



**Meeting of National
Psycho-Oncology Societies**

8th World Congress of Psycho-Oncology

**Thursday, 19 October 2006
1:30 – 3:30 PM**

Russott Hotel Congress Centre, Hall L

Venice, Italy

Contact Information for National Psycho-Oncology Society Representatives

Argentina	Nancy Ferro PhD	nancyferro@ciudad.com.ar
Argentina	Francesco Matozza	fmatozza@fibertel.com.ar
Argentina	Dra Viviana Sala	hcuriess@intramed.net.ar
Australia	Phyllis N Butow PhD	phyllisb@psych.usyd.edu.au
Australia	Afaf Girgis PhD	afaf.girgis@newcastle.edu.au
Australia	Carrie E Lethborg MSW	lethboce@svhm.org.au
Australia	Jane Turner	j.turner@psychiatry.uq.edu.au
Australia	Simon Wein MBBS, FRACP, FRChPM	simon.wein@petermac.org
Austria	Elisabeth Andritsch MD	elisabeth.andritsch@klinikum-graz.at
Austria	Gabriele Dietmaier	gabriele.dietmaier@klinikum-graz.at
Austria	Hellmut E Samonigg MD	helmut.samonigg@meduni-graz.at
Bangladesh	Mohammed Alim	zshamiu12@yahoo.com
Bangladesh	Sanowar Hossain	sanowarhossaindr@hotmail.com
Belgium	Isabelle Bragard	isabelle.bragard@ulg.ac.be
Belgium	Darius Razavi MD	drazavi@ulb.ac.be
Brazil	Maria Carolina Brando MMS	carolinabrando@uol.com.br
Brazil	Vicente Augusto de Carvalho MD	vicenteacarvalho@uol.com.br
Brazil	Nely A Guernelli-Nucci	nnucci@terra.com.br
Brazil	Elisa Maria Perina	perina@boldrini.org.br
Canada	Barry D Bultz PhD, C Psych	bdbultz@ucalgary.ca
Canada	Mary Jane Esplen PhD, RN	mesplen@uhnres.utoronto.ca
Canada	Zeev Rosberger PhD	zeev@psych.mcgill.ca
Chile	Jens Bucher BS	jb@persona.cl
Chile	Marcelo Campillay PhD	mcampillay@altavista.com
China	Cheung Bo Ying Bowil	canlink@hkcf.org
China	Cecilia Chan PhD	cecichan@hkucc.hku.hk
China	Richard Fielding	fielding@hkusua.hku.hk
China	Fengguang Hu	Sviminrd0513@hotmail.com
China	Wendy Wing Tak Lam PhD, RN	wwtlam@hkucc.hku.hk
China	Lili Tang MD	tanglili2005@hotmail.com
China	Cheng Venus	canlink@hkcf.org
China	Paul Yin	springrite@yahoo.com
Colombia	Cesar Gonzales	cegonzal@emcali.net.co
Colombia	Alicia Krikorian	akrikorian@une.net.co
Colombia	Hernan G Rincon MD	sopsycol@anotcl.lat.net
Cyprus	P Hadjikos	
Cyprus	Dominique Verplancken-Kanaris MS	dominique_kanaris@hotmail.com
Czech Republic	Libuse Kalvodova	dana.kekrtova@pharma.novartis.com
Denmark	Pernille Envold Hansen	pernille@cancer.dk
Denmark	Anders Bonde Jensen MD	a.bonde@inet.unl2.dk
Denmark	Christoffer Johansen MD, PhD, DMSc	christof@cancer.dk
Ecuador	Maria Alvarado-Moreno	mariacaridad_alvaradom@yahoo.com
Egypt	Ahmed Eltobgy	eltobgy@dr.com
Finland	Paivi Hietanen	paivi.hietanen@flmnet.fi
France	Marie-Frederique Bacque	mfbacque@club-internet.fr

