

## 'I know they are distressed. What do I do now?'

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### Abstract

Significant advances have been made in our understanding of psychological adjustment to cancer over the last 40 years. Most clinicians now recognise the importance of psychosocial factors and the need for skills in emotional support. In the first phase of psycho-oncology, pioneering work in the 1970s and 1980s mapped the extent of psychological morbidity in cancer. This has been followed by a second phase where clinical trials have demonstrated that psychological treatments are effective. But although clinicians may feel more confident in identifying distress and listening to the patient, they rarely feel confident that they possess the skills to help. This paper will review the progress through the first two phases and argue that we are now in the third phase where we can begin to examine methods for delivering cost-effective psychological care. One of these methods is to equip staff with basic skills to understand and manage psychological distress. This paper will also describe a programme over the last 10 years to evaluate the effectiveness and clinical impact of such training for palliative care professionals.

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### The three phases of psycho-oncology

Significant advances have been made in our understanding of psychological adjustment to cancer over the last 40 years. Most clinicians now recognise the importance of psychosocial factors and the need for skills in emotional support. In the first phase of psycho-oncology, pioneering work in the 1970s and 1980s mapped the extent of psychological morbidity in cancer. This has been followed by a second phase where clinical trials have demonstrated that psychological treatments are effective. But although clinicians may feel more confident in identifying distress and listening to the patient, they rarely feel confident that they possess the skills to help. This paper will review the progress through the first two phases and argue that we are now in the third phase where we can begin to examine methods for delivering cost-effective psychological care. One of these methods is to equip staff with basic skills to understand and manage psychological distress. This paper will also describe a programme over the last 10 years to evaluate the effectiveness and clinical impact of such training for palliative care professionals.

#### Phase I: defining the need

Significant scientific interest in the psychosocial needs of people with cancer began in the late 1970. Although some clinicians and researchers had reported levels of psychological distress and psychiatric morbidity in oncology populations [1,2], the sample sizes were small, selection of participants was not always representative and methods of assessment were not rigorous. It was not until the late

1970s and 1980s that more methodologically sound and systematic studies began in this area. The first well-designed large scale investigation of the prevalence of psychological disorders across a range of cancer diagnoses was carried out by Derogatis and colleagues [3]. A selection of new admissions to the inpatient and outpatient facilities in three US hospitals were assessed using a diagnostic interview and self-rating measure of psychological symptoms (symptom checklist-90 (SCL-90)). The researchers found an overall prevalence of DSM III psychiatric disorders of 47%. The conclusion that 'the pervasive emotional distress and dysphoria often associated with cancer may not be an inherent part of the neoplastic disease but rather a separate and potentially treatable condition' established the rationale for assessing cancer patients for psychological morbidity. Farber *et al.* [4] found similarly high levels of distress on the SCL-90 of 34%. Further large scale studies have been carried out since then and have yielded similar results. One of the largest samples utilised a database of over 4000 cancer patients who had completed the Brief Symptom Inventory [5] as part of their comprehensive cancer care and found an overall prevalence rate for distress of 35% [6]. Another approach of researchers at this time was to explore the effects of cancer treatments such as mastectomy and colostomy on psychological adjustment. They found that up to a quarter of women remained depressed 1 year after mastectomy [7,8], and that 25–50% of people post-colostomy experienced psychological distress [9,10].

This first phase of psycho-oncology was essential to establish the scope of psychological distress in people with cancer and to challenge certain prejudices and attitudes of denial that prevailed at the time. One strong belief

was that depression was inevitable in someone with a life threatening illness. These pioneering studies showed that the majority of people with cancer did not meet the criteria for psychiatric disorder, and even if the criteria are broadened to account for patients with 'demoralisation' secondary to their illness [11], this remains the case. They helped to demonstrate to oncologists that appropriate sadness and grieving is not the same as depression. We now have some knowledge of the biological, psychological and social factors that predispose to depression in cancer [12], but anxiety disorders have been less fully researched. A second belief was that asking people with cancer about psychological distress might be harmful, but participants' responses to being included in the research were largely very positive, disproving the idea that probing about psychological distress was harmful. These findings helped to establish liaison psychiatry and health psychology as legitimate enterprises in oncology settings. They also led to developments in screening and assessment for use in clinical settings. Attention has been paid to the challenges in separating the physical symptoms of cancer from the somatic symptoms of depression (for a discussion see Riba & Grassi [13]). A number of instruments are available to measure psychological distress such as the distress thermometer [14], anxiety and depression such as the Hospital Anxiety and Depression Scale [15]; and work has been carried out to hone screening questions down to just one or two questions a busy clinician can ask their patients [16]. Despite these advances, it has proven difficult to show any effect of screening on identification rates or outcome of depression [17].

**Phase 2: developing and demonstrating effective interventions**

Another important question raised by sceptical clinicians from the beginning has been 'Even if I do know my patient is depressed/anxious, what can be done about it?' Having established the level of psychological distress, it was necessary to demonstrate that this suffering could be alleviated. Pharmacotherapy for depression has been more systematically studied than anxiety in this area. Antidepressants have been shown to be effective in medical illness generally [18,19] and also in palliative care [20]. A range of psychological treatments have also been shown to be helpful in people with cancer. These have primarily but not exclusively been cognitive behavioural in orientation, because this approach has traditionally been more at ease with the empirical method and the use of randomised controlled trials, and also because it lends itself well to brief, structured, manualised interventions. Cognitive behaviour therapy (CBT) has been delivered both as individual sessions and in groups. The groups have often been psychoeducational in nature with components such as relaxation and stress

management, problem solving and cognitive restructuring. Individual CBT has tended to be more individually tailored to the patient's problems (e.g. Greer *et al.* [21]). See Moorey & Greer [22] for a description of CBT techniques and a discussion of the evidence for its effectiveness in oncology. In summary, there is a substantial evidence for the effectiveness of CBT in psychological distress, where studies have focused on anxiety and depression and also in symptom management (e.g. insomnia [23]; fatigue [24]). Cognitive behavioural interventions have consistently been found to be more effective than waiting list control and treatment as usual conditions. There are several other promising psychological treatments including supportive-expressive therapy [25], emotionally focused couple therapy [26], mindfulness-based stress reduction [27] and meaning making [28], which have all been shown to be effective in randomised controlled trials. There have been relatively few direct comparisons of therapies and where this has been performed, no therapy has been clearly demonstrated to be superior. Meta-analyses of psychological treatments in patients with cancer and physical illness have found larger effect sizes for studies that selected participants with significant psychological morbidity, rather than studies that included an unselected group of cancer patients (Figure 1, [29–31]). This has implications for who we offer psychological interventions in oncology settings.

**Phase 3: disseminating psychological skills**

The need and effectiveness of psychological interventions has been established, but there will never be enough mental health practitioners in oncology and palliative care settings to deliver these to all those who might benefit. For this reason, the third phase of psycho-oncology needs now to focus on cost-effective ways to disseminate psychological skills. The UK NICE Supportive and Palliative Care Improving Outcomes Guidelines [32] offers a convincing model of how stepped care can be applied to this area. There are four levels of increasing specialisation in

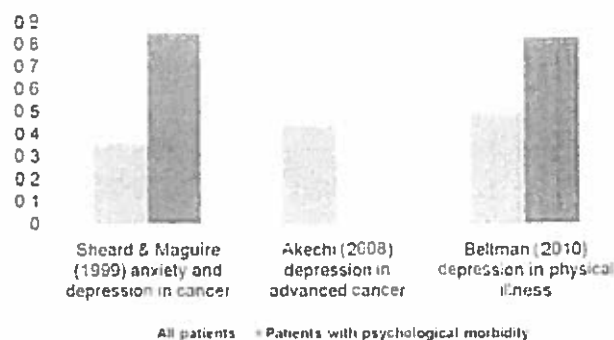


Figure 1. Meta-analyses of psychological treatment in cancer and physical illness

psychological skills. At the first level, all health care professionals should have skills in effective information giving, compassionate communication and general psychological support, as well as being able to recognise levels of psychological distress that require further help. A number of schemes to train professionals in these skills have been in place for some time now. There is a recommendation that for these to be effective, they need to be skills-based and organised in small groups of up to six participants and comprise at least 20-h training [33]. Although there is good evidence for the ability of these programmes to improve competencies in the short term [34] and 12 months after training [35], their impact on physicians' ability to detect distress and on patient outcomes is less well-established [33]. At the next level, health care professionals are trained in simple psychological intervention skills such as problem solving to be used with distressed patients. At level 3, more formal psychological interventions come into play such as counselling, whereas level 4 is the domain of liaison psychiatrists and clinical, health psychologists and other specialist mental health practitioners who will see the most serious cases. Figure 2 illustrates some of the innovative ways that these levels of intervention may be delivered.

