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Titre :

Proposer une rencontre systématique avec le psycho-oncologue après l'annonce du cancer favorise-t-il d'autres consultations psychologiques ? Un essai contrôlé randomisé

Title:

Does proposing a systematic encounter with the psycho-oncologist after the announcement of cancer promote further psychological consultations? A randomized controlled trial

Titre court :

La rencontre systématique avec le psycho-oncologue

Short Title:

The systematic encounter with the psycho-oncologist

Résumé

Objectifs : Évaluer l’intérêt et l’efficacité d’une rencontre systématique avec un psycho-oncologue sur la perception du psychologue chez les hommes et les femmes atteints de cancer. Procédure : Les patients qui ont rencontré systématiquement le psychologue ont été comparé à un groupe contrôle. Les symptômes d’anxio-dépression et la perception que les patients ont du psychologue ont été évalués à deux reprises : lors du diagnostic et 4 mois plus tard, pendant le traitement. Résultats : Dans l'ensemble du groupe, nous n'avons pas observé de différences significatives entre les conditions concernant la perception du psychologue, mais le sexe était un facteur critique associé à la fois à la perception du psychologue et à d'autres consultations psychologiques. Les hommes qui ont rencontré un psychologue peu après le diagnostic ont continué un suivi psychologique dans une bien plus grande mesure que ceux du groupe contrôle. À l'inverse, les femmes ont suivi un soutien psychologique, qu'elles aient rencontré le psychologue ou non. Conclusion : Les résultats indiquent qu'une rencontre avec le psychologue peut être utile pour susciter un intérêt pour un soutien psychologique, en particulier pour les hommes.

Mots clés : intervention, perception, psychologue, soutien, Cancer

Abstract

Aims: To assess the interest and the efficacy of a systematic encounter with a psycho-oncologist on the perception of the psychologist among men and women with cancer. *Procedure*: The patients who systematically encounter the psycho-oncologist were compared to a control group. Anxio-depression symptoms and the patients' perception of the psychologist were assessed on two occasions: at the time of diagnosis and 4 months later, during treatment. *Results*: On the overall group, we failed to observe significant differences between conditions about the perception of the psychologist, but gender was a critical factor associated with both perception of the psychologist and further psychological consultations. Those men who met a psychologist soon after diagnosis continued to meet the psychologist to a far greater extent than those in the control group. Conversely, women pursued psychological support whether they had encountered the psychologist or not. *Conclusion*: Results indicate that an encounter with the psychologist can be helpful to elicit interest in a psychological support, especially for men.

Keywords: intervention, perception, psychologist, support, Cancer

Introduction

Due to the potentially mortal consequences of cancer, the impact of the announcement of this disease generates psychological difficulties that may be detrimental to patients [1]. Prevalence of emotional distress in cancer patients ranges between 35 to 45% [2]. Hence, psychological interventions after a diagnosis of cancer may be of use in helping patients [3-5]. Strategies have been proposed to identify patients at risk of developing emotional distress and to offer early psychological intervention to help cope with cancer [2]; other studies have supported the effectiveness of such interventions [6-8]. However, despite the high prevalence rate of psychological difficulties and the efficacy of psycho-oncological interventions, the number of patients asking for psychological support remains low. Indeed, a survey conducted among 980 cancer patients indicated that only 14-19% of patients asked and received psychological care [9].

Several reasons can explain this low rate of psychological consultation. Firstly, studies indicated that, during treatment, patients place greater importance on the somatic consequences of cancer and on cancer care while, to a great extent, failing to heed the emotional difficulties they may encounter [10]. Secondly, the fear of psychological treatment and/or of stigmatization following a consultation with a psychologist can also be considered as a barrier to the full utilisation of psychological services [11]. A study also reported that 90% of patients from 27 mental health centres in the USA expressed trepidation regarding psychological consultation seeing it as only being appropriate in cases of “madness” [12]. These observations therefore highlighted the importance of the negative stereotypes that patients held about psychologists, due to misunderstanding about the nature of their interventions. This lack of knowledge can thus lead to a misperception of psychologists and become an obstacle in the inclination to meeting with a psycho-oncologist. In addition, a study has argued that the lack of access to psycho-oncology care was more significant in men than in women [10]. This observation corroborated a report of the Belgian National Institute of Statistics and Economic Studies, which reported that women were

more likely to consult a psychologist than men because they were better aware of their own distress and that they were more able to accept that they could potentially develop mental illness [13].

