Psycho-oncology in Advanced Cancer: CALM Therapy a Canadien Psychological Intervention

Paulina Troncoso G.[1] Anne Rydall[1] Gary Rodin[1 2 3]

ABSTRACT

Advanced cancer is associated with numerous challenges including progressive physical deterioration that triggers fears regarding dependence and loss of autonomy, mortality and meaning of life. The continuous increase in survival in oncology patients has led them to live in a process of adaptation and continuous changes, which carries a great emotional burden for both the patient and his or her family. Many terminal cancer patients meet criteria for a psychiatric diagnosis or sign distress, with depressive symptoms being very frequent. This makes us think of the imperative need for appropriate interventions for people in this situation, where existential issues, restructuring of purpose, interpersonal relationships, meaning of life and the process of dying and death play a fundamental role.

The aim of this work is to describe a Canadian experience of a brief individual psychological therapy called Managing Cancer and Living Meaningfully (CALM), which was developed and evaluated over the last 10 years in Toronto. CALM Therapy was designed to reduce distress and promote psychological well-being in patients with advanced cancer; this article will describe its main components, characteristics and evidence of its benefit for this population.

Key words: advanced cáncer, psychological therapy, psychological intervention

INTRODUCTION

Cancer is currently considered a pandemic, with a trend of 16 million new cases expected by the year 2030 according to World Health Organization(WHO) (1). In Canada, 2 out of every 5 people will develop cancer in their lifetime, with a 5-year survival of 63% across all cancer types (2). In a 2015 comparison of the quality and availability of palliative care in 80 countries, referred to as the Quality of Death Index, Canada ranked among the top countries in the world having a good quality of dying index overall score (3).

The Canadian bio-psychosocial approach for cancer patients and their families aims to preserve the best possible quality of life during the trajectory of the disease. The process of dying and death is an open and widely discussed topic in this society and increasingly in medicine in general (4, 5). The conditions necessary for a good death across cultures include the

Aceptado:
Recibido:

1 Department of Supportive Care, Princess Margaret Cancer Centre, University Health Network 610 University Ave., 16-712, Toronto, Ontario, M5G 2M9, Canada.

2 Department of Psychiatry, University of Toronto, Toronto, Canada.

3 Princess Margaret Cancer Research Institute, Princess Margaret Cancer Centre, University Health Network, Toronto, Canada

absence of pain, recognizing and resolving personal, delegating control, maintaining continuity in meaningful relationships and functioning at the most effective level possible within of the limits of disability (6). However, the resource limitations in developing countries make this more difficult to achieve (7).

Cassell (8) emphasized that the alleviation of suffering and the cure of disease are equally important goals in medicine and oncology. The greater the threat perceived by the person and the less support that is available may mean that the psychological suffering is greater (9). Pain and other physical symptoms can generate suffering, but psychological suffering may arise from multiple sources and require different interventions. Most diagnostic and treatment strategies in oncology are directed to cancer itself but much fewer to the subjective experience of the individual, including their emotions, religious beliefs and existential concerns (10).

A variety of psychiatric and psychological disturbances have been identified in patients with advanced cancer. Among the most frequent psychiatric disorders are adjustment disorders, depression and anxiety disorders. The highest levels of anxiety are observed at the time of diagnosis and recurrence. Finally, depression becomes a common pathway along with the progression of the disease and increasing proximity to death (11). Depression can be considered a final common pathway of distress in response to the symptomatic burden of the disease and interaction with psychosocial factors including attachment security, self-esteem and spiritual well-being (12). Approximately 25% of patients with advanced disease suffer from clinically significant depression (Rodin et al 2009) and these symptoms tend to increase with disease progression Lo et al 2011 (13). It has also been shown that depressed patients have worse prognosis and higher mortality rates than people with physical illnesses without an associated psychological component (14). Depression at the end of life has been strongly associated with the desire for hastened death, which can be seen clinically in the request for patient-assisted death in countries where it is legalized (15, 16) Suicide rates increase in this phase of life in the context of poorly controlled pain, depression, demoralization and poor family support (17)

Other psychological disturbances in individuals with advanced disease include demoralization and loss of meaning, the loss of dignity, and existential distress 18-20)

Symptoms of demoralization including feelings of hopelessness or loss of meaning or purpose of life, attitudes of pessimism, helplessness, feeling / trapped, personal failure, or absence of a future worth fighting () This may occur in the absence of major depression or other psychiatric disorders and the characteristic phenomena persist for more than two weeks with fluctuations in their intensity (18). The loss of dignity occurs when individuals lose their sense of self worth and self –esteem (19). Existential distress refers to …

In this context of terminal illness, individuals must face the threat of death and the progression of illness while also trying to live in the present (18). This paradox called double awareness refers to living in the face of death and dying while living. In the / context of advanced disease, it describes the capacity of individuals to sustain and negotiate the dialectical tension that arises between remaining engaged in the world, while preparing for impending death. Psychotherapeutic interventions in this context may allow them to live with a better quality of life and to process the experience of impending mortality (21).