France	Sarah Dauchy	sdauchy@igr.fr
France	Sylvie Dolbeault MD	sylvie.dolbeault@curie.net
France	Jean-Luc Machavoine	jl.machavoine@baclesse.fr
France	Daniel Oppenheim	openheim@igr.fr
France	Michel Reich MD	m-ronsse@o-lambret.fr
France	Pierre Saltel	saltel@lyon.fnclcc.fr
Germany	Uwe Koch MD, PhD	koch@uke.uni-hamburg.de
Germany	Anja Mehnert PhD	mehnert@uke.uni-hamburg.de
Germany	Andrea Schumacher	anschum@uni-muenster.de
Germany	Joachim Weis DrPhil	weis@tumorbio.uni-freiburg.de
Greece	George Christodoulou MD	gnchrist@compulink.gr
Greece	Vassilis Iakovidis MD	
Greece	Gerassimos A Rigatos MD	
Greece	Panagiotis Sakellaropoulos	ekpsath@otenet.gr
Hungary	Maria Molnar	foig@kmk.hu
Hungary	Katalin Muszbek MD	katalin.muszbek@hospicehaz.hu
Hungary	Magda Rohanszky	mrohanszky@laszlokorhaz.hu
Iceland	Halla Thorvaldsottir	hallath@landspitali.is
India	Santosh Kumar Chaturvedi MD	skchatur@gmail.com
India	Manoj Pandey	manojpandey66@gmail.com
India	Bejoy Thomas	bejoyct@rediffmail.com
India	Aruna P Tole	aptole@vsnl.in
India	Chitra Venkiteswaran	chitven@hotmail.com
Indonesia	Magdalena Surjaningsih Halim PhD	magdalena.halim@atmajaya.ac.id
Iran	Gholamhossein Mob	gh_mobaraky@yahoo.com
Iran	Ali Montazer Moghaddam	ali@icord.jd.ac.ir
Iran	Ali Montazeri MPH, PhD, FFPH	ali@jdcord.jd.ac.ir
Ireland	Ursula M Courtney	ursula@arccancersupport.ie
Ireland	Shawn Steggles PhD	shawn.steggles@slh.ie
Ireland	Shelagh Wright PhD	shelagh.wright@dcu.ie
Israel	Lea Baider PhD	baider@cc.huji.ac.il
Israel	Shulamith Kreitler PhD	krit@netvision.net.il
Israel	Shlomit Perry PhD	perrys@clalit.org.il
Italy	Florence Didier	florence.didier@ieo.it
Italy	Luigi Grassi MD	luigi.grassi@unife.it
Italy	Paolo Gritti	paolo.gritti@uninaz.it
Italy	Gabriella G Morasso	gabriella.morasso@istge.it
Italy	Antonella Surbone MD, PhD, FACP	asurbone@esoncology.org
Japan	Tatsuo Akechi MD, PhD	takechi@med.nagoya-cu.ac.jp
Japan	Yosuke Uchitomi MD, PhD	yuchitom@east.ncc.go.jp
Japan	Shigeto Yamawaki MD	yamawaki@hiroshima-u.ac.jp
Jordan	Jamal R Khatib MD	jkhatib@khcc.jo
Korea, Rep. of	Seong-Jin Cho MD	lawdoc@kcch.re.kr
Korea, Rep. of	Jong-Heun Kim MD, PhD	psy@ncc.re.kr
Korea, Rep. of	Jae Hyun Park MD	jaehyun@ncc.re.kr
Latvia	Sergeis Kusnecova	
Lithuania	Giedre Bulotiene MD	giebul@yahoo.com

Malaysia	Thamboo P Deraraj	
Mexico	Jesus Almanza MD	almanzaj@yahoo.com
Monaco	Nicole Gulochet	gulochet@onpg.mc
Nepal	Bhakta Man Shrestha MD, PhD	bpkmch@npl.healthnet.org
Nepal	Lily Thapa	lily@mos.com.np
Netherlands	Neil K Aaronson PhD	naaron@nki.nl
Netherlands	Eveline Bleiker	e.bleiker@nki.nl
Netherlands	Johanna de Haes PhD	j.c.dehaes@amc.uva.nl
Netherlands	Joke Fleer	j.fleer@chir.azg.nl
Netherlands	Josette Hoekstra-Weebers PhD	j.hoekstra-weebers@psb.umcg.nl
Netherlands	Bob F Last PhD	b.f.last@amc.uva.nl
Netherlands	Margot E Remie	margotremie@devruchtenburg.nl
Netherlands	Robbert Sanderman	r.sanderman@med.rug.nl
Netherlands	Martina Sita Vos MD	msitavos@wxs.nl
New Zealand	Peter Bucklan	peterb@nshospice.co.nz
New Zealand	Judy Forsyth	jforsyth@akcansoc.org.nz
New Zealand	Graeme Kidd	kido@xtra.co.nz
New Zealand	Johan S Nel	johan.nel@midcentral.co.nz
New Zealand	Douglas Richard Sexton	oxford378@xtra.co.nz
Nigeria	Rose Ekama Ilesanmi RN, MSN	roslynilesanmi@yahoo.com
Nigeria	Christopher Ndekwo	goziendekwo@yahoo.com
Nigeria	Adenike Onibokun PhD, RN, FUICC	nike1955@yahoo.com
Norway	Stein Kaasa	stein.kaasa@medisin.ntnu.no
Norway	Borrik Schjoedt	bosc@helse-bergen.no
Pakistan	Fatima Hussain	
Pakistan	Nisar Hussain	nisari@hotmail.com
Pakistan	Jamil Tahir	sjrkalis@yahoo.com
Peru	David Jauregul MD	davidja@terra.com
Philippines	Bernadette Arcena M.D.	psych_babes@yahoo.com
Philippines	Antonio C Sison MD	dopamine@hellokitty.com
Poland	Krystyna de Walden-Galuszko	galuszko@ptpo.org.pl
Poland	Justyna Pronobis	pronobisju@wp.pl
Poland	Manena Samanlokiewicz	psychonk@dsk.lublein.pe
Portugal	Emilia Albuquerque MD	eapsiq@croc.min-saude.pt
Portugal	Rosario Bacalhau MS	rosariobacalhau@iol.pt
Portugal	Antonio Barbosa MD	abarbosa@netcabo.pt
Portugal	Virgilio Kasprzykowski MD	v.kkk@usa.net
Portugal	Lucia Maria Silva Monteiro MD	lucia.monteiro@netcabo.pt
Portugal	Luzia Travado PhD	luziatravado@netcabo.pt
Romania	Ciprian Ablea	mst@xnet.ro
Romania	Busila Emiliar	violeta@rotravelpius.com
Russia	Dmitry Vybornykh MD, PhD	dvyh@yandex.ru
Serbia Montenegro	Suzanna Tosia-Golubovic	
Singapore	Frances Yee	frances.yee@kkh.com.sg
Slovenia	Urška Lunder MD	urska.lunder@mail.ljudmila.org
South Africa	Ruth Valerie N Benjamin MA	ruthbenj@global.co.za
South Africa	Martin Chasen	champ@sprint.ca