To overcome the difficulty of facilitating access to psychological care, we planned a systematic encounter between patients and a psychologist just after the confirmation of a cancer diagnosis. In order to study the benefit of this systematic approach, we conducted a longitudinal study with men and women suffering from cancer with two main objectives. Firstly, we tested the hypothesis that patients who had met the psychologist would have a better perception of the psychologist during oncological treatments than those patients who had not met the psychologist. Secondly, we assessed during oncological treatments the predictors of the psychological support received. We expected that patients who met the psychologist would continue to receive more psychological support, 4 months after cancer diagnosis, than patients in the control group. We also expected that the systematic encounter with a psychologist would particularly help the more distressed patients to further ask for psychological support.

Method

Participants and setting

Between May 2013 and October 2014, cancer patients who received a diagnosis of cancer in St Luc university hospital in Belgium were invited to participate to our study and signed an informed consent. Exclusion criteria were age <18, not French-speaking, being not aware of the cancer diagnosis, and being not able to complete the questionnaires by themselves. Confidentiality of collected data was guaranteed. Written informed consent was obtained from all individual participants included in the study. The ethical committee of our institution approved the research protocol.

Study design

Participants were asked to answer the questionnaire twice: (T1) within the week of cancer diagnosis announcement and (T2) 4 months later, during oncological treatments. The questionnaire was sent by post or the internet. If they had difficulties with any item, participants were able to ask for help by contacting the principal investigator (DO) by phone or email. If the questionnaire was not completed and returned after a week, a reminder was given by email or phone. Should there be no response to the reminder, it was considered that the patient had refused to participate in the study. The participants who were included in the study were randomly assigned into one of the two groups by random draw conducted by the principal investigator: the systematic encounter (SE) condition in which patients met the psychologist once within the week after the announcement of the diagnosis and a control group (CG) of patients who did not receive the visit of a psychologist.

Intervention

The systematic encounter [14] that was proposed to cancer patients consisted of three main steps. The first step of this encounter consisted of a mutual presentation between the psychologist and the patient. The patient was also proposed to talk freely about how he or she experienced the diagnosis of cancer. Then, a second step involved an active and semi-structured interview of the patient’s experience that targeted specifically an assessment of patient’s needs, distress, and coping strategies. Finally, in a third step, the psychologist assessed the patient's expectations and his or her request for the continuation of psychological support. The psychological support was proposed by the multidisciplinary team and was explained to be integrated as a part of the transdisciplinary care. Future support was never imposed.

Measures

The assessment consisted of four instruments. The entire set of questionnaires was used in T1. The psychosocial, distress, and clinical psychologist perception questionnaires were only used in T2.

The Demographic characteristics were based on participants' self-reports and included gender, age, cultural background, marital status, family, education, and employment status. Disease and psychological characteristics were obtained from patients and medical reports including personal history of cancer and cancer diagnosis.

The Psycho-social questionnaire evaluated the existence of psychological difficulties, psychiatric medication, and of history of psychological help. The emotional and instrumental social support networks were also assessed (i.e. number of persons who could provide emotional and instrumental social support) and classified into 3 categories; 0-5; 6-10; and more than 10 people. Participants also reported their level of satisfaction with their emotional and instrumental social support on two Likert scales that ranged from 1(not satisfied) to 5(completely satisfied) [15] .

Anxiety and depression were assessed by the Hospital Anxiety and Depression Scale (HADS) [16]. This self-rating scale was developed for use with patients in general practice and consists of two subscales of 7 items each, measuring anxiety and depression respectively. Each item is scored between 0 and 3. Each sub-scale score is obtained by summing up the 7-items scores, with a total score hence ranging from 0 to 21. The scale has been translated and validated in French for cancer context [17, 18]. In the current sample the Cronbach's α were of .83 and .74 at T1, .74 and .79 at T2 for Anxiety and Depression respectively.