Levels 3 and 4 are the most scarce resource because only a small number of mental health professionals or trained therapists are available in oncology and palliative care settings. Although we know that psychological treatment is helpful in oncology, we do not know what constitutes the effective ingredients of therapy packages. A recent pilot trial at St Christophers' Hospice supported by the King's Health Partners' Biomedical Research Centre investigated the acceptability of three sessions plus one follow-up session CBT intervention to palliative care patients. The therapists involved in the study found that their preconceptions about needing six to eight sessions to effectively treat patients were overcome by

the discovery that brief, problem-focused assessments could be performed in a short time and therapy instituted quickly. Given that half of patients in palliative care treatment may not be well enough to continue therapy beyond 6 weeks [36], this brief intervention may deserve more attention. People with physical illness tend not to use mental health services [37], but the UK Improving Access to Psychological Therapies (IAPT) initiative is an attempt to make evidence-based treatment for common mental disorders more open to patients in primary care. It is expanding from anxiety and depression in physically well people to include medically unexplained symptoms and long-term conditions. The CanTalk trial [38] is comparing CBT with treatment as usual for depression in advanced cancer: therapists in IAPT are trained in adapting CBT for use with cancer patients. The links between general practitioners and these services established in this study may break down some of the barriers to people with cancer accessing psychological therapies services. There are several innovative approaches to disseminating skills at level 2 such as guided self help delivered face-to-face or by telephone. Structured telephone sessions delivered by nurses have been found to give short-term and long-term benefits for concerns about recurrence [39,40]. The remaining sections of this paper will describe a programme of research, teaching and dissemination that has focused on training palliative care health professionals in 'first aid CBT', which can be used as part of their everyday clinical practice.

### Training palliative care professional in 'first aid CBT'

#### Proof of concept and competence

Building on the model of CBT for cancer developed by Greer & Moorey [41,42], Kathryn Mannix adapted the therapy for the treatment of patients with advanced and

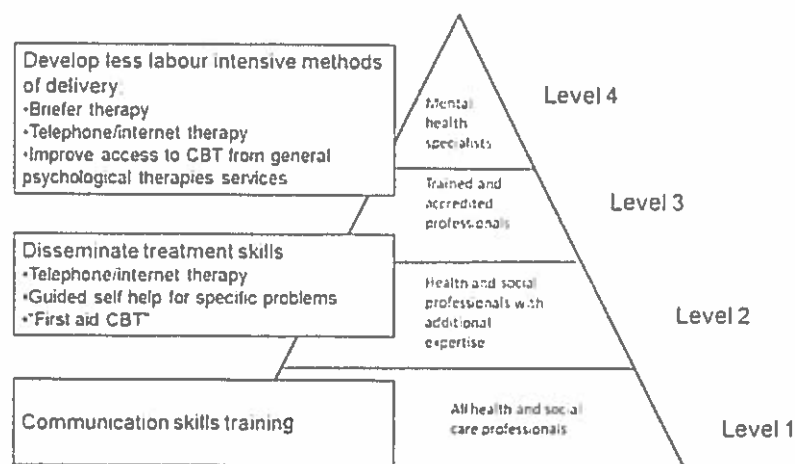


Figure 2. Improving access to psychological help for cancer patients

terminal illness in her work as a palliative care physician. Much of this therapy needed to be brief and was often carried out as part of generic palliative medicine practice. The next logical step was to pass these skills to colleagues to use 'first aid CBT' in their own clinical practice.

'First aid CBT' teaches the CBT model in a flexible way that allows practitioners to employ the approach at three levels. The first level involves using CBT techniques to establish an understanding of the patient's problems. This includes simple problem definition, asking 'curious questions' to understand how the patient sees their situation, utilising the five areas model to map thoughts, emotions, behaviours and physical symptoms and linking these to identify vicious circles maintaining problems. This can help both patient and clinician feel less overwhelmed and confused by their psychological distress. This may be all that is required for some patients, or that it is possible to achieve in a single consultation. At the second level, simple cognitive or behavioural technique is used to address specific problems. These might include behavioural techniques such as a graded approach to exercise to overcome fatigue or depression or challenging avoidance through experiments; or cognitive techniques such as questioning the evidence for a negative thought or using a cost-benefit analysis to work with a dilemma such as whether to pursue more chemotherapy. These brief interventions can also be used in a single session or over a couple of meetings. Some clinicians may have time to work for longer with patients over a series of sessions and can begin to follow through on interventions and monitor progress. All the first aid CBT methods can be used with people with everyday problems in coping with cancer and those with mild levels of anxiety and depression. With patients with more significant emotional problems, they may be used as holding techniques while waiting for an assessment from a mental health professional or they may be used under supervision from a mental health professional.

First aid cognitive behaviour therapy

Level of intervention	Techniques
1. Understanding the patient's problems.	Problem identification, curious questioning, mapping thoughts, feelings, behaviours and physical symptoms, identifying maintenance cycles.
2. Simple cognitive and behavioural techniques.	Identifying and testing negative thoughts, cost-benefit analysis of thoughts or behaviours, problem solving, graded task assignment and behavioural activation, behavioural experiments.
3. Brief course of cognitive behaviour therapy.	Working across three to six sessions on problems and goals, setting homework assignments between sessions and monitoring progress.

Palliative care professionals were taught basic CBT skills through nine workshops extending over a 3-month period. They then received 3-month skills building through regular supervision. At this point, the participants

were randomly allocated to either receive continued supervision for six more months or no CBT supervision [43]. The palliative care professionals submitted tapes of their sessions with patients before the training commenced, at the end of the 3 months training, at the end of the skills building phase and then at 3 and 6 months after randomisation. Therapists experienced in CBT for psychological disorders in physical illness rated the recordings of sessions on the Cognitive Therapy First Aid Rating Scale (CFARS) [43]. The raters were blind to the time point and group from which the recordings were taken. There was improvement in competence over the training period and both groups scored just below the CFARS cut off (30) for basic competence. Over the subsequent 6 months, the group receiving supervision continued to improve and reached a level confirming them as proficient first aid therapists. Although not deteriorating in their skills, the control group did not improve to reach the point where they could be seen as proficient. This study demonstrated that it is possible to train non-mental health professionals in the basics of CBT. It also underlined the importance of continuing supervision in maintaining and developing skills. The taught component of the training was only 9 days over 3 months, but it took a full year of supervised practice for the therapists to reach a reasonably high level of competence in CBT.

#### Demonstrating effectiveness

It may be possible to train palliative care professionals to deliver therapy well, but this does not necessarily mean that this has any greater effect than their usual care. Moorey *et al.* [36] replicated Mannix' training with a group of home care nurses at St Christopher's Hospice, London. Fourteen clinical nurse specialists (CNSs) were randomised to either receive CBT training (6 days training + weekly supervision) or to continue their usual practice. The effectiveness of the training was assessed by measures of the nurses' knowledge and competence. The nurses administered the Hospital Anxiety and Depression Scale [15] to all their new patients, and those who scored in the clinical range were invited to take part in the trial and followed up for 16 weeks: anxiety and depression scores of patients seen by both groups of nurses were assessed at 6, 10 and 16 weeks.

The CBT training was similar to the training in the previous study. The training covered the cognitive model as applied to cancer and some of the key components of CBT. These included how to help patients identify and define problems and goals, how to structure sessions, the principles of collaborative empiricism and guided discovery and the use of homework assignments. These core characteristics of CBT were adapted for the patient population and the fact that this work was often carried out in the setting of a physical health consultation.

