



Biologic, psychological, and social health needs in cancer care: how far have we come?

*F. Schulte PhD**

In 2007, the U.S. Institute of Medicine delivered a report titled *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*¹, in which gaps in the provision of psychosocial care for cancer patients were identified. The report highlighted that, despite a burgeoning evidence base demonstrating the effectiveness of a variety of psychosocial health interventions for patients and survivors of cancer, the psychosocial health needs of patients were not being adequately met. That report brought to the forefront the necessity not simply to consider the psychosocial needs of cancer patients, but to carefully integrate psychosocial assessment and subsequent treatment with management of the physical needs of each patient. In essence, one set of needs cannot be conceived without the other. Cancer care for the “whole patient” must consider biologic, psychological, and social factors.

The article titled “The influence of chemotherapy-induced neurotoxicity on psychological distress and sleep disturbance in cancer patients” by Hong and colleagues that appears in this issue of *Current Oncology* is a prime example of the intricate relationship between physical and psychosocial symptoms in cancer care. The article explores the relationships of chemotherapy-induced peripheral neurotoxicity (CIPN) with psychosocial distress and reduced sleep quality in newly diagnosed cancer patients. Specifically, the study sampled 706 newly diagnosed cancer patients between 18 and 70 years of age undergoing cancer therapy at four institutions across China. Patients completed measures designed to operationalize peripheral neurotoxicity, anxiety and depression, and sleep quality. Results revealed that, after controlling for age, sex, education level, social supports, fatigue, disease stage, and tumour site, patient-reported neurotoxicity was the most significant predictor of depression and anxiety; CIPN also significantly predicted sleep quality.

Unfortunately, this research was not longitudinal in design, limiting the ability of the authors to determine causation. Questions might therefore arise

about whether patients experiencing greater psychosocial distress—including depression, anxiety, and poor sleep—are more likely to report greater self-perceived peripheral neurotoxicity or whether CIPN leads to an increased frequency of psychosocial difficulties. The potential to understand causation is further affected by the inclusion of a self-report measure of CIPN comprising only two items, which precludes a broader clinical picture of additional chemotherapy side effects that might also be affecting psychosocial symptoms. Nevertheless, this research emphasizes a significant link between chemotherapy-induced neurotoxicity and psychosocial symptoms. Most notable is the finding that the relationship extends over and above those of other variables known to affect mood and anxiety, including social supports and fatigue.

Today, almost 7 years since the Institute of Medicine report, research continues to overwhelmingly support an association of the prevalence of psychosocial symptoms with the physical side effects of cancer treatment. Has care for the cancer patient become better integrated with respect to assessing, monitoring, and treating the “whole patient”—that is, including the biologic, psychological, and social needs? Based on their research findings, Hong *et al.* conclude that ongoing assessment of peripheral neuropathies should be emphasized. As health care practitioners and academics, we have an ongoing responsibility to recognize, monitor, document, and treat psychosocial symptoms across the cancer continuum.

Since the early 2000s, a tremendous movement has begun to screen for psychosocial distress in all cancer patients. Psychosocial distress is now acknowledged internationally as “the 6th vital sign”². The cost of unidentified psychosocial distress in cancer patients, survivors, and families is severe. Patients experiencing multiple stressors can have more difficulty making decisions and adhering to treatment recommendations. They can also strain the resources of oncology teams by requiring more health care personnel time to deal with nonmedical

concerns³. Further, when psychosocial distress is not addressed, the ways that patients with cancer and their families cope with the disease is affected. Beyond the direct impact on patient and family, the cost of unidentified psychosocial distress is a public health concern. Patients and families who do not receive the help they need are at risk of developing chronic mental health issues that will ultimately require time, resources, and financial expenditures from the health care system⁴. Psychosocial care should not be considered a luxury—it is a necessity.

CONFLICT OF INTEREST DISCLOSURES

The author has no financial conflict of interest to declare.

REFERENCES

1. Adler NE, Page AEK. *Institute of Medicine: Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs*. Washington, DC: The National Academies Press;

2008. [Available online at: http://books.nap.edu/openbook.php?record_id=11993; cited March 26, 2014]

2. Bultz BD, Carlson LE. Emotional distress: the sixth vital sign in cancer care. *J Clin Oncol* 2005;23:6440–1.
3. Kazak AE, Cant MC, Jensen MM, *et al*. Identifying psychosocial risk indicative of subsequent resource use in families of newly diagnosed pediatric oncology patients. *J Clin Oncol* 2003;21:3220–5.
4. Chiles JA, Lambert MJ, Hatch AL. The impact of psychological interventions on medical cost offset: a meta-analytic review. *Clin Psychol Sci Pract* 1999;6:204–220.

Correspondence to: Fiona Schulte, Alberta Children's Hospital, 2888 Shaganappi Trail NW, Calgary, Alberta T3B 6A8.

E-mail: fiona.schulte@albertahealthservices.ca

- * Departments of Oncology and Paediatrics, University of Calgary; Alberta Children's Hospital Research Institute; and Haematology, Oncology and Transplant Program, Alberta Children's Hospital, Calgary, AB.