The task of facing death requires the ability to find meaning in life while also facing death. of the desire to order and find the meaning to continue living with a sense of vitality, Existential philosophy broadly asserts that awareness of life-death tension has the potential to become a source of great despair as well as of profound meaning (22).

While “Talking about death” can be

uncomfortable, it has been shown that open-ended questions in therapeutic sessions allow patients to discuss their concerns about dying and death and can improve psychological well-being. This may contribute to an enriching and effective therapeutic process, with great significance for both the patient and their family and environment (23). Early interventions to manage the challenges in advanced disease and to treat depressive symptoms or psychological symptoms can help protect or improve emotional well-being and quality of life. However, most patients who suffer from depression at this stage of the disease are not referred to psychiatry and may not receive adequate treatment (24). A routine assessment of psychological symptoms in all stages of cancer disease has the potential to ensure effective and specific interventions (25, 26).

The treatment of psychological or psychiatric symptoms in advanced cancer requires a multidisciplinary approach. Important factors include strong communication between the oncologist and the Psycho-oncology team, specialized training of the nursing team and the social workers and early integration of a palliative care team. All of these factors contribute to better psychosocial care for distressed patients with advanced cancer. In institutions with limited resources and few professionals with specialized training in Psycho-oncology and palliative care, it may be difficult to provide such comprehensive and necessary care for such patients. (27, 28).

Psycotherapeutic Interventions in Advanced Cancer and Palliative Care

Psychotherapeutic interventions at the end of life aim to reduce emotional discomfort and to facilitate adaptation to the final stage of life (30). Individuals with advanced cancer and depressive symptoms tend to prefer psychotherapeutic interventions over pharmacological treatment, and to value the emphasis communication, the understanding of emotional experience and the search for meaning for current life (28).

Group therapies for terminal patients including supportive-expressive (31-33), cognitive-existential (18, 34, 35) and meaning-centered (36). However, the feasibility of group therapies may be limited for various reasons in patients with advanced disease. Problems such as the lack of flexibility in scheduling schedules and the difficulty of patients with advanced disease to absorb the emotional burden of other patients in the same group, and the preference of patients for private spaces to discuss certain personal problems that overwhelm them (37).

There is currently evidence that individual psychotherapies have shown benefit in patients with advanced disease. Dignity therapy focuses on strengthening the sense of dignity and is intended for patients near or close to the death (38, 39). Individual therapy, focused on meaning, seeks to improve the patient's spiritual well-being and sense of meaning and purpose (40, 41). CALM individual therapy, developed in Toronto, Canada 10 years ago, has proven to be an effective intervention in the relief of depressive symptoms in patients with advanced cancer and helps to address the challenges patients face at the end of life (47)

Managing Cancer and Living Meaningfully Therapy (CALM)

CALM is a supportive-expressive, individual, brief, semi-structured therapy designed to alleviate emotional distress and promote psychological growth in patients with advanced cancer and with feelings of threat in his current life due to cancer. This intervention arises from a longitudinal program of research and from theories related to attachment and the existential. This therapy aims to alleviate suffering by facilitating affective regulation, problem solving and reflection in the domains in which challenges for patients and caregivers typically arise. The short-term nature of the intervention allows CALM therapy to be administered to patients with limited life expectancy and is feasible in oncology and

medical care settings.

The sense of limited time and uncertain future in individuals with advanced disease can increase their motivation to seek help and participate in a psychological intervention. As an individual therapy, CALM can be adapted to the unique needs of patients and allows privacy with respect to personal and sensitive problems that may arise, as well as flexibility regarding the content and timing of the sessions. The latter is important to meet the needs of patients struggling with a fluctuating state of health, complicated treatment schedules and unpredictable hospitalizations. CALM shares with Dignity therapy a focus on identity and self-concept and preparation for the death of patients near the end of life. However, CALM is intended for ambulatory patients who are in early stages of terminal disease (usually with more than 6-18 months of estimated survival), when they are still active and able to benefit from the therapy but are living with knowledge that death is inevitable. Early referral for CALM helps patients learn how to cope in the best possible way as their health declines, and helps them to live the best quality of life in the time they have left.

Structure of CALM

CALM therapy optimally consists of six individual sessions of 45 to 60 minutes over a period of three to six months, although the number of sessions may vary, depending on the circumstances of each patient. The CALM sessions address four broad and interrelated domains that are considered important and relevant in this population. Symptom management and communication with health care providers, changes in oneself and relationships with others close to them, sense of meaning and purpose and future and mortality. These domains are treated with all patients at some point during the intervention, although the sequence and relative emphasis in each domain varies, depending on their urgency and the relative importance in each case. The primary caregiver of each patient has the opportunity to participate in one or more sessions to allow the exploration of the relationship between the patient and their primary caregiver and to support the dyad in anticipating and preparing for the future.