South Africa	Linda Greeff	linda.greeff@cancercare.co.za
Spain	Alfonso D Blanco	picabla@us.es
Spain	Maria L Die-Trill PhD	mdietrill@tiscali.es
Spain	Tania Estape	fefoc@fefoc.org
Spain	Francisco Gil PhD	fgil@ico.scs.es
Sweden	Birgitta Berglof	birgitta.berglof@skane.se
Sweden	Christina Bolund PhD	christina.bolund@ks.se
Sweden	Yvonne Brandberg	yvonne.brandberg@ce.ks.se
Sweden	Pia Dellson	pia.dellson@skane.se
Sweden	Maria Hellbom	maria.hellbom@skane.se
Switzerland	Jürg Bernhard PhD	Juerg.Bernhard@ibcsg.org
Switzerland	Maria Stella de Sabata	sds@uicc.org
Switzerland	Christoph Hurny MD	christoph.huerny@buergerspital.ch
Switzerland	Cecilia Sepulveda	sepulvedac@who.int
Switzerland	Friedric Stiefel MD	fredric.stiefel@eilot.unil.ch
Switzerland	Andreas Ullrich	ullrich@who.int
Switzerland	Brigitta Wossmer PhD	woessmerb@uhbs.ch
Syria	Abdul Nasser Kaaden	a.kaaden@scs-net.org
Taiwan	Ging-Long Wang MD, MPH	ginglongwang@mail.kfcc.org.tw
Thailand	Tana Nilcahikovit MD	hatnc@mahidol.ac.th
Turkey	Sedat Ozkan MD, PhD	sedatozkan_klp@yahoo.com
Turkey	Haldun Soygur	soygur.haldun@isbank.net.tr
Ukraine	Shahid Farooq	shahidfarooq@rediffmail.com
Ukraine	Mykola Kovalchuk	lifeafterdeath@inbox.ru
United Kingdom	Karen Cox	karen.cox@nottingham.ac.uk
United Kingdom	Andreas Fichtinger	a.fichtinger@sussex.ac.uk
United Kingdom	Penelope Hopwood MD, PRC Psych	penny.hopwood@christie-tr.nwest.nhs.uk
United Kingdom	Joanna Kemp	joannake@yahoo.co.uk
United Kingdom	Manoj Kumar MBBS, DPM, MD, MRCPsych	manoj.kumar@leedsmh.nhs.uk
United Kingdom	Donald Sharp PhD	d.m.sharp@hull.ac.uk
United Kingdom	Margaret Watson PhD	maggie.watson@rmh.nhs.uk
United Kingdom	Craig Allen White	craig.white@aapct.scot.nhs.uk
Uruguay	Ruben M Cesarco MD	rcesarco@mednet.org.uy
USA	Elliott Graham	egramham@apos-society.org
USA	Jimmie C Holland MD	hollandj@mskcc.org
USA	David W Kissane MD	kissaned@mskcc.org
USA	Alan D Valentine MD	avalenti@mdanderson.org
USA	Deane L Wolcott MD	dwolcott@aptiumoncology.com
Venezuela	Teresita Casati	ecasati@cantv.net