Problems and goals therefore need to be more modest than in non-health populations, sessions need to be more flexible and structure applied more lightly, and homework assignments need to be agreed in the context of the patient's level of physical health. Basic CBT interventions were taught through didactic methods, demonstration and practice role plays and small group exercises. These focussed on activity scheduling with particular attention to graded task assignment, behavioural experiments and the use of cognitive restructuring. The application of CBT to commonly occurring problems in palliative care such as panic, insomnia and hopelessness were addressed.

The CNSs valued the training and described a number of improvements in their practice [44]. They reported improved communication skills with an increased ability to listen and respond to patients; improved assessment skills, particularly the basic five areas model that allowed them to map the physical, emotional, cognitive and behavioural components of the patients adjustment, leading to an ability to clarify and break down the patient's concerns and areas of anxiety into more detail; improved ability to summarise and feed back; increased confidence to 'stay with' difficult issues and feelings and consequently, less temptation to provide reassurance or refer on to other services such as social work or liaison psychiatry.

At the end of the training, the nurses took on patients and carried out the first aid CBT in patients own homes integrating them with their usual physical palliative care support. Each CBT nurse was expected to deliver a minimum of four sessions for each patient in the trial. Patients treated by both the CBT trained nurses and control group improved in depression, but the CBT nurses produced significantly greater improvement in anxiety scores [36].

Mannix [45] has suggested a model for cascading these skills in palliative care (see Figure 3). All staff are trained

in communication skills. Interested staff can be trained in first aid CBT to allow them to function at level 2, and those who show a facility for this approach can go on to train as CBT therapists via a diploma course in CBT. These therapists would then be available to train and supervise other staff. This model is currently in operation in Newcastle, UK where several staffs have been trained as specialist CBT therapists and at St Christopher's Hospice where one of the palliative care CNSs has acquired a post-graduate diploma in CBT and has a split post-combining CNS work with CBT training, supervision and delivery of therapy.

This model has also been trialled across the UK. Basic skills training in first aid CBT is available as an introductory 3-day course (2 days workshop plus a follow up workshop 1–3 months later) at several centres. Palliative care workers who have attended this course were then eligible to take part in a 6-day training funded by the UK Department of Health as an innovations grant. The aim of this initiative was to improve access for palliative care patients to CBT-based interventions by increasing the pool of CBT 'first aiders' by 120 over a 3-year period (2009–2013) and also to train a cohort of 12 trainers to deliver the programme in the future.

The training is based on the previous training [43,36]. It consists of 3 × 2-day workshops over 6 months with five supervision sessions spaced between the workshops. The workshops are a mixture of didactic presentations, small group exercises such as case conceptualisation and treatment planning exercises, demonstration role plays and DVDs and skills-based role play practice. A set of powerpoint presentations, case vignettes and training materials have been created as a workbook for trainers. Between workshops, the participants attend supervision given by CBT therapists who have experience of working with physical health problems. One of the innovative

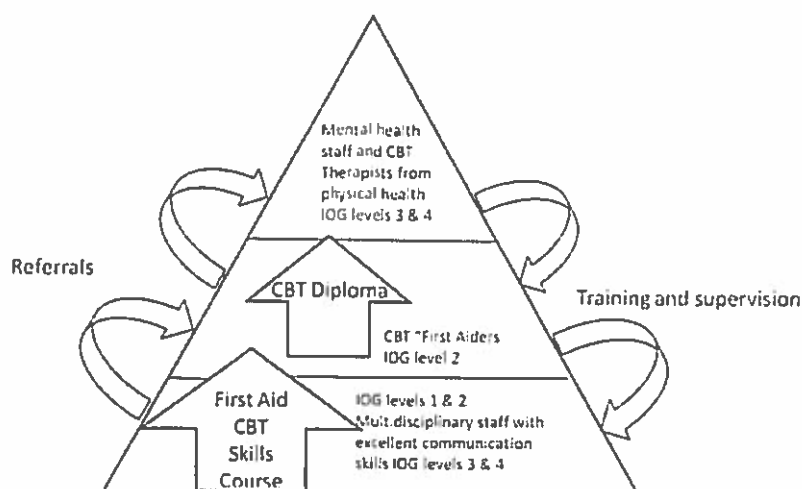


Figure 3. Cognitive behaviour therapy (CBT) skills cascade model for palliative care

features of this approach is how it builds on the students' skills from one workshop to the next. It sets clear learning objectives, and students must demonstrate that they have achieved these by explaining how they have used particular techniques with patients in their clinical practice. The homework between Days 1/2 and Days 3/4 is to prepare a 7-min powerpoint presentation of no more than four slides describing their patient's background, the collaboratively agreed problems and a conceptualisation of these using the five areas model of thoughts, feelings, physical symptoms and behaviour. The homework for Days 3/4 to Days 5/6 is to build on this by including a treatment plan and intervention techniques in the next powerpoint presentation. Participants have found this a challenging but very worthwhile exercise that reinforces their learning because it involves summarising and describing what they have been doing.

The course has been evaluated in a similar way to the previous trainings. At the end of the course, participants carry out a 20-min role play with an actor that is audio recorded. This is then rated using the CFARS. Figure 4 shows the CFARS scores for this training in comparison with the earlier trainings. The first bar in the figure are from the control group nurses in Moorey *et al.* [36] whose mean CFARS score was 19. The next bar represents the score of the palliative care professionals in Mannix *et al.* [43] who were randomised to receive no supervision in the last 6 months of the trial. These two groups received the least training input and not surprisingly, their CFARS scores are below the cut off for first aid competency. The last three bars represent the CFARS scores for the therapists in Mannix *et al.* [43] and Moorey *et al.* [36] who received the full training and supervision and the 104 participants in the dissemination training. CFARS scores for these groups were 34.4, 35.9 and 36.2, respectively. These data suggest that it is possible to train palliative care practitioners to a competent standard of CBT.

The course also obtained detailed feedback from the students, and the comments are very similar to those reported by Cort *et al.* [44].

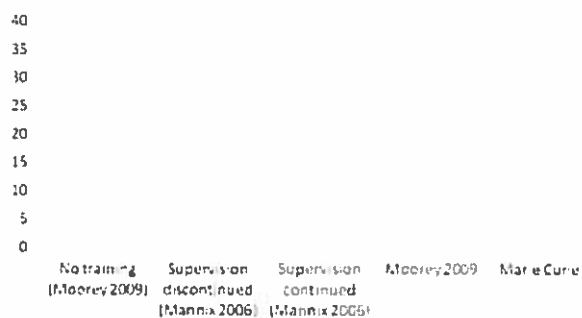


Figure 4. Palliative care professionals' CFARS scores following cognitive behaviour therapy training

- 'In a single consultation, the skills help to obtain a clearer history and the bigger picture, which then helps to address patient's physical and emotional symptoms'.
- 'I see things differently. I feel I can challenge patients if needed—a new skill'.
- 'This course has completely turned my practice round in only positive directions'.

## Conclusions

Psycho-oncology has progressed through three phases over the last 40 years: from mapping the extent and severity of psychological distress in people with cancer, through the development and evaluation of therapies, to the point where we can now begin to test models for disseminating psychological skills to health care professionals. Further work is still needed in the first two areas. We are far from being able to efficiently and reliably identify patients in need in the clinical setting; the clinical and cost-effectiveness of psychological interventions is not completely evident; and the key components of effective interventions are yet to be established. However, we have made sufficient progress in phases 1 and 2 that we can now roll out psychological skills beyond specialist mental health practitioners. The research programme described here for training palliative care practitioners in 'first aid' CBT demonstrates that it is possible to deliver and evaluate this type of training in an advanced cancer setting. We have shown that this training

1. Increases confidence and competence;
2. Can have a direct impact on patients' anxiety; and
3. Can be disseminated through a cascade system.

This programme builds on the basic communication skills that are essential in the cancer field by offering a simple and acceptable method for understanding distress and giving psychological help. More work is needed to establish the sustainability of this model and its effect on patient outcomes. But we can be confident that graduates of this training feel much better equipped to manage the distress that they encounter daily in their work with people with life limiting illness.