Patients Suitable for CALM are those with advanced or metastatic cancer who have some interest and capacity for reflection as well as a sufficient physical and cognitive capacity to be able to attend the therapeutic sessions in a period of 3 to 6 months.

The process of CALM therapy

The following are the ingredients in CALM therapy that contribute to its therapeutic effects.

The supportive relationship: the most important element of CALM therapy is the patient-therapist relationship. The CALM therapist works to understand empathically the patients' felt experience and understand its meaning. Therapists become witnesses to the experience of patients, helping them to address fears of isolation and dependency, to manage feelings of grief and loss and identify their strengths and potential adaptive coping strategies.

Authenticity: the therapeutic stance is one of authentic engagement with the patient. The therapists accept and resonate with the patient's fears and hopes.

Changing framework and flexibility: fluctuations in patients´ clinical state, control of symptoms and receipt of prognostic news may drastically alter their capacity or motivation for self-reflection.

Modulation of Affect emotional hyperarousal and constriction can occur transiently, persistently or alternately, causing distress and interfering with the processing of emotional experience. CALM therapists aim to help patients modulate the intensity of emotions to keep this within a tolerable range.

Renegotiation of attachment security: the threat of illness heightens attachment needs and makes them more salient. CALM therapy addresses emotional disruption

caused by this potential attachment crisis and helps individuals and their caregivers re-establish restore equilibrium in their attachment relationships.

Mentalization and double awareness: individuals vary widely in their capacity for self-reflection, and what has been termed mentalization (i.e., the capacity to reflect on feeling states, to distinguish them from literal facts and to accept the possibility of multiple perspectives). Being able to mentalize diverse feeling of states allows individuals to sustain a "double awareness" of the possibilities of living as well as the eventuality of dying.

The joint creation of meaning: relational theory emphasizes mutuality in the therapeutic situation, wherein patients and therapists co-create the meaning and understanding of the patient's experience.

The Content of CALM therapy

The content of the therapy is organized into four interrelated domains. This are::

Domain one: Symptom management and communication with health care providers. Understanding the disease, symptoms and treatment process are central concerns of patients and their families. How to manage these concerns and the decision-making process are complex tasks that overwhelm many patients? Support for this process and for the relationships with health care professionals may improve adherence to medical treatments and understanding of the objectives of treatment. Important dimensions of

domain include: understanding the disease and managing symtoms, supporting medical decisionmaking and supportive collaborative relationship with health care providers.

Domain two: Changes in Self and Relationships with Close Others.

Self-concept, the experience of support and comfort with it and communication and cohesion in their interpersonal relationships are included in this domain.

Domain three: Sense of Meaning and Purpose.

This domain includes the life narrative /, the personal meaning of the disease, and life and the reframing of life priorities when time is short fee.

Domain four: The Future and Mortality.

Recognition of anticipated fears, balance of living and dying, and advanced care planning are included in this domain, with the aim of achieving a balance between the tasks of living and living and dying / (42).

Evidence of CALM Therapy

There has been evidence about the benefit of CALM emerging in the past decade. A rigorous research program has phase I, phase II, phase Ibis and a large phase III RCT recently completed (Rodin et al 2018). These studies have demonstrated the feasibility, acceptance and effectiveness of the intervention in reducing the frequency and severity of depressive symptoms, as well as a better preparation for the end of life. (42-47)

The Phase III Study is a randomized controlled clinical trial carried out over a period of 4 years (2012-2016). In this study, 305 patients were recruited, 151 patients randomized to CALM therapy and 154 to usual care. The group that received CALM therapy reported less depressive symptoms at 3 and 6 months later. Statistically significant differences were also found in a better preparation for the end of life at 6 months compared with the usual care group.

The CALM Intervention offers a safe and flexible place to process the experience of living with advanced cancer, allows conversation about the future and dying and death, and helps in navigating the health system, resolving relational tensions and giving an opportunity to be seen as a complete person within a health system (47).

Conclusion and Next Challenges

There are many challenges that patients and family members living with advanced cancer must face. Psychological and psychiatric symptoms are common and often

overlooked by the health team, Patients and family members have said that the opportunity to talk about their fears and about the challenges that face them have provided great relief.

The training of health professionals in bio-psycho-social and spiritual approach may help them to detect and treat psychological suffering of patients with advanced disease. An intervention developed and tested in Canada, called CALM, has proven to be a cost-effective, brief, flexible individual therapy that can be adjusted to the needs of individual patients can relieve depressive symptoms, and help the patient with advanced disease to face the challenges ahead,

CALM therapy is now in the process of being expanded globally because the concerns of patients with advanced cancer and the challenges in psychosocial care are universal.

A global network with clinical training and the collection of evidence regarding outcomes is now being established, Further information about the Global CALM program is available at the Global institute of Psychosocial, Palliative and End of Life Care (www.GIPPEC.org)

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Mailing to:
Dra. Paulina Troncoso G.
43 Kennedy Avenue, M6S2X6, Toronto
paulina.troncoso@uhnresearch.ca
647-289 7679
fax: 416-3404739