**Meeting of National Societies
8th World Congress of Psycho-Oncology
Thursday, 19 October 2006
1:30 – 3:30 PM
Russott Hotel Congress Centre, Hall L**

National Survey Questions

1. Please give us the name of your country's psychosocial or psycho-oncology society, its official mailing and e-mail address, website (if available), and the president or representative to IPOS along with his/her e-mail address. If you have no society in your country, describe the current state of development of an organization.
2. To what degree is psychosocial care incorporated in routine cancer care? In cancer centers? In primary health care? Please describe. What are the difficulties encountered in improving care?
3. Have you developed any screening methods for distress or standards of care for management of psychosocial distress?
4. Please describe the current training and educational programs (e.g. post-graduate courses) in psychosocial and psycho-oncology in your country.
5. Please describe current research groups and major projects going on in psycho-oncology in your country and interest in cross-cultural collaboration.
6. Please describe ways that IPOS could be helpful to your country's efforts in improving training, research and clinical care.
7. What, in your opinion, are the most important issues and barriers our field should address in 2007 regarding training, research and clinical care?
8. Describe how psycho-oncologists are involved in your country in the different aspects of cancer care.
 - a. Prevention/Early detection
 - b. Symptom control
 - c. Palliative care
 - d. Survivorship
9. What are the major obstacles in funding for training, research and clinical care?

National Survey Results

Australia

1. COSA Psycho-Oncology Group

The current national group that exists in Australia is the Psycho-Oncology Group of the Clinical Oncological Society of Australia (COSA). Its objectives are to:

1. promote research into psychological status and its relationship to cancer management and outcomes;
2. raise awareness of the importance of psycho-social issues in the management of the cancer patient and to improve the quality and availability of services in this area;
3. collaborate in multi-disciplinary research;
4. train researchers and promote career paths.

The Psycho-Oncology Group welcomes participation by all health professionals involved in cancer care. This group has been discussing the need to become a more recognised national society and will be holding a facilitated workshop in November 2006 to progress this.

Mailing address and other contact details

COSA Office

Medical Foundation Building

Level 5, 92 Parramatta Rd,

Camperdown NSW 2050

Phone: +61 2 9036 3100

Fax: +61 2 9036 3101

E-mail: cosa@cancer.org.au

Current Chair (2002-December 2006)

Professor Afaf Girgis

Director, Centre for Health Research & Psycho-Oncology (CHeRP)

The Cancer Council NSW/University of Newcastle

Locked Bag 10

WALLSEND NSW 2287

Ph: +61 2 4924 6376

Fax: +61 2 4924 6208

E-mail: Afaf.Girgis@newcastle.edu.au

NB: A new Chair will be elected by the end of 2006 and commence the role from January 2007.

2. While psychosocial care is informally incorporated into routine care, the degree to which psychosocial needs are identified and met is variable. In many care settings, particularly regional and rural areas, there is no standardised process by which psychosocial risk factors are routinely assessed or patients referred on to appropriate services. Whilst specialist oncology units usually recognise the importance of psychosocial care, the models of care differ between networks, and identification and management of problems is dependent on the skills of individual treating health professionals. As a result, access to psycho-oncology services is often in response to specific crises.

Psychosocial care may be more routine in the inpatient setting where care and access to health professionals is more intensive and hence, problems are more likely to be recognised and referrals made. As inpatients, patients have greater access to social workers and psychologists.

Few health services have psycho-oncology teams (i.e. psycho-oncologists and social workers working together). More commonly, hospital oncology units have a permanent social worker and access to a psychologist on a referral basis. Few psycho-oncologists are available nationally, with specialist training in this field in its infancy.

NSW Psychosocial Support Project - Gynaecological Oncology

The NSW Psychosocial Support Project, Gynaecological Oncology, is a funded initiative of the Greater Metropolitan Clinical Taskforce (GMCT) of NSW Health. The aim of the project is to promote, improve and enhance the psychosocial support given to women, their carers and friends, who have been diagnosed with a gynaecological cancer in NSW. The main aim of this project is to highlight the importance of providing to every woman diagnosed with a gynaecological cancer, adequate emotional, psychological and practical support available from time of diagnosis, throughout treatment, aftercare and palliation if necessary. The Psychosocial Support Project was funded by the GMCT to identify and implement the most efficient and effective strategies to address the psychosocial needs of women with a gynaecological cancer across NSW. The project has with limited resources developed projects that target women, their carers and families directly, general practitioners, nurses and other allied health professionals currently working in the area of gynaecological cancer care.

