

What is psychosocial care and how can nurses better provide it to adult oncology patients

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ABSTRACT

Objective

This paper explores psychosocial care; the potential barriers, how nurses provide it, utilise assessment tools and the impact, issues and benefits of providing effective psychosocial care.

Primary argument

Nurses are in a unique position to monitor patients and their psychosocial care. However there remains a barrier to exploring some of these facets of care. Nurses need to be more inclusive of patient's sexuality, spirituality, optimism and hope when assessing psychosocial care and quality of life as these subjects can be the least explored by staff with their patients.

Conclusion

As hospital nurses we see the patient and their family throughout their cancer journey and are in a unique position to monitor a patient's psychosocial coping and any distress. Providing psychosocial care to patients is essential but can be an over looked part of nursing care. In university we are taught how to be nurses but how to communicate with patients and other health care professionals is part of on the job training. Psychosocial care is part of a holistic patient perspective and allows patients to seek both informational and emotional support from care givers to help them manage their cancer journey.

INTRODUCTION

Psychosocial care is important not only to patients but also to the staff providing that care. Patients consistently report having significant informational and emotional needs that are often unmet during their cancer journey (Sussman and Baldwin 2010). Nurses can provide both care and support with verbal and written advice to patients. Written information is especially important for newly diagnosed patients who may not retain a lot of information due to an overload of information at initial diagnosis. This allows patients to base their understanding of cancer on sound information rather than anecdotes and misinformation (Moody 2003). Nurses play a pivotal role in the psychosocial care of oncology patients throughout their journey. Nurses see patients at their worst and at their best; from diagnosis, through treatment, through to cure or palliative and end of life care, it is a long journey which is shared between patient and health care practitioner. There are two important issues in the delivery of psychosocial care to cancer patients: recognition of distress and the available mental health resources (Muriel et al 2009). The question then is how effectively do we address psychosocial care with our patients?

What is psychosocial care?

Psychosocial support involves the culturally sensitive provision of psychological, social and spiritual care (Hodgkinson 2008). Nurses play a unique role in supporting patients; by building dialogue with patients nurses can begin to understand how patients view themselves as individuals, what is important to them, and how their relationship with others may affect their decisions and their ability to live with those decisions during their treatment and beyond (Ellis et al 2006). Good communication and assessment skills are essential to building a rapport with patients and can help the nurse develop a clinical relationship with the patient and their family. In some cases cancer can be considered a chronic disease, and with that the patient and their family will be hospitalized throughout their disease trajectory. This gives hospital based nurses the optimal chance of building and gaining patients trust and initiating

support for patients and their family. Nurses strive to treat patients individually as each patient requires specific physical, symptomatic and psychosocial care (Watts, Botti and Hunter 2010). The provision of good psychosocial care has been shown to be beneficial for patients by reducing both psychological distress and physical symptoms through increasing quality of life, enhancing coping and reducing levels of pain and nausea with a consequent reduction on demands for hospital resources (Ellis et al 2006; Carlson and Bultz 2003).

Why is psychosocial care important?

Approximately 350,000 Australians are diagnosed with cancer each year and as a consequence will experience a variety of psychosocial and emotional responses (Botti et al 2006). A study by Kenny et al (2007) found up to 60% of patients diagnosed with cancer have major difficulties dealing with psychological issues and these patients report oncology providers do not consider psychosocial support integral to their care and fail to recognise, adequately treat, or offer referral for psychological distress (Muriel et al 2009). Psychosocial care is important; it has a huge impact on quality of life and encompasses a broad spectrum of issues in cancer care including physical, social, cognitive, spiritual, emotional and role functioning as well as psychological symptomology, pain and other common physical symptoms such as headaches, sleep disturbance and gastrointestinal upset (Carlson and Bultz 2003). All oncology patients will be affected in some way by their treatment. Structured assessment undertaken by oncology nurses enables us to identify patients at risk for poor adjustment early and can help to direct the use of interventions aimed at fostering a sense of optimism and ultimately improve health related quality of life during survivorship (Mazanec et al 2010). As hospital nurses we see the patient and their family throughout their cancer journey and are in a unique position to monitor a patient's psychosocial coping and any distress. Emotional distress can occur at any time along the disease trajectory and is defined as a change in thinking, feelings and behaviours that occur in the response

to diagnosis, prognosis, treatment and events that occur in the clinical course of cancer (Grimm 2005). Just as the patient is an individual so to is the disease trajectory on which they travel and there is no uniform response to treating all patients with the same type of cancer in the same way.