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## References

1. Peck A. Emotional reactions to having cancer. *Am J Roentgenol* 1972;114:591–599.
2. Hinton J. Psychiatric consultation in fatal illness. *Proc R Soc Med* 1972;65:29–32.
3. Derogatis LR, Morrow GR, Fetting JH, et al. The prevalence of psychiatric disorders among cancer patients. *J Am Med Assoc* 1983;249:751–757.
4. Farber JM, Weinerman BH, Kuypers JA. Psychosocial distress of oncology patients. *J Psychosoc Oncol* 1984;2:109–118.
5. Derogatis LR. The Brief Symptom Inventory (BSI): Administration, Scoring and Procedures Manual (3rd edn), National Computer Systems: Minneapolis, MN, 1993.
6. Zabora J, Brintzenhofesoc K, Curbow B, Hooker C, Piantadosi S. The prevalence of psychological distress by cancer site. *Psycho-Oncology* 2001;10:19–28.
7. Morris T, Greer HS, White P. Psychological and social adjustment to mastectomy: a two-year follow-up study. *Cancer* 1977;77:2381–2387.
8. Maguire GP, Lee EG, Bevington DJ et al. Psychiatric problems in the first year after mastectomy. *Br Med J* 1978;1:963–965.
9. Devlin HB, Plant JA, Griffin M. Aftermath of surgery for ano-rectal cancer. *Br Med J* 1971;3:413–418.
10. Eardley A, George WD, Davis F et al. Colostomy: the consequences of surgery. *Clin Oncol* 1976;2:277–283.
11. Kissane DW, Clark DM, Street AF. Demoralisation syndrome: a relevant psychiatric diagnosis for palliative care. *J Palliat Care* 2001;17:12–21.
12. Miller K, Massie MJ. Depressive Disorders. In *Psycho-oncology* (second edition), Holland JC, Breitbart WS, Jacobsen PB (eds.), Oxford University Press: Oxford, 2010, p 313.
13. Riba M, Grassi L (Eds) WPA educational programme on depressive disorders: physical illness and depression. Volume II. World Psychiatric Association: Geneva, 2008.
14. Holland JC, Bultz BD. National Comprehensive Cancer Network (NCCN). The NCCN guideline for distress management: a case for making distress the sixth vital sign. *J Natl Compr Canc Netw* 2007;5:3–7.
15. Zigmond AS, Snaith RP. The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scand* 1983;67:361–370.
16. Chochinov H, Wilson K, Enns M et al. Are you depressed? Screening for depression in the terminally ill. *Am J Psychiatry* 1997;154:674–676.
17. Gilbody S, Sheldon T, House A. Screening and case-finding instruments for depression: a meta-analysis. *Can Med Assoc J* 2006;178:997–1003.
18. Gill D, Hatcher S. Antidepressants for depression in medical illness. *Cochrane Database Syst Rev* 2000; 4: Art. no.: CD001312.
19. Rayner L, Price A, Evans A, Higginson IJ, Valsraj K, Hotopf M. Antidepressants for depression in physically ill people. *Cochrane Database Syst Rev* 2010; 3: Art. no.: CD007503. DOI: 07510.001002/14651858, CD14007503.
20. Rayner L, Price A, Evans A, Valsraj K, Hotopf M, Higginson I. Antidepressants for the treatment of depression in palliative care: a systematic review and meta-analysis. *Palliat Med* 2011;25:36–51.
21. Greer S et al. Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. *Br Med J* 1992;304:675–680.
22. Moorey S, Greer S. The Oxford Guide to CBT for People with Cancer. Oxford University Press: Oxford, 2012.
23. Espie CA et al. Randomised controlled clinical effectiveness trial of cognitive behaviour therapy compared with treatment as usual for persistent insomnia in patients with cancer. *J Clin Oncol* 2008;26:4651–4658.
24. Goedenorp MM, Gielissen MF, Verhagen CA, Bleijenberg G. Psychosocial interventions for reducing fatigue during cancer treatment in adults. *Cochrane Database Syst Rev* 2009; CD006953.
25. Kissane DW et al. Supportive-expressive group therapy for patients with primary breast cancer: survival and psychosocial outcomes from a randomized controlled trial. *Psycho-Oncology* 2007;16:277–286.
26. McLean LM, Jones JM, Rydall AC et al. A couples intervention for patients facing advanced cancer and their spouse caregivers: outcomes of a pilot study. *Psycho-Oncology* 2008;17:1152–1156.
27. Lengacher CA, Johnason-Marland V, Post-White J. Randomized controlled trial of mindfulness-based stress reduction (MBSR) for survivors of breast cancer. *Psycho-Oncology* 2009;18:1261–1270.
28. Lee V et al. Meaning-making intervention during breast or colorectal cancer treatment improves self-esteem, optimism and self-efficacy. *Soc Sci Med* 2006;62:1133–1145.
29. Sheard T, Maguire P. The effect of psychological interventions on anxiety and depression in cancer patients: results of two meta-analyses. *Br J Cancer* 1999;80:1770–1780.
30. Akechi T et al. Psychotherapy for depression among incurable cancer patients. *Cochrane Database Syst Rev* 2008;2: CD00553775.
31. Beltman MW, Oude Voshaar RC, Speckens AE. Cognitive-behavioural therapy for depression in people with a somatic disease: meta-analysis of randomized controlled trials. *Br J Psychiatry* 2010;197:11–19.
32. National Institute for Health and Clinical Excellence CSGSP. Improving supportive and palliative care for adults with cancer, 2004.
33. Merckaert I, Libert Y, Razavi D. Communication skills training in cancer care: where are we and where are we going? *Curr Opin Oncol* 2005;17:319–330.
34. Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R. Efficacy of a Cancer research UK communications skills training model for oncologists: a randomised controlled trial. *Lancet* 2002;359:650–656.
35. Fallowfield L, Jenkins V, Farewell V, Solis-Trapala I. Enduring impact of communication skills training: results of a 12 month follow-up. *Br J Cancer* 2003;89:1445–1449.
36. Moorey S, Cort E, Monroe B, et al. A cluster randomised controlled trial of cognitive behaviour therapy for common mental disorders in patients with advanced cancer. *Psychol Med* 2009;39:713–723.
37. Kadan-Lottick NS, Vanderwerker LC, Block SD et al. Psychiatric disorders and mental health service use in patients with advanced cancer: a report from the copinG with cancer study. *Cancer* 2005;104:2872–2881.
38. National Institute for Health Research. CanTalk: the clinical and cost-effectiveness of CBT plus treatment as usual for the treatment of depression in advanced cancer: a randomised controlled trial. 2012. [Http://www.hta.ac.uk/2508](http://www.hta.ac.uk/2508).
39. Mishel MH et al. Benefits from an uncertainty management intervention for African American and Caucasian older long-term breast cancer survivors. *Psycho-Oncology* 2005;14:962–978.
40. Gil KM et al. Benefits of the uncertainty management intervention for African American and White older breast cancer survivors: 20 month outcomes. *Int J Behav Med* 2006;13:286–294.
41. Moorey S, Greer S. Psychological Therapy for Patients with Cancer: A New Approach. Heinemann: Oxford, 1989.
42. Moorey S, Greer S. Cognitive Behaviour Therapy for People with Cancer. Oxford University Press: Oxford, 2002.
43. Mannix K et al. Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliat Med* 2006;20:579–584.
44. Cort E, Moorey S, Hoitopf M, Kapari M, Monroe B, Hansford P. Palliative care nurses' experience of training in cognitive behaviour therapy and taking part in a randomized controlled trial. *Int J Palliat Nurs* 2009;15:290–298.
45. Mannix K. Creating a Cognitive-Behavioural Skills Cascade for Palliative Care Practitioners. Department of Health Innovations grant 2009–2012 (Unpublished manuscript).

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### Abstract

Significant advances have been made in our understanding of psychological adjustment to cancer over the last 40 years. Most clinicians now recognise the importance of psychosocial factors and the need for skills in emotional support. In the first phase of psycho-oncology, pioneering work in the 1970s and 1980s mapped the extent of psychological morbidity in cancer. This has been followed by a second phase where clinical trials have demonstrated that psychological treatments are effective. But although clinicians may feel more confident in identifying distress and listening to the patient, they rarely feel confident that they possess the skills to help. This paper will review the progress through the first two phases and argue that we are now in the third phase where we can begin to examine methods for delivering cost-effective psychological care. One of these methods is to equip staff with basic skills to understand and manage psychological distress. This paper will also describe a programme over the last 10 years to evaluate the effectiveness and clinical impact of such training for palliative care professionals.