Accomplishments to date:

- In conjunction with NSW Health and Life Force Foundation the development of the 'Directory of gynaecological oncology treatment and support services'. This directory informs general practitioners and women about the specialist gynaecological oncology units, linked rural clinics and psychosocial support services available across NSW
- Organize and facilitate state-wide health professional network meetings
- The development of the gynaecological cancer support website www.gynaecancersupport.org.au. That includes:
 - Establishment of an on-line women's virtual community
 - On-line support network for health professionals
 - RACGP accredited eLearning continuing education for general practitioners (described in Question 4 response below).

Some difficulties encountered in improving psychosocial care overall are:

- Limited training given to medical staff on the importance of identifying psychosocial needs and referring to relevant practitioners.
- Less than optimal understanding about the emotional impact of a cancer diagnosis and the appropriate avenues of supports available.
- Psychosocial care for patients seen as an issue that needs addressing but no champion to further its presence/cause.
- Funding deficit to provide comprehensive psychosocial services.
- Minimal to moderate management and clinical support for psychosocial services within the cancer centre.
- Competing priorities in terms of time and resources to provide such care.

The following comments were received regarding gaps in provision of psychosocial cancer support services, in relation to gynaecological oncology specifically, in NSW:

- Whilst each of the specialist gynaecological oncology units incorporates and recognises the importance of psychosocial care, the models of care differ between each of the networks.
- No capacity to formally research alternative and emerging models of psychosocial care.
- Due to insufficient resources, the capacity to adequately follow up all women after discharge, particularly those from the rural areas is limited.
- Professional links and referral pathways to the various services available are often ad hoc.
- Women living in rural and remote areas lack the opportunity for ongoing psychosocial support.
- Limited Medicare cover for psychosocial support results in many women not being able to access professional assistance when needed.

3. As a result of the development and implementation of touch screen computer surveys for routine self-assessment of needs for psychosocial support in patients waiting for appointments at cancer clinics, a number of cancer services are routinely assessing and receiving printed feedback on the self-identified needs of their patients. This is happening mostly in NSW, Australia's largest state, but is starting to receive interest from other states. This initiative was progressed with equipment funding from the Cancer Institute NSW, through a research group (Centre for Health Research & Psycho-oncology), rather than initiated by the cancer centres themselves.

There have been attempts to develop more standardised referral pathways on a state level, but this work is still in development. In the meantime, development of some local referral pathways is reported by some centres to have resulted in more regular and appropriate referrals to oncology social work services. Locally developed screening measures tend to be used in a somewhat ad hoc manner and without well developed referral pathways; hence, appropriate referrals are not always made.

In some cancer services, psycho-oncology staff members attend multi-disciplinary meetings in an attempt to identify patients early that may have psychosocial distress.

Clinical practice guidelines for the psychosocial care of adults with cancer

The National Breast Cancer Centre (a Federally funded national organisation with the remit of improving outcomes for patients with breast and ovarian cancer in Australia) and National Cancer Control Initiative in Australia have developed a comprehensive set of guidelines to outline gold standard psychosocial care: the Clinical practice guidelines for the psychosocial care of adults with cancer (<http://www.nbcc.org.au/bestpractice/psychosocial/index.html>). A number of accompanying resources have also been developed to facilitate their uptake by health professionals, including a summary card and a series of workshops conducted nationally to discuss referral and care pathways.

However, the uptake of the Guidelines is variable and in some centres, there are no reported standards of care for management of psychosocial distress. Medical staff will typically call the oncology social worker, the consult and liaison team, or breast care nurse specialist if they are concerned about the patient's level of distress, but there is no "triaging" process/protocol in place to determine who to refer to and when is most appropriate to refer.

The National Breast Cancer Centre has recently initiated a project to develop patient information based on the Clinical Practice Guidelines, to provide adult cancer patients with information about the importance of psychosocial and supportive care issues during their journey and to empower patients to seek improved communication with their treatment team.

National Breast Cancer Centre Psychosocial Care Referral Checklist

The National Breast Cancer Centre is currently piloting a Psychosocial Care Referral Checklist for use by multidisciplinary teams to assist in identifying patients who may be at increased risk of psychosocial distress, using criteria identified in the Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer. The Checklist also incorporates the NCCN Distress Thermometer to assess the patient's current level of psychosocial distress. It is expected that results from the pilot will be available in late 2006.

Indicators for Psychosocial Care

The National Breast Cancer Centre is currently developing a series of indicators for psychosocial care that could be used by health services to identify whether practice is in line with the Clinical Practice Guidelines for the Psychosocial Care of Adults with Cancer. It is proposed that the Indicators may eventually form the basis for accreditation processes around psychosocial care. The Indicators will be circulated for broad review before being finalised in late 2006.