How can we provide psychosocial care?

Providing good psychosocial care comes down to good communication skills, both verbal and non-verbal. Communication in the context of cancer care includes general interactional skills to convey empathy and support and to provide medical information that is understood and retained. A relationship of health care providers with patients is based on trust, being open and honest, understanding, being present, respect, setting mutual goals and providing social support (Ritchie 2001). This relationship can be an important support and buffer for cancer patients experiencing distress (Rodin et al 2009b). Non-verbal communication can convey a great deal to patients who may scrutinise their doctors or nurses for nuances of expression or demeanour (Fallowfield and Jenkins 1999). Non-verbal communication is seen by patients as indicators for good or bad news just as much as the actual words spoken. Verbal communication is crucial to building and maintaining this relationship, to transmit information, to provide support and to negotiate treatment decisions (Rodin et al 2009a). The relationships nurses build with patients can also vary among patients; the age and gender of the patient can have an impact on the relationship built. There can be a difference in tactics when discussing the same complex issues with patients of different ages. It is important to provide informational support that consists of the availability and provision of concrete and age-appropriate information (Zebrack et al 2010). Patients will be in different life stages so issues such as fertility, finance and study may affect different people in different ways. Part of the nurse's role in psychosocial care is being able to provide the resources and education particular to the individual patients needs.

Nurses as well as other practitioners need to create an environment in which the patient feels comfortable and safe to relate and communicate. This therapeutic relationship plays a vital role to

patients and their families and they do rely on nursing staff for the emotional journey they are on. Oh and Kim (2010) have shown that psychological issues can influence cancer recovery with patients that experience psychological distress such as anxiety and depression often experiencing increased physical side effects and more difficulty managing their self care and experiencing an overall reduced quality of life. Vodermaier et al (2009) state that relatively brief but validated questionnaires would seem to be the tools of choice for routine screening of cancer patients emotional distress. An advantage to systematic screening of cancer patients for emotional distress is that it is likely to promote equal access to psychological services, where as a system based only on physician or patient initiated referrals might fail to identify and/or overlook a substantial proportion of emotionally distressed patients who are in need of supportive treatment. Cancer in particular is known to be a highly stressful experience associated with emotional difficulties (Lin and Bauer-Wu 2003).

What issues need to be more thoroughly addressed by staff with patients to improve quality of life?

Nurses need to be more inclusive of patient's sexuality, spirituality, optimism and hope when assessing psychosocial care and quality of life. Cancer is considered to be de-sexualising, having both a direct effect on a person's sexual response cycle and an indirect one on body image (Kotronoulas et al 2009). In cancer care specifically there appears to be a conception that people with cancer do not have sex (Quinn 2003). Every human being has a sexual dimension; even patients with advanced cancer or terminal care have a fundamental need for human intimacy. Anxiety, depression, despair, feelings of social isolation, lowered self-esteem, fear of abandonment, loss of control over bodily functions, and so on may also affect one's manifestation of sexuality (Katronoulas et al 2009). Assessment and good communication skills are important to building therapeutic relationships, thus allowing patients to feel comfortable in verbalising their feelings. Oncology nurses need to possess knowledge as well as exert sound judgement and a high level of sensitivity in dealing with patient's sexual health needs. A study by Katronoulas et al (2008) found nurses often

fail or avoid addressing, assessing and discussing sexual problems with their patients and prefer to deal with it when patients bring up their sexual health. Barriers to taking a sexual history in assessment include lack of time; fear of intruding or offending the patient, belief that cancer patients are too ill or not interested in sex, belief that disfigured bodies are not sexually attractive, lack of adequate training/skills, cultural issues; gay patient, single patient, different cultural beliefs about illness and disease, age and gender of patient, presence of a third party (partner, parent) and a fear of opening 'Pandora's box' in regard to previous sexual assault or difficult relationship (Sundquist and Yee 2003).