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### The three phases of psycho-oncology

Significant advances have been made in our understanding of psychological adjustment to cancer over the last 40 years. Most clinicians now recognise the importance of psychosocial factors and the need for skills in emotional support. In the first phase of psycho-oncology, pioneering work in the 1970s and 1980s mapped the extent of psychological morbidity in cancer. This has been followed by a second phase where clinical trials have demonstrated that psychological treatments are effective. But although clinicians may feel more confident in identifying distress and listening to the patient, they rarely feel confident that they possess the skills to help. This paper will review the progress through the first two phases and argue that we are now in the third phase where we can begin to examine methods for delivering cost-effective psychological care. One of these methods is to equip staff with basic skills to understand and manage psychological distress. This paper will also describe a programme over the last 10 years to evaluate the effectiveness and clinical impact of such training for palliative care professionals.

#### Phase I: defining the need

Significant scientific interest in the psychosocial needs of people with cancer began in the late 1970. Although some clinicians and researchers had reported levels of psychological distress and psychiatric morbidity in oncology populations [1,2], the sample sizes were small, selection of participants was not always representative and methods of assessment were not rigorous. It was not until the late

1970s and 1980s that more methodologically sound and systematic studies began in this area. The first well-designed large scale investigation of the prevalence of psychological disorders across a range of cancer diagnoses was carried out by Derogatis and colleagues [3]. A selection of new admissions to the inpatient and outpatient facilities in three US hospitals were assessed using a diagnostic interview and self-rating measure of psychological symptoms (symptom checklist-90 (SCL-90)). The researchers found an overall prevalence of DSM III psychiatric disorders of 47%. The conclusion that 'the pervasive emotional distress and dysphoria often associated with cancer may not be an inherent part of the neoplastic disease but rather a separate and potentially treatable condition' established the rationale for assessing cancer patients for psychological morbidity. Farber *et al.* [4] found similarly high levels of distress on the SCL-90 of 34%. Further large scale studies have been carried out since then and have yielded similar results. One of the largest samples utilised a database of over 4000 cancer patients who had completed the Brief Symptom Inventory [5] as part of their comprehensive cancer care and found an overall prevalence rate for distress of 35% [6]. Another approach of researchers at this time was to explore the effects of cancer treatments such as mastectomy and colostomy on psychological adjustment. They found that up to a quarter of women remained depressed 1 year after mastectomy [7,8], and that 25–50% of people post-colostomy experienced psychological distress [9,10].

This first phase of psycho-oncology was essential to establish the scope of psychological distress in people with cancer and to challenge certain prejudices and attitudes of denial that prevailed at the time. One strong belief



was that depression was inevitable in someone with a life threatening illness. These pioneering studies showed that the majority of people with cancer did not meet the criteria for psychiatric disorder, and even if the criteria are broadened to account for patients with 'demoralisation' secondary to their illness [11], this remains the case. They helped to demonstrate to oncologists that appropriate sadness and grieving is not the same as depression. We now have some knowledge of the biological, psychological and social factors that predispose to depression in cancer [12], but anxiety disorders have been less fully researched. A second belief was that asking people with cancer about psychological distress might be harmful, but participants' responses to being included in the research were largely very positive, disproving the idea that probing about psychological distress was harmful. These findings helped to establish liaison psychiatry and health psychology as legitimate enterprises in oncology settings. They also led to developments in screening and assessment for use in clinical settings. Attention has been paid to the challenges in separating the physical symptoms of cancer from the somatic symptoms of depression (for a discussion see Riba & Grassi [13]). A number of instruments are available to measure psychological distress such as the distress thermometer [14], anxiety and depression such as the Hospital Anxiety and Depression Scale [15]; and work has been carried out to hone screening questions down to just one or two questions a busy clinician can ask their patients [16]. Despite these advances, it has proven difficult to show any effect of screening on identification rates or outcome of depression [17].

### Phase 2: developing and demonstrating effective interventions

Another important question raised by sceptical clinicians from the beginning has been 'Even if I do know my patient is depressed/anxious, what can be done about it?' Having established the level of psychological distress, it was necessary to demonstrate that this suffering could be alleviated. Pharmacotherapy for depression has been more systematically studied than anxiety in this area. Antidepressants have been shown to be effective in medical illness generally [18,19] and also in palliative care [20]. A range of psychological treatments have also been shown to be helpful in people with cancer. These have primarily but not exclusively been cognitive behavioural in orientation, because this approach has traditionally been more at ease with the empirical method and the use of randomised controlled trials, and also because it lends itself well to brief, structured, manualised interventions. Cognitive behaviour therapy (CBT) has been delivered both as individual sessions and in groups. The groups have often been psychoeducational in nature with components such as relaxation and stress

management, problem solving and cognitive restructuring. Individual CBT has tended to be more individually tailored to the patient's problems (e.g. Greer *et al.* [21]). See Moorey & Greer [22] for a description of CBT techniques and a discussion of the evidence for its effectiveness in oncology. In summary, there is a substantial evidence for the effectiveness of CBT in psychological distress, where studies have focused on anxiety and depression and also in symptom management (e.g. insomnia [23]; fatigue [24]). Cognitive behavioural interventions have consistently been found to be more effective than waiting list control and treatment as usual conditions. There are several other promising psychological treatments including supportive-expressive therapy [25], emotionally focused couple therapy [26], mindfulness-based stress reduction [27] and meaning making [28], which have all been shown to be effective in randomised controlled trials. There have been relatively few direct comparisons of therapies and where this has been performed, no therapy has been clearly demonstrated to be superior. Meta-analyses of psychological treatments in patients with cancer and physical illness have found larger effect sizes for studies that selected participants with significant psychological morbidity, rather than studies that included an unselected group of cancer patients (Figure 1, [29–31]). This has implications for who we offer psychological interventions in oncology settings.

### Phase 3: disseminating psychological skills

The need and effectiveness of psychological interventions has been established, but there will never be enough mental health practitioners in oncology and palliative care settings to deliver these to all those who might benefit. For this reason, the third phase of psycho-oncology needs now to focus on cost-effective ways to disseminate psychological skills. The UK NICE Supportive and Palliative Care Improving Outcomes Guidelines [32] offers a convincing model of how stepped care can be applied to this area. There are four levels of increasing specialisation in

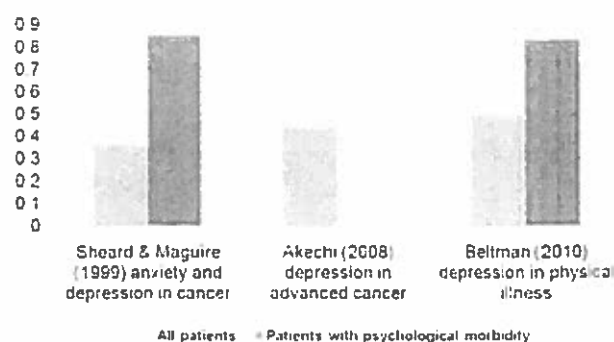


Figure 1. Meta-analyses of psychological treatment in cancer and physical illness

psychological skills. At the first level, all health care professionals should have skills in effective information giving, compassionate communication and general psychological support, as well as being able to recognise levels of psychological distress that require further help. A number of schemes to train professionals in these skills have been in place for some time now. There is a recommendation that for these to be effective, they need to be skills-based and organised in small groups of up to six participants and comprise at least 20-h training [33]. Although there is good evidence for the ability of these programmes to improve competencies in the short term [34] and 12 months after training [35], their impact on physicians' ability to detect distress and on patient outcomes is less well-established [33]. At the next level, health care professionals are trained in simple psychological intervention skills such as problem solving to be used with distressed patients. At level 3, more formal psychological interventions come into play such as counselling, whereas level 4 is the domain of liaison psychiatrists and clinical, health psychologists and other specialist mental health practitioners who will see the most serious cases. Figure 2 illustrates some of the innovative ways that these levels of intervention may be delivered.