The degree of positive perception that people have toward the clinical psychologist was assessed by an instrument with two parts [19]. The first assesses the perceived characteristics of the clinical psychologist. Respondents are asked to evaluate how well 11 groups of adjectives (e.g., "cold, indifferent") describe the psychologist. Each adjective is listed on a Likert scale ranging from 1

("not at all") to 10 ("completely"). The second part consists of an assessment of the valence of each characteristic as being positive, negative, or neutral (3 response categories).

The score of this scale is calculated by subtracting the total of the adjectives assessed as "negative" from the total of the adjectives assessed as "positive". A positive result is interpreted as a favourable perception of the clinical psychologist while a negative result expresses an unfavourable perception of this profession. A score of zero represents a neutral perception of the clinical psychologist.

As this scale was only available in English, it was translated into French using the back-translation method to limit translation errors (source language to the target language and target language to the source language). A pre-test was performed on small sample (N=10) and no understanding or completion difficulties were reported. In the current sample, Cronbach's α were .78 at T1 and .62 at T2.

Statistical analyses

After checking the normality assumptions, statistical analysis included descriptive statistics on socio-demographic, medical, and psychological data. Differences between the control and the encounter group were tested by repeated measures ANOVA, the Chi-square test and t-tests based on the hypotheses tested. Logistic regressions were also constructed according to the hypotheses and variables tested by a method of down hierarchical regression. The p-value threshold at inclusion was .05(IN) and .01(OUT) at exclusion. Statistical analyses were performed using SPSS 23 software.

Results

Participants

Two hundred and fifty-eight patients were invited to participate in this study though only 141 were included and randomized: 73 patients were allocated to SE and 68 to CG. Altogether, 109

patients (63 in SE and 46 in CG) returned the questionnaire at the beginning (T1) and 40 (23 in SE and 17 in CG), 4 months later (T2) (See Figure 1). As shown in Table 1, which describes socio-demographic data, no significant differences were found for socio-demographic data, except for age that was younger in women.

As shown in Table 2, which describes psychosocial data in T1, gender differences appeared on three variables. Firstly, women tended to report psychological difficulties before the discovery of cancer more frequently than men. Secondly, more women had already met with a psychologist before the announcement of cancer diagnosis than men. Thirdly, although randomly assigned to conditions, more women revealed to be in the encounter condition than men. This last difference could be explained by the fact that the visit paid to the women was made during their hospitalization while the consultation with the men who were never hospitalized had to be organized in an outpatient setting. Thus, it appeared that a high proportion of men in the psychological consultation condition did not come to the planned encounter with the psychologist.

Patients who met the psychologist would have a better perception of the psychologist during oncological treatments than patients who did not meet him

Results showed that the psychologist's evaluation scores were largely positive (M=29.36; SD=27.05) in T1 (N=105). Among patients who had never consulted a psychologist (N=91), the scores were also very positive (M=28.52; SD=28.41), and not significantly different from those who had already consulted a psychologist, $t(105)=.31$, $p=n.s.$ Results did not confirm Condition, $F(1, 36)=.87$, *ns*, or Time main effects, $F(1, 36)=.72$, *ns*, nor the Time by Condition interaction, $F(1, 36) = .44$, *ns*, on the perception of clinical psychologists.

Also, results revealed that there was no difference in perception by gender, $F(1, 34)=.06$, *ns*. However, results indicated a significant Time X Condition X Gender triple interaction, $F(1, 34)= 5.34$, $p=.03$, $\eta^2 = .14$. Results showed that the average positive perception scores significantly

decreased between T1 (*M*=25.63, *SD*=29.64) and T2 (*M*=23.57; *SD*=30.21) among men, *t*(32)= 4.96, *p*<.001, d=.07, while among women, the perception score significantly increased between T1 (*M*=30.15, *SD*=27.81) and T2 (*M*=32.46; *SD*=20.43), *t*(57)=8.25, *p*<.001, d=.09. In addition, in T2, men in the encounter condition tended to have a much more positive perception of the psychologist (*M*=43.17, *SD*=27.16) than those who had not met the psychologist initially (*M*= 14.33, *SD*=28.04), *t*(13)=1.97, *p*=.07 , d=1.04.. This tendency was not present in women who positively and similarly assessed the psychologist in both conditions (T1: *M*=32.87, *SD*=28.78 ; T2: *M*=32.46, *SD*=20.44), *t*(23) =.06, *ns*.