Spirituality also needs to be addressed more proactively in hospital settings. Spiritual well-being is a subjective experience that occurs both within and outside of traditional religious systems (Rodin et al 2009); spirituality is especially awakened at the end of life as patients seek purpose and meaning (Demierre et al 2003). A palliative care centre review conducted by Mishra et al (2010) found 98% of patients interviewed with advanced cancer were spiritually grounded to their faith and religion and believed that God would help them. Another benefit of patients faith was it was found it helped to decrease these patients' anxiety. A review conducted by Mazanec et al (2010) found that spirituality was the strongest predictor of social well-being and a significant predictor of emotional and functional well-being in the quality of life of patients and families with cancer. Screening for spiritual distress is an integral component of psychosocial care provided by oncology nurses and may be facilitated by a simple assessment tool. Evaluation of a patients' sense of spiritual well-being may also provide another avenue by which to assess optimism, given the significant correlation between optimism and spirituality and finding that spirituality significantly predicted health related quality of life (Mazanec et al 2010). Patients with spiritual distress need to be referred to a trained spiritual care provider, which are either present or can be accessed in all Australian hospitals.

Optimism is a personality feature that has been associated with psychological well-being and

positive health outcomes in healthy individuals and in patients with cancer (Mazanec et al 2010). Optimism and pessimism have been linked to coping styles; optimists tend to use active problem solving strategies when confronted with a stressor, whereas pessimists generally use avoidant coping. Optimism is a complex characteristic with cognitive, emotional and motivational aspects. Mazanec et al (2010) suggest that bolstering optimism by reducing negative thoughts is an interventional strategy that may have implications for patients with cancer. Identifying patients coping strategies can help to identify the amount and type of psychosocial support the patient will need.

Hope is an important component in psychosocial care. Reb (2007) states that hope includes reflection, re-evaluation, finding meaning and the development of new goals. Revising goals so they are flexible and more realistic allows people to be more motivated to achieve attainable goals. Hope is not only based on a cure or being disease free but attaining the best quality of life they can have. Focusing on attainable goals can promote a sense of meaning and personal control. Nurses find the balance between truth telling and nurturing hope is an important aspect of fostering hope (Schofield et al 2006). Some nurses believe fostering false hope of a cure when a cure is not possible ultimately can be a source of regret as it may hinder patients and their family from making sensible treatment and lifestyle decisions. A study conducted by Reb (2007) found that communication style and relationships with healthcare providers were significant recurring themes that influenced hope. Nurses need to be able to engage patients and their families positively and to provide hope no matter what the shape hope comes in.

What are the limitations to providing effective psychosocial care?

To provide effective psychosocial care, it is a requirement that we build a relationship with the patient, however to build this relationship there is need to gain the patients trust and it is not until this trust is gained that psychosocial care can be provided. Primary care nursing is essential for both

the nurse and the patient to continue with continuity of care, however whilst an important role it does not facilitate the establishment of new relationships for the patient as they are always with the same nurse. In a work-force that is mainly made of part-time workers it is increasingly hard to build quality therapeutic relationships with patients when staff are exposed to patients on an intermittent basis. Another pitfall of this continual change in carers can be ineffective communication occurring between the ward nurses and the ward doctors as well as between the ward nurses themselves (Botti et al 2006). Lack of communication can be reflected by staff either repeating or omitting things said on a previous shift and patients becoming distressed because they feel that no one is sure what is happening.

Health professionals who feel insufficiently prepared in communication skills are reported to have a higher level of stress (Botti et al 2006). There is evidence of high stress levels among oncology nursing staff and that a common source of stress is associated with the provision of emotional support for patients and their families (Botti et al 2006).

A study by Botti et al (2006) found that high workload and a lack of available time were cited as potential barriers that limited nurse's opportunity to sit down and engage in conversation with patients to elicit their specific needs. In a study by Mishra et al (2010) doctors and nurses stated they were unwilling to enquire about the psychological impact of the diagnosis and treatment of cancer because they were concerned they may not be able to deal with any problems they may elicit and if encountered it would take so much time that they can not cope with their workload. However, Kenny et al (2007) argue that nurses often use work pressure as 'blocking tactics' which prevent patients from divulging information that nurses do not feel they have the capacity to deal with.

Health practitioners have recognised the difficulty in setting professional boundaries when providing care (Watts et al 2010). Professional boundaries provide limitations on behaviours between health professionals and patients in recognition of the power

differential between the influence of the former and the vulnerability of the later (Lancaster 2008). The potentially chronic nature of cancer as an illness means that health care professionals are more likely to have a prolonged therapeutic relationship with patients and their families.

Mishra et al (2010) found that doctors and nurses use interviewing strategies designed to keep the interview emotionally neutral instead of asking more appropriate questions about a patient's psychological adaptation or lack of it. The use of these distancing tactics has been found to be common in both doctors and nurses.