4. Despite psychosocial issues being identified as one of the areas of highest need for continuing professional development by health professionals, few continuing education programs targeting this area are reported. A number of short programs have been conducted (of several hours or days in length) and mainly focus on communication skills for doctors and nurses. Groups including the National Breast Cancer Centre are offering small amounts of competitive funding for cancer centres to run communication skills training, using trained facilitators who have completed a Train-the-Trainer course conducted by the National Breast Cancer Centre.

Specific professional training for social workers and psycho-oncologists wishing to specialise in the area of oncology is in its infancy, with a small number of post-graduate programs available in Australia. A graduate diploma in Psycho-oncology has recently commenced at the University of Melbourne.

Post graduate course for General Practitioners (GPs)

The NSW Psychosocial Support Project, Gynaecological Oncology, is a funded initiative of the Greater Metropolitan Clinical Taskforce (GMCT) of NSW Health. This group has developed a course specifically for GPs. "Supporting the journey of women with a gynaecological cancer" is an eLearning course accredited by the Royal Australian College of General Practitioners (RACGP) and was developed to improve the psychosocial care given to women at a time when they are often highly distressed, anxious and uncertain about their future.

As the primary case manager, the general practitioner is key to providing the kind of psychosocial care that women need from the time of that initial diagnosis through to palliation in some cases. A cancer diagnosis impacts on every aspect of a woman's life requiring a holistic approach. The challenge for the doctor is to be able to integrate their response to the physical aspects of the illness whilst providing ongoing psychological, psychosexual and emotional support.

This course is therefore designed to introduce to the GP a range of topics related to the psychosocial care of women diagnosed with a gynaecological cancer. However, it is true to say that many of the issues presented in this course are common to many people diagnosed with a life threatening illness.

There are 7 separate learning modules:

- **Gynaecological cancers and patient management issues**
Overview of gynaecological cancers in NSW; familial cancer risks; epidemiology; associated psychosocial issues; plus patient management issues including follow-up after treatment.
- **Psychosocial distress in gynae-oncology patients**
Description of the different phases of the journey; differentiate between persistent elevated distress and normal response to an extreme situation; coping strategies.
- **Pain Management**
Basic principles of pain management relief in cancer care.
- **Complementary and Alternative Medicine (CAM)**
Description of complementary and alternative treatment; patterns of use; safety issues; risks and benefits; professional responsibility;
- **Sexuality**
Sexuality within the cancer experience; common problems in sexual function; how to address fertility issues, menopause and sexual function problems; PLISSIT model.
- **End of Life Issues**
Illness transition; negotiating ceasing active treatment; goal setting framework; addressing spiritual care; palliative care; terminal care phase; grief and bereavement.
- **Survivorship Issues**
Common responses of people post cancer treatment with a good prognosis.

Continuing Professional Development Packages for Cancer Health Professionals

The Australian Government has provided funding to a multi-group consortium to investigate, develop and pilot models for continuing professional development packages targeting cancer specialists, counselors and general practitioners. Recommendations from Phase 1 of the project include providing training in the use of psychosocial support screening tools and appropriate referral for psychosocial support.

The Queensland Cancer Fund in collaboration with The University of Queensland has developed a structured workshop based on the Clinical Practice Guidelines for the Psychosocial Care of adults with cancer, comprising an overview of the impact of cancer, supplemented with a series of case vignettes which are presented to outline strategies for responding to patient need. The workshops incorporate a tiered approach to psychosocial care, detailing the need for good communication and information for all patients, with more specialized treatment being necessary for patients with increased distress. The target audience is wide, with all health professionals involved in the care of patients with cancer invited, and workshops have been held at 8 sites throughout Queensland including several provincial cities. Participants receive a detailed workshop manual, and a summary card of the Psychosocial Guidelines. Participants are encouraged to think about innovative ways of delivering psychosocial care, including development of clinical care pathways, or modifying utilization of existing services. Evaluations of these workshops have been extremely positive. A DVD has been produced of the workshops and a strategy is being developed for a Train-the-Trainer series of workshops in which local champions from regions throughout the state will be invited to participate, with the intent that they then disseminate the workshop material locally.

Specialist breast nurses

Specialist breast nurses have become important members of the breast cancer team as evidence has emerged about the benefits of the role for patients with breast cancer. A set of competency standards for Specialist Breast Nurses developed by the National Breast Cancer Centre in 2005 identifies Supportive Care as a key domain of practice. While it is recognised that the Specialist Breast Nurse

role is not to provide psychological or psychiatric counselling, the role does include advanced skills in identifying, validating and prioritising anticipated and potential psychological and support needs of patients. A number of Specialist Breast Nurse educational courses and practicums are available across Australia.