Predictors of a psychological support during oncological treatments

Fifty-seven point five percent of patients (n=23) who responded in T2 (N=40) continued psychological support during cancer treatment. Among them, 39% pursued psychological support following the systematic encounter with the psychologist.

We then examined the predictors at T1 of psychological support during cancer treatments (at T2). Gender, condition assignment (systematic encounter or not), anxiety score, depression score and perception of clinician psychologist were set as predictors in the logistic regression. In support of our hypothesis, the initial visit of the psychologist predicted psychological support during cancer treatment. Patients were more inclined to receive psychological help during cancer treatment when they had met the psychologist (81.8%) than when they had not (18.2%), $\chi^2(1, N=40) = 3.67$, $p=.05$. Interestingly, a higher level of anxiety was also a predictor of future self-initiated psychological consultation ($p=.01$)

However, results showed that anxiety ($p=.03$) and gender ($p=.07$) were related to psychological support during cancer treatment. Firstly, the patients that were more anxious in T2 tended to pursue psychological support more so than others. Secondly, women were found to ask for psychological support during cancer treatments whether or not they had initially met the psychologist, $\chi 2$ (1, N=21) = .01, *ns*. In contrast, the results showed that men who had met a psychologist after diagnosis

continued to consult a psychologist during treatment more often that men who had not met a psychologist, $\chi 2(1, N=19) = 6.10$, $p =. 013$.

Discussion

In order to promote the psychological support of cancer patients, an encounter with a psychologist was systematically proposed to patients. The main objective was to test whether this first encounter at diagnosis increased the positive perception of the psychologist and the likelihood of accessing psychological support during cancer treatment in case of need.

Results did not confirm the hypothesis of improved perception of the psychologist in cancer patients among patients who had met the psychologist. We observed that patients did not endorse a negative perception of the psychologist, in contrast with what Alonso and colleagues had described: a fear of stigma was associated with insufficient knowledge of the psychologist's role and was considered as the main obstacle to psychological support [20]. Our results however revealed that the initial encounter with the psychologist had a different influence on the clinical psychologist's perception according to gender. From the diagnosis to cancer treatment, women had a similar perception of the psychologist whether they had met the psychologist or not, while for men their positive perception had improved only when they had initially met the psychologist. This result is in line with a previous study in a population of students, which revealed that male subjects were somewhat unfamiliar with the role of the psychologists and that they felt it more inconvenient to meet with them [12]. The present study showed that the perception of the psychologist was enhanced by an encounter with a psychologist only among men. This encounter with a psychologist informs patients of what can be proposed and also decreases the preconceived ideas that might limit access to psychological support among men.

In addition, our results indicated that this encounter promoted future psychological consultations during cancer treatments for men. In fact, women consulted more frequently during cancer treatment, whether or not they had had the systematic encounter, as opposed to men who continued

to consult the psychologist only when they had met the psychologist initially. Altogether, these results are consistent with previous observations, which reported that men were less likely to begin psychological support than women [10]. Indeed, a majority of psycho-oncological consultations are conducted with women according to this study.

Our study also indicated that a high level of anxiety prompts patients to consult a psychologist. Our results showed that the more anxious patients pursued psychological consultation. This is consistent with many works that assert the importance of psychological support in case of anxiety disorder [21, 22]. In oncology, it is particularly important to encourage this support because the diagnosis of cancer is experienced as a traumatic life experience that induces anxiety in a third of cases [23].