The balance between providing quality psychosocial support and the emotional impact of their role has been identified by many authors as a type of conflict that ultimately leads to emotional exhaustion (Kenny et al 2007; Botti et al 2006). Nurses working in oncology clinical environments have high levels of perceived stress, emotional exhaustion and professional burnout (Watts et al 2010) and a report by Barrett and Yates (cited in Watts et al 2010) states that more than 70% of their sample of Australian oncology nurses are experiencing moderate to severe stress. Burnout is a syndrome of physical and emotional exhaustion and is especially common in highly technical and highly emotional areas (Watts et al 2010). This is also exacerbated as nurses who care for patients with cancer are often committed to and often develop close therapeutic relationships with them. For nurses to be emotionally present requires openness, commitment and the ability to understand the patient's world as he or she views it (Ritchie 2001). The inability to debrief in the professional setting resulted in any unresolved issues being transferred to the personal environment. Watts et al (2010) discussed that with experience, one is able to leave patient-related experiences at work, suggesting the nurse new to the area is particularly vulnerable to negative patient experiences. Nurses themselves can be a limitation to providing effective psychosocial care. If nurses do not take care of their own psychosocial care they may not be able to give a lot of themselves to their patients. Whilst we are

taught not to get emotionally involved with patients it can be hard not to form attachments with patients that represent frequently to the hospital or day centre. Experience can allow nurses to manage the emotional toll better than junior staff; however we need to ensure we can retain junior staff by providing them with support as required as well.

What are the benefits to providing effective psychosocial care?

Biomedical researchers have begun to acknowledge that cancer treatment itself (surgery, radiation, chemotherapy) can result in long-term psychological impact which can in turn impact quality of life (Boykoff et al 2009). Due to the nature of cancer it is easy to recognise the impact that nurses can have on assessment and intervention along the disease continuum. It is not an essential component in assessing patients for emotional distress that nurses have any background knowledge in mental health. Rodin (2008) suggested nurses with no previous psychiatric experience can deliver a cost-effective collaborative psychosocial intervention for cancer patients with major depressive disorder.

By providing appropriate psychosocial care we can decrease the time patients are in hospital with side effects relating to anxiety and stress. Hospitals and health care systems are looking for cost effective ways to help meet budget demands whilst still achieving customer and patient satisfaction.

How we can improve psychosocial care

Cancer care can be a stressful working environment for staff that are called upon to deliver highly complex and technical care while constantly dealing with the distress and suffering of very ill and dying patients and their families (Lancaster 2008). Oncology work environments can be improved by focusing on modifiable factors such as staff development that will lead to better job satisfaction and staff retention (Watts et al 2010). The development of effective strategies to assist clinicians to use communication skills in the provision of care is fundamental to achieving optimal psychosocial outcomes for patients (Botti et al 2006). Such communication is vital to enable the provision of appropriate, accurate, and

detailed information to the patient and the key stages relating to the pathological process of the disease.

Clinical supervision is well recognised in the literature as an effective strategy for enhancing professional development, promoting self-awareness, and providing support, and has been used extensively across professional groups (Botti et al 2006). Clinical supervision offers the opportunity for reflection and self-insight and can be a medium for exploring issues such as over-involvement and dependency that can develop when caring for people with cancer (Kenny et al 2007).

Time constraints of health professionals and insufficient knowledge about the appropriate screening tool may partially account for the infrequent use of high-quality screening instruments in cancer care settings (Vodermaier et al 2009). It is important to ensure that nurses have the necessary time management tools to provide efficient and timely nursing care.

CONCLUSION

Nurses use psychosocial support to help establish therapeutic relationships. These relationships are built through psychological, social, and spiritual care. Today, effective high quality cancer care is viewed as involving more than just the delivery of anti-cancer therapy. Increasingly cancer service providers are required to address patients supportive care needs (Harrison et al 2009). As hospital nurses we see the patient and their family throughout their cancer journey and are in a unique position to monitor a patients' psychosocial coping and distress. Empowering patients through support and education enables them to have some feeling of control. Health care professionals that use empathy, understanding, and reassurance contribute to positive psychological outcomes for patients (Lin and Bauer-Wu 2003). Patients feel supported in a holistic approach that focuses on their quality of life, intimate relationships, and social situation (Sundquist and Yee 2003).

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