5. Australia has a number of well-established and quite research-active groups working in the area of psycho-oncology. Some of these groups are funded in part by the state based Cancer Councils (charity organisations which also support research), including the Centre for Health Research & Psycho-oncology in NSW, the Centre for Behavioural Research in Cancer Control in Victoria and the Viertel Centre for Research in Cancer Control in Queensland. Psychosocial research is also undertaken in other well-established research centres attached to various Universities and major hospitals, including the Medical Psychology Research Unit in NSW, the Peter MacCallum Cancer Centre in Victoria, the School of Public Health at Queensland University of Technology, the WA Centre for Cancer and Palliative Care, and several others.

Psycho-Oncology Co-operative Group

A psycho-oncology research umbrella group was formed in 2006, with funding from the Cancer Institute NSW and more recently, with national government funding. The group was conceived in response to a recognised need to develop the capacity and coordinated collaboration to conduct large-scale, multi-centre psycho-oncology and supportive care research.

The Psycho-Oncology Co-operative Group's mission is to improve the outcomes of patients experiencing a diagnosis of cancer, their families and carers through evaluation and implementation of psychosocial and supportive care interventions for patients, carers, health professionals and the health care system. It aims to:

1. Bring together researchers, clinicians and health care professionals in Australia and New Zealand with an interest in Psycho-Oncology and foster collaboration
2. Develop large-scale, multi-centre Psycho-Oncology studies of clinical relevance and importance
3. Develop more formal links with cancer clinical trial groups to facilitate psychosocial sub-studies
4. Promote Psycho-Oncology research
5. Support emerging new researchers in this area.

Group Chair
Professor Phyllis Butow
Medical Psychology Research Unit
Brennan MacCallum Building (A18)
School of Psychology
University of Sydney NSW 2006
Ph: +61 2 9351 2859
Fax: +61 2 9036 5292
E-mail: phyllisb@psych.usyd.edu.au

Group Co-ordinator
Dr Rebecca Hagerty
Medical Psychology Research Unit
Brennan MacCallum Building (A18)
School of Psychology
University of Sydney NSW 2006
Ph: +61 2 9351 2157
Fax: +61 2 9036 5292
E-mail: rebeccah@psych.usyd.edu.au

Psycho-oncology Research Summary

PoCoG requested information from its membership in 2006 on current psycho-oncology research. It received 31 replies from Australia and New Zealand, reporting approximately 78 research projects, covering the following project themes:

- Doctor-patient communication/relationship:
 - Why do patients seek a 2nd opinion
 - Attitudes to shared decision making among different medical specialist groups
 - Improving informed consent and decision-making
 - Use of multimedia
 - Measures of patient attitudes to medical decision-making
 - Improving the chemotherapy consent process: Longitudinal assessment of patient recall
 - Enhancing cancer patient participation when discussing clinical trial enrolment with the use of a question prompt sheet
 - Discussing prognosis
- Information tools/interventions for patients
 - Decision aids
 - Question prompt lists for patients considering clinical trial enrolment
 - Use of multimedia
 - Improving informed consent to chemotherapy: Written information versus and interactive CD-ROM
 - A video resource to improve psychological adjustment after cancer treatment
 - Education intervention to enhance outcomes for patients commencing chemotherapy
- Social
 - Cultural issues
 - Cancer in Aboriginal people
 - Cross-cultural communication about prognosis of metastatic breast cancer.
- Palliative Care
 - Experiences of Palliative Care Services
 - Pain management interventions in palliative care patients.
 - A supportive care program designed to reduce perceived needs and psychological distress and enhance quality of life amongst people with incurable lung cancer
 - Timing of palliative care
 - Pain management interventions in palliative care patients.
 - End-of-life decision-making
 - Palliative Care in the community for people not enrolled in a hospice program