Study limitations

This study had some limitations including the fact that only patients with hormone-dependent cancers and prognosis were involved. We were also confronted with some difficulty in including men in the systematic encounter group, a high proportion of them not having come to the planned encounter with the psychologist. Because of this limitation, we have unfortunately been confronted with a gender difference on psychosocial variables of our study and a possible bias in the selection of men. We were also been confronted to important dropouts and therefore to a small sample in T2. It would be useful in the future to assess the importance of a systematic encounter by extending this assessment to other cancers and by acquiring additional information regarding clinical interest.

Conclusion

In conclusion, the originality of this study was to investigate the impact of the perception of the psychologist on psychological support. It was, specifically, intended to explore the worth of a systematic encounter with a psycho-oncologist. Our study also suggests that it is particularly useful

to systematically introduce potential psychological support provided as part of the hospital care to men who have recently been diagnosed with cancer. Women were found to continue psychological support according to their level of anxiety and men depending both on their level of anxiety and if they had met the psychologist. Consequently, as a clinical implication, we propose a two-level procedure. The first level consists of an evaluation of distress and particularly the anxiety of patients with standardized tools such as the Distress Thermometer [2, 24]. Patients with significant scores would receive the visit of the psychologist. The second level involves a systematic encounter for men. It does seem very much worthwhile to offer support to promote their perception of the psychologist.

Compliance with ethical standards

Ethical approval: "All procedures performed in studies involving human participants were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its later amendments or comparable ethical standards."

Competing interests: The authors state that they have no interests, which may be perceived as posing conflict or bias.

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Figure 1. Consort Flow Chart Diagram