Levels 3 and 4 are the most scarce resource because only a small number of mental health professionals or trained therapists are available in oncology and palliative care settings. Although we know that psychological treatment is helpful in oncology, we do not know what constitutes the effective ingredients of therapy packages. A recent pilot trial at St Christophers' Hospice supported by the King's Health Partners' Biomedical Research Centre investigated the acceptability of three sessions plus one follow-up session CBT intervention to palliative care patients. The therapists involved in the study found that their preconceptions about needing six to eight sessions to effectively treat patients were overcome by

the discovery that brief, problem-focused assessments could be performed in a short time and therapy instituted quickly. Given that half of patients in palliative care treatment may not be well enough to continue therapy beyond 6 weeks [36], this brief intervention may deserve more attention. People with physical illness tend not to use mental health services [37], but the UK Improving Access to Psychological Therapies (IAPT) initiative is an attempt to make evidence-based treatment for common mental disorders more open to patients in primary care. It is expanding from anxiety and depression in physically well people to include medically unexplained symptoms and long-term conditions. The CanTalk trial [38] is comparing CBT with treatment as usual for depression in advanced cancer: therapists in IAPT are trained in adapting CBT for use with cancer patients. The links between general practitioners and these services established in this study may break down some of the barriers to people with cancer accessing psychological therapies services. There are several innovative approaches to disseminating skills at level 2 such as guided self help delivered face-to-face or by telephone. Structured telephone sessions delivered by nurses have been found to give short-term and long-term benefits for concerns about recurrence [39,40]. The remaining sections of this paper will describe a programme of research, teaching and dissemination that has focused on training palliative care health professionals in 'first aid CBT', which can be used as part of their everyday clinical practice.

### Training palliative care professional in 'first aid CBT'

#### Proof of concept and competence

Building on the model of CBT for cancer developed by Greer & Moorey [41,42], Kathryn Mannix adapted the therapy for the treatment of patients with advanced and

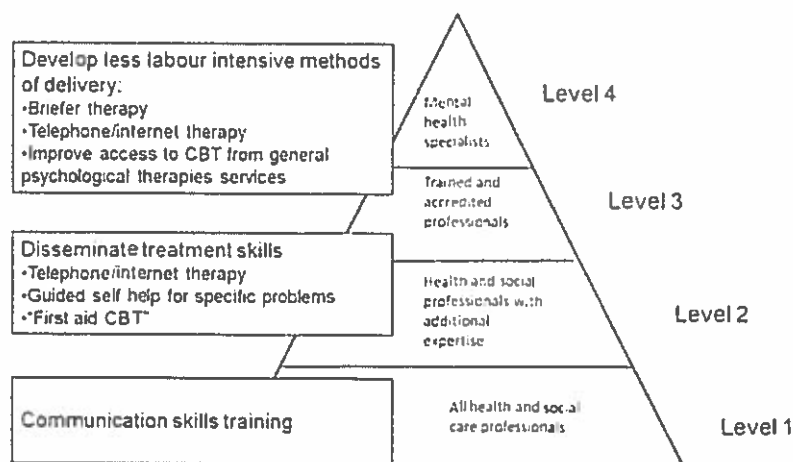


Figure 2. Improving access to psychological help for cancer patients

terminal illness in her work as a palliative care physician. Much of this therapy needed to be brief and was often carried out as part of generic palliative medicine practice. The next logical step was to pass these skills to colleagues to use 'first aid CBT' in their own clinical practice.

'First aid CBT' teaches the CBT model in a flexible way that allows practitioners to employ the approach at three levels. The first level involves using CBT techniques to establish an understanding of the patient's problems. This includes simple problem definition, asking 'curious questions' to understand how the patient sees their situation, utilising the five areas model to map thoughts, emotions, behaviours and physical symptoms and linking these to identify vicious circles maintaining problems. This can help both patient and clinician feel less overwhelmed and confused by their psychological distress. This may be all that is required for some patients, or that it is possible to achieve in a single consultation. At the second level, simple cognitive or behavioural technique is used to address specific problems. These might include behavioural techniques such as a graded approach to exercise to overcome fatigue or depression or challenging avoidance through experiments; or cognitive techniques such as questioning the evidence for a negative thought or using a cost-benefit analysis to work with a dilemma such as whether to pursue more chemotherapy. These brief interventions can also be used in a single session or over a couple of meetings. Some clinicians may have time to work for longer with patients over a series of sessions and can begin to follow through on interventions and monitor progress. All the first aid CBT methods can be used with people with everyday problems in coping with cancer and those with mild levels of anxiety and depression. With patients with more significant emotional problems, they may be used as holding techniques while waiting for an assessment from a mental health professional or they may be used under supervision from a mental health professional.

First aid cognitive behaviour therapy	
Level of intervention	Techniques
1. Understanding the patient's problems.	Problem identification, curious questioning, mapping thoughts, feelings, behaviours and physical symptoms, identifying maintenance cycles.
2. Simple cognitive and behavioural techniques.	Identifying and testing negative thoughts, cost-benefit analysis of thoughts or behaviours, problem solving, graded task assignment and behavioural activation, behavioural experiments.
3. Brief course of cognitive behaviour therapy.	Working across three to six sessions on problems and goals, setting homework assignments between sessions and monitoring progress.

Palliative care professionals were taught basic CBT skills through nine workshops extending over a 3-month period. They then received 3-month skills building through regular supervision. At this point, the participants

were randomly allocated to either receive continued supervision for six more months or no CBT supervision [43]. The palliative care professionals submitted tapes of their sessions with patients before the training commenced, at the end of the 3 months training, at the end of the skills building phase and then at 3 and 6 months after randomisation. Therapists experienced in CBT for psychological disorders in physical illness rated the recordings of sessions on the Cognitive Therapy First Aid Rating Scale (CFARS) [43]. The raters were blind to the time point and group from which the recordings were taken. There was improvement in competence over the training period and both groups scored just below the CFARS cut off (30) for basic competence. Over the subsequent 6 months, the group receiving supervision continued to improve and reached a level confirming them as proficient first aid therapists. Although not deteriorating in their skills, the control group did not improve to reach the point where they could be seen as proficient. This study demonstrated that it is possible to train non-mental health professionals in the basics of CBT. It also underlined the importance of continuing supervision in maintaining and developing skills. The taught component of the training was only 9 days over 3 months, but it took a full year of supervised practice for the therapists to reach a reasonably high level of competence in CBT.

Demonstrating effectiveness

It may be possible to train palliative care professionals to deliver therapy well, but this does not necessarily mean that this has any greater effect than their usual care. Moorey *et al.* [36] replicated Mannix' training with a group of home care nurses at St Christopher's Hospice, London. Fourteen clinical nurse specialists (CNSs) were randomised to either receive CBT training (6 days training + weekly supervision) or to continue their usual practice. The effectiveness of the training was assessed by measures of the nurses' knowledge and competence. The nurses administered the Hospital Anxiety and Depression Scale [15] to all their new patients, and those who scored in the clinical range were invited to take part in the trial and followed up for 16 weeks; anxiety and depression scores of patients seen by both groups of nurses were assessed at 6, 10 and 16 weeks.

The CBT training was similar to the training in the previous study. The training covered the cognitive model as applied to cancer and some of the key components of CBT. These included how to help patients identify and define problems and goals, how to structure sessions, the principles of collaborative empiricism and guided discovery and the use of homework assignments. These core characteristics of CBT were adapted for the patient population and the fact that this work was often carried out in the setting of a physical health consultation.

Problems and goals therefore need to be more modest than in non-health populations, sessions need to be more flexible and structure applied more lightly, and homework assignments need to be agreed in the context of the patient's level of physical health. Basic CBT interventions were taught through didactic methods, demonstration and practice role plays and small group exercises. These focussed on activity scheduling with particular attention to graded task assignment, behavioural experiments and the use of cognitive restructuring. The application of CBT to commonly occurring problems in palliative care such as panic, insomnia and hopelessness were addressed.

