspective on the prevalence of chronic pain and the possibility of comorbid behavioral disorders, including opioid dependency, among some individuals in that population.[5]

In their comprehensive 2012 meta-analysis of psychosocial interventions for cancer pain, Gorin and colleagues[6] reviewed 37 studies containing 4199 patients. They found a weighted average effect size of psychological interventions on pain severity of 0.34 ($P<.001$), and an effect size of psychological interventions on pain interference of 0.40 ($P<.001$). These moderate-size results support the value of integrating behavioral health expertise and interventions into cancer treatment settings,[7] particularly in an era in which concerns about opioid abuse are creating increased caution among patients and prescribing clinicians.

DIAGNOSTIC AND INITIAL TREATMENT PHASE

For many individuals, receiving a new cancer diagnosis and engaging in initial diagnostic testing and treatment can be overwhelming and traumatic experiences. A new cancer diagnosis can also reactivate distress and trauma-related symptoms in those with a trauma history, including prior medical trauma, childhood abuse, domestic violence, military service, high trauma-exposure occupations, and/or other sources of high stress or trauma.[8,9] Even when pain has been one of the presenting symptoms that led to a cancer diagnosis, many factors can conspire to lead to inadequate attention to cancer pain and its management at that early juncture. From the patient side, those factors may include fears that pain correlates with disease severity or recurrence risk, concerns that pain complaints will create an impression of weakness or will distract the oncologist from the war against the disease, wishes to avoid appearing to be seeking drugs for pain management, or beliefs that cancer pain cannot be managed.[10,11] It seems reasonable to consider these factors as elemental to psychological approaches to helping patients get better cancer pain control.

Although clinician attitudes and health system-imposed obstacles are not the focus of this article, it would be a major omission not to acknowledge their importance as potential obstructing or facilitating factors. In the face of a national opioid misuse epidemic and mounting pressures on prescribers to minimize or avoid opioid prescriptions entirely, physicians have retreated from the decade of pain and pain as the fifth vital sign almost to a don't ask, don't tell modus operandi. Particularly for patients with cancer pain, this can be another kind of malignancy. The national opioid abuse problem, and the sometimes sensationalistic press it generates, has the potential to drive many cancer pain patients underground, exploiting their baseline fears and making it easier to disavow the pain problem until it cannot be ignored. Clinician discomfort with opioid prescribing can easily become a confounding factor. When this happens, the unnecessary suffering that results is unfortunate and may contribute to worse medical outcomes.[12]

In light of the challenges related to opioid management of cancer pain, the strong and enduring evidence that psychological interventions are effective in reducing pain during the early phases of cancer diagnosis and treatment has become even more relevant. **Table 1** presents the best-studied interventions and the supporting science for those in the early phases of cancer diagnosis and treatment.