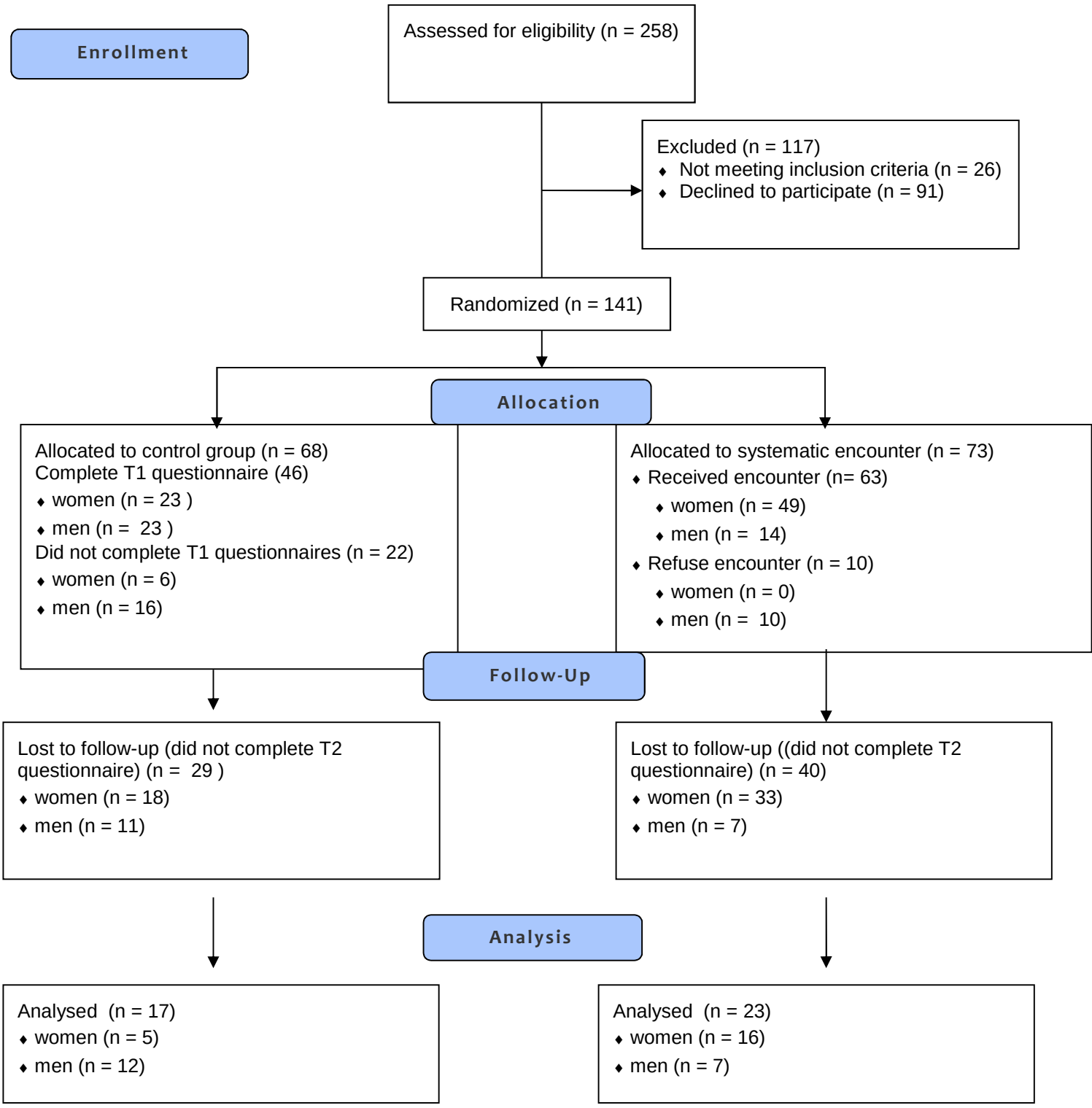


Table 1. Socio-demographic data in T1 (following the announcement of cancer diagnosis)

Charactersitics	Men *n*=37	Women *n*=72	Total *n*=109	*Tests*
Age (in years)				
Mean	59.68	54.63	56.34	2.34 [a] **
SD	9.05	11.34	10.84	
Min	27	29	27	
Max	76	85	85	
Marital status, n (%)				
In couple	28 (75.70)	45 (62.5)	73 (67.0)	1.92 [b]
Single	9 (24.30)	27 (37.5)	26 (33.0)	
Children, n (%)				
Yes	32 (86.5)	66 (91.7)	98 (89.9)	.72 [b]
No	5 (13.5)	6 (8.3)	11 (10.1)	
Professional activity, n (%)				
Yes	20 (54.1)	37 (51.4)	57 (55.3)	.07 [b]
No	17 (45.9)	33 (48.6)	50 (44.7)	
Missing	0	2	2	
Education, n (%)				
Primary school	0	2 (2.8)	2 (1.9)	6.99 [b]
Inferior secondary school	2 (5.4)	7 (9.9)	9 (8.3)	
Superior secondary school	7 (18.9)	20 (28.2)	27 (25)	
Superior School	14 (37.8)	30 (42.3)	44 (40.7)	
University	14 (37.8)	12 (16.9)	26 (24.1)	
Missing	0	1	1	
Culture, n (%)				
Europe	37 (100)	69 (95.8)	106 (97.2)	2.13 [b]
Outside Europe	0	3 (4.2)	3 (2, 8)	

Note.

[a] t-test ; [b] Chi-square test.

*** $p <$ .001 ; ** $p <$ .01 ; * $p <$ .05 ; † $p <$ .10

Table 2. Gender differences on psychosocial data in T1 (following the announcement of cancer diagnosis)

Characteristics	Men n=37	Women n=72	Total n=109	χ^2 test
Psychological difficulties before cancer diagnosis, n (%)				
Yes	4 (10.8)	19 (26.4)	23 (21.1)	3.56 †
No	33 (89.2)	53 (73.6)	86 (78.9)	
Psychological help outside the hospital during treatment, n (%)				
Yes	1 (2.7)	11 (15.3)	12 (11.0)	2.76 †
No	36 (97.3)	61 (84.7)	97 (89.0)	
Encounter with the psychologist, n (%)				
Yes	14 (37.8)	49 (68.1)	63(57.8)	9.14 **
No	23 (62.2)	23 (31.9)	46 (42.2)	

Note. *** $p < .001$; ** $p < .01$; * $p < .05$; † $p < .10$