The CNSs valued the training and described a number of improvements in their practice [44]. They reported improved communication skills with an increased ability to listen and respond to patients; improved assessment skills, particularly the basic five areas model that allowed them to map the physical, emotional, cognitive and behavioural components of the patients adjustment, leading to an ability to clarify and break down the patient's concerns and areas of anxiety into more detail; improved ability to summarise and feed back; increased confidence to 'stay with' difficult issues and feelings and consequently, less temptation to provide reassurance or refer on to other services such as social work or liaison psychiatry.

At the end of the training, the nurses took on patients and carried out the first aid CBT in patients own homes integrating them with their usual physical palliative care support. Each CBT nurse was expected to deliver a minimum of four sessions for each patient in the trial. Patients treated by both the CBT trained nurses and control group improved in depression, but the CBT nurses produced significantly greater improvement in anxiety scores [36].

Mannix [45] has suggested a model for cascading these skills in palliative care (see Figure 3). All staff are trained

in communication skills. Interested staff can be trained in first aid CBT to allow them to function at level 2, and those who show a facility for this approach can go on to train as CBT therapists via a diploma course in CBT. These therapists would then be available to train and supervise other staff. This model is currently in operation in Newcastle, UK where several staffs have been trained as specialist CBT therapists and at St Christopher's Hospice where one of the palliative care CNSs has acquired a post-graduate diploma in CBT and has a split post-combining CNS work with CBT training, supervision and delivery of therapy.

This model has also been trialled across the UK. Basic skills training in first aid CBT is available as an introductory 3-day course (2 days workshop plus a follow up workshop 1–3 months later) at several centres. Palliative care workers who have attended this course were then eligible to take part in a 6-day training funded by the UK Department of Health as an innovations grant. The aim of this initiative was to improve access for palliative care patients to CBT-based interventions by increasing the pool of CBT 'first aiders' by 120 over a 3-year period (2009–2013) and also to train a cohort of 12 trainers to deliver the programme in the future.

The training is based on the previous training [43,36]. It consists of 3 × 2-day workshops over 6 months with five supervision sessions spaced between the workshops. The workshops are a mixture of didactic presentations, small group exercises such as case conceptualisation and treatment planning exercises, demonstration role plays and DVDs and skills-based role play practice. A set of powerpoint presentations, case vignettes and training materials have been created as a workbook for trainers. Between workshops, the participants attend supervision given by CBT therapists who have experience of working with physical health problems. One of the innovative

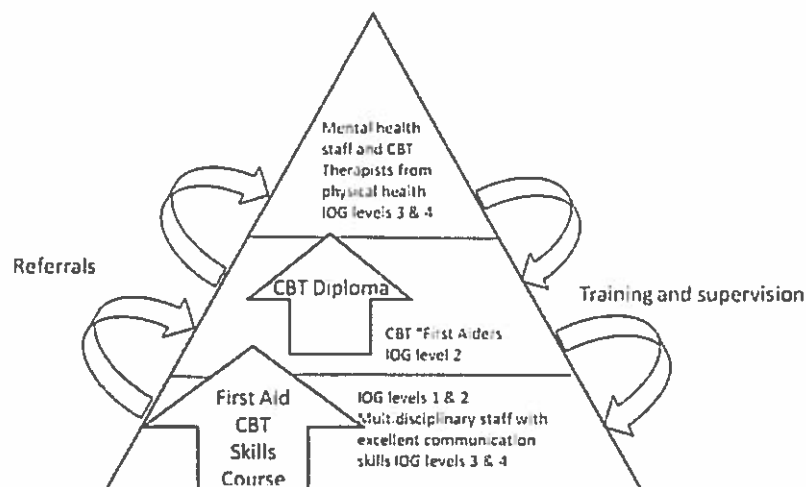


Figure 3. Cognitive behaviour therapy (CBT) skills cascade model for palliative care

features of this approach is how it builds on the students' skills from one workshop to the next. It sets clear learning objectives, and students must demonstrate that they have achieved these by explaining how they have used particular techniques with patients in their clinical practice. The homework between Days 1/2 and Days 3/4 is to prepare a 7-min powerpoint presentation of no more than four slides describing their patient's background, the collaboratively agreed problems and a conceptualisation of these using the five areas model of thoughts, feelings, physical symptoms and behaviour. The homework for Days 3/4 to Days 5/6 is to build on this by including a treatment plan and intervention techniques in the next powerpoint presentation. Participants have found this a challenging but very worthwhile exercise that reinforces their learning because it involves summarising and describing what they have been doing.

The course has been evaluated in a similar way to the previous trainings. At the end of the course, participants carry out a 20-min role play with an actor that is audio recorded. This is then rated using the CFARS. Figure 4 shows the CFARS scores for this training in comparison with the earlier trainings. The first bar in the figure are from the control group nurses in Moorey *et al.* [36] whose mean CFARS score was 19. The next bar represents the score of the palliative care professionals in Mannix *et al.* [43] who were randomised to receive no supervision in the last 6 months of the trial. These two groups received the least training input and not surprisingly, their CFARS scores are below the cut off for first aid competency. The last three bars represent the CFARS scores for the therapists in Mannix *et al.* [43] and Moorey *et al.* [36] who received the full training and supervision and the 104 participants in the dissemination training. CFARS scores for these groups were 34.4, 35.9 and 36.2, respectively. These data suggest that it is possible to train palliative care practitioners to a competent standard of CBT.

The course also obtained detailed feedback from the students, and the comments are very similar to those reported by Cort *et al.* [44].

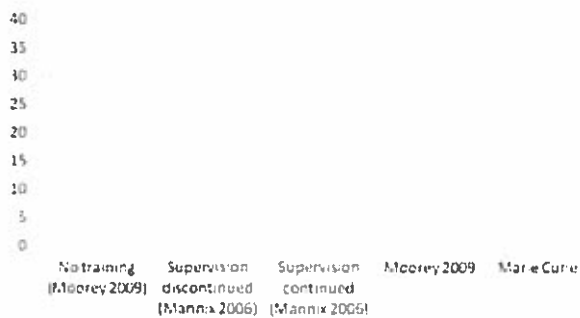


Figure 4. Palliative care professionals' CFARS scores following cognitive behaviour therapy training

- 'In a single consultation, the skills help to obtain a clearer history and the bigger picture, which then helps to address patient's physical and emotional symptoms'.
- 'I see things differently. I feel I can challenge patients if needed—a new skill'.
- 'This course has completely turned my practice round in only positive directions'.

## Conclusions

Psycho-oncology has progressed through three phases over the last 40 years: from mapping the extent and severity of psychological distress in people with cancer, through the development and evaluation of therapies, to the point where we can now begin to test models for disseminating psychological skills to health care professionals. Further work is still needed in the first two areas. We are far from being able to efficiently and reliably identify patients in need in the clinical setting; the clinical and cost-effectiveness of psychological interventions is not completely evident; and the key components of effective interventions are yet to be established. However, we have made sufficient progress in phases 1 and 2 that we can now roll out psychological skills beyond specialist mental health practitioners. The research programme described here for training palliative care practitioners in 'first aid' CBT demonstrates that it is possible to deliver and evaluate this type of training in an advanced cancer setting. We have shown that this training

1. Increases confidence and competence;
2. Can have a direct impact on patients' anxiety; and
3. Can be disseminated through a cascade system.

This programme builds on the basic communication skills that are essential in the cancer field by offering a simple and acceptable method for understanding distress and giving psychological help. More work is needed to establish the sustainability of this model and its effect on patient outcomes. But we can be confident that graduates of this training feel much better equipped to manage the distress that they encounter daily in their work with people with life limiting illness.

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I would like to thank the many committed and talented people who have helped my own journey through the phases of psycho-oncology. Steven Greer and Maggie Watson have made pioneering contributions to phases 1 and 2. Kath Mannix had the vision that CBT could be applied in palliative care and our work in phase 3 has been led by her. At St Christopher's Hospice, the support of Barbara Monroe and the clinical skills and enterprise of Liz Cort, Kathy Burn and her CNS colleagues made it possible to complete a randomised controlled trial in palliative care. Finally, the enthusiasm of the team training palliative care professionals in CBT skills (Kath Mannix, Nigel Sage and Christine Baker) has inspired me to see that the CBT that Steven Greer and I began to apply applied to early stage cancer in the 1987 has come so far.