- The Palliative Care Support Study -a randomised control trial to establish the efficacy of a new and innovative intervention -Dignity Therapy -for patients in the last months of their life and their families. Collaborative with Perth, Australia, Winnipeg, Canada and New York City, USA.
- Cancer risk/genetics
 - Behavioural factors and other personal characteristics
 - Screening
 - Knowledge and attitudes towards cancer and cancer risk
 - Psychosocial predictors of developing breast cancer in women from high risk breast cancer families
 - Psychological responses to genetic testing in high risk melanoma families
- Psycho-biological impact of cancer/treatment
 - Impact of chemotherapy on cognitive function
 - Psychological stress and immunity in patients with breast cancer post-treatment
 - Determinants of Nausea in Palliative Care Patients
 - Effects of symptom clusters on physical and psychological functioning of patients with metastatic Cancer
 - Pain management interventions in palliative care patients.
 - The influence of expectations on experience: Why chemotherapy toxicities vary among patients with colorectal cancer
 - The association between serum anticholinergic levels and diagnosis or future development of delirium in palliative care patients with advanced cancer.
 - The effect of adjuvant chemotherapy on cognitive functioning in early breast cancer.
- Financial cost of cancer to patient
 - Patient out-of-pocket expenses due to prostate cancer and predictors of high individual costs of prostate cancer
 - The informal care requirements and impact of prostate cancer on employment
 - The lost productive work (paid and unpaid activities) to society from men having prostate cancer
 - Predictors of high individual costs of prostate cancer.
- Psychological needs and interventions
 - Anxiety in cancer patients
 - Quality of life
 - Spiritual well-being
 - Spirituality in NZ End-of-life Cancer Care
 - Relationship between social support, treatment and demographic factors relate to levels of anxiety, depression and unmet needs among colorectal patients
 - RCT of Dignity Therapy -for palliative care patients in the last months of their life and their families
 - A tailored pathfinder intervention to reduce the unmet psychosocial needs of colorectal cancer patients
 - Efficacy of emotion focused psychotherapies for reducing distress and improving immune function and quality of life in cancer patients
 - Evaluating the Family Meeting model as an instrument of psycho-spiritual care of palliative patients and their families

- Needs of young women:
 - Menopause after breast cancer in young women
 - Education and support modules on the management of menopause after cancer
- Needs of men with cancer
 - Coping in men with advanced prostate cancer, and their loved ones
- Interventions other
 - Exercise interventions for women with breast cancer
 - Yoga for cancer patients
 - Chinese exercise in cancer
- Survivors needs
 - Cancer survivors' and partners' unmet supportive care needs: the CASUN (cancer survivors unmet needs measure)
- Quality of life
 - Psychosocial predictors of outcome ovarian cancer.
 - Efficacy of emotion focused psychotherapies for reducing distress and improving immune function and quality of life in cancer patients
- Carers
 - Concerns, self-perceived needs, and supportive interventions, for informal cancer carers
 - Needs of female and male carers.
- Support groups
 - Interventions to support leaders of cancer support groups.
 - Model for bowel cancer support groups
 - Peer support for patients with lung cancer
 - Cancer helpline as a method for providing psychosocial assessment and support
- Training programs for health professionals
 - Discussing prognosis & end-of-life issues in palliative care
 - Communicating effectively and ethically about clinical trials
- Management of patients and access to care
 - The experience of the patient pathway by patients of royal Adelaide hospital receiving treatment for cancer
 - Improving continuity of clinical care and educating general practitioners
 - A randomised controlled trial of consumer-driven multi-disciplinary care to manage the needs of men with prostate cancer
 - Palliative care in the community for people not enrolled in a hospice program
 - Consumer-driven multi-disciplinary care to manage the needs of men with prostate cancer

- Development of measures
 - Measures of perceived needs for young persons with cancer and their parents
 - Development of a perceived needs questionnaire for Canadian cancer survivors and their significant others
- Other:
 - Professional mentoring
 - The development of consumer criteria for judging research protocols.
 - Psycho-oncology co-operative research group.
 - Psychosocial care needs of people with cancer in regional areas.

International collaboration

Australia is involved in several international studies, including a three-nation study (Australia, Canada and the US) trialling dignity therapy for people in the last months of their life, an Australian and Canadian study of the prognostic information needs of people with advanced cancer, an RCT of decisions aids conducted by the ANZ Breast Cancer Trials Group and an RCT of a communications skills training skills package being conducted by the International Breast Cancer Study Group (Australia, NZ, Switzerland, Germany, Austria). We are open to increasing the extent of such collaborations in areas of mutual interest.

6. Providing opportunities for health professionals, and psycho-oncology specialists in particular, to experience models of care delivery in international settings would help provide local staff with expertise to help establish workable care models in the variety of settings within the Australian health care system.
7. The limited transference of research findings into clinical practice is a major problem for psycho-oncology. While this is partly due to the lack of recognition of the importance of the psychosocial needs of people with cancer and their families by some health professionals, it is also a symptom of limited funding in an environment where health services are required to prioritise services and care. One of the main priorities would be lobbying to raise the profile within the medical community of the importance of addressing patients' psychosocial issues.
8. As previously described, services are very variable across Australia. Involvement of psycho-oncologists specifically in the following aspects of cancer care is likely to be determined by availability of funding and staff resources at the local levels. Hence, it is difficult to give a national picture.
 - a. Probably limited. A more coordinated approach is most likely to be available at services offering screening/early detection, such as in breast cancer screening (mammography screening) services.
 - b. Within the