## References

1. Peck A. Emotional reactions to having cancer. *Am J Roentgenol* 1972;114:591-599.
2. Hinton J. Psychiatric consultation in fatal illness. *Proc R Soc Med* 1972;65:29-32.
3. Derogatis LR, Morrow GR, Fetting JH, et al. The prevalence of psychiatric disorders among cancer patients. *J Am Med Assoc* 1983;249:751-757.
4. Farber JM, Weinerman BH, Kuypers JA. Psychosocial distress of oncology patients. *J Psychosoc Oncol* 1984;2:109-118.
5. Derogatis LR. The Brief Symptom Inventory (BSI): Administration, Scoring and Procedures Manual (3rd edn), National Computer Systems: Minneapolis, MN, 1993.
6. Zabora J, Brintzenhofesoc K, Curbow B, Hooker C, Piantadosi S. The prevalence of psychological distress by cancer site. *Psycho-Oncology* 2001;10:19-28.
7. Morris T, Greer HS, White P. Psychological and social adjustment to mastectomy: a two-year follow-up study. *Cancer* 1977;77:2381-2387.
8. Maguire GP, Lee EG, Bevington DJ et al. Psychiatric problems in the first year after mastectomy. *Br Med J* 1978;1:963-965.
9. Devlin HB, Plant JA, Griffin M. Aftermath of surgery for ano-rectal cancer. *Br Med J* 1971;3:413-418.
10. Eardley A, George WD, Davis F et al. Colostomy: the consequences of surgery. *Clin Oncol* 1976;2:277-283.
11. Kissane DW, Clark DM, Street AF. Demoralisation syndrome: a relevant psychiatric diagnosis for palliative care. *J Palliat Care* 2001;17:12-21.
12. Miller K, Massie MJ. Depressive Disorders. In *Psycho-oncology* (second edition), Holland JC, Breitbart WS, Jacobsen PB (eds.), Oxford University Press: Oxford, 2010, p 313.
13. Riba M, Grassi L (Eds) WPA educational programme on depressive disorders: physical illness and depression. Volume II. World Psychiatric Association: Geneva, 2008.
14. Holland JC, Bultz BD. National comprehensive Cancer Network (NCCN). The NCCN guideline for distress management: a case for making distress the sixth vital sign. *J Natl Compr Canc Netw* 2007;5:3-7.
15. Zigmond AS, Snaith RP. The Hospital Anxiety and Depression Scale. *Acta Psychiatrica Scand* 1983;67:361-370.
16. Chochinov H, Wilson K, Enns M et al. Are you depressed? Screening for depression in the terminally ill. *Am J Psychiatry* 1997;154:674-676.
17. Gilbody S, Sheldon T, House A. Screening and case-finding instruments for depression: a meta-analysis. *Can Med Assoc J* 2006;178:997-1003.
18. Gill D, Hatcher S. Antidepressants for depression in medical illness. *Cochrane Database Syst Rev* 2000; 4: Art. no.: CD001312.
19. Rayner L, Price A, Evans A, Higginson IJ, Valsraj K, Hotopf M. Antidepressants for depression in physically ill people. *Cochrane Database Syst Rev* 2010; 3: Art. no.: CD007503. DOI: 07510.001002/14651858, CD14007503.
20. Rayner L, Price A, Evans A, Valsraj K, Hotopf M, Higginson I. Antidepressants for the treatment of depression in palliative care: a systematic review and meta-analysis. *Palliat Med* 2011;25:36-51.
21. Greer S et al. Adjuvant psychological therapy for patients with cancer: a prospective randomised trial. *Br Med J* 1992;304:675-680.
22. Moorey S, Greer S. The Oxford Guide to CBT for People with Cancer. Oxford University Press: Oxford, 2012.
23. Espie CA et al. Randomised controlled clinical effectiveness trial of cognitive behaviour therapy compared with treatment as usual for persistent insomnia in patients with cancer. *J Clin Oncol* 2008;26:4651-4658.
24. Goedenorp MM, Gielissen MF, Verhagen CA, Bleijenberg G. Psychosocial interventions for reducing fatigue during cancer treatment in adults. *Cochrane Database Syst Rev* 2009; CD006953.
25. Kissane DW et al. Supportive-expressive group therapy for patients with primary breast cancer: survival and psychosocial outcomes from a randomized controlled trial. *Psycho-Oncology*, 2007;16:277-286.
26. McLean LM, Jones JM, Rydall AC et al. A couples intervention for patients facing advanced cancer and their spouse caregivers: outcomes of a pilot study. *Psycho-Oncology* 2008;17:1152-1156.
27. Lengacher CA, Johnason-Marland V, Post-White J. Randomized controlled trial of mindfulness-based stress reduction (MBSR) for survivors of breast cancer. *Psycho-Oncology* 2009;18:1261-1270.
28. Lee V et al. Meaning-making intervention during breast or colorectal cancer treatment improves self-esteem, optimism and self-efficacy. *Soc Sci Med* 2006;62:1133-1145.
29. Sheard T, Maguire P. The effect of psychological interventions on anxiety and depression in cancer patients: results of two meta-analyses. *Br J Cancer* 1999;80:1770-1780.
30. Akechi T et al. Psychotherapy for depression among incurable cancer patients. *Cochrane Database Syst Rev* 2008;2: CD00553775.
31. Beltman MW, Oude Voshaar RC, Speckens AE. Cognitive-behavioural therapy for depression in people with a somatic disease: meta-analysis of randomized controlled trials. *Br J Psychiatry* 2010;197:11-19.
32. National Institute for Health and Clinical Excellence CSGSP. Improving supportive and palliative care for adults with cancer, 2004.
33. Merckaert I, Libert Y, Razavi D. Communication skills training in cancer care: where are we and where are we going? *Curr Opin Oncol* 2005;17:319-330.
34. Fallowfield L, Jenkins V, Farewell V, Saul J, Duffy A, Eves R. Efficacy of a Cancer research UK communications skills training model for oncologists: a randomised controlled trial. *Lancet* 2002;359:650-656.
35. Fallowfield L, Jenkins V, Farewell V, Solis-Trapala I. Enduring impact of communication skills training: results of a 12 month follow-up. *Br J Cancer* 2003;89:1445-1449.
36. Moorey S, Cort E, Monroe B, et al. A cluster randomised controlled trial of cognitive behaviour therapy for common mental disorders in patients with advanced cancer. *Psychol Med* 2009;39:713-23.
37. Kadan-Lottick NS, Vanderwerker LC, Block SD et al. Psychiatric disorders and mental health service use in patients with advanced cancer: a report from the copinG with cancer study. *Cancer* 2005;104:2872-2881.
38. National Institute for Health Research. CanTalk: the clinical and cost-effectiveness of CBT plus treatment as usual for the treatment of depression in advanced cancer: a randomised controlled trial. 2012 [Http://www.hta.ac.uk/2508](http://www.hta.ac.uk/2508).
39. Mishel MH et al. Benefits from an uncertainty management intervention for African American and Caucasian older long-term breast cancer survivors. *Psycho-Oncology* 2005;14:962-978.
40. Gil KM et al. Benefits of the uncertainty management intervention for African American and White older breast cancer survivors: 20 month outcomes. *Int J Behav Med*, 2006;13:286-294.
41. Moorey S, Greer S. Psychological Therapy for Patients with Cancer: A New Approach. Heinemann: Oxford, 1989.
42. Moorey S, Greer S. Cognitive Behaviour Therapy for People with Cancer. Oxford University Press: Oxford, 2002.
43. Mannix K et al. Effectiveness of brief training in cognitive behaviour therapy techniques for palliative care practitioners. *Palliat Med* 2006;20:579-584.
44. Cort E, Moorey S, Hotopf M, Kapari M, Monroe B, Hansford P. Palliative care nurses' experience of training in cognitive behaviour therapy and taking part in a randomized controlled trial. *Int J Palliat Nurs* 2009;15:290-298.
45. Mannix K. Creating a Cognitive-Behavioural Skills Cascade for Palliative Care Practitioners. Department of Health Innovations grant 2009-2012 (Unpublished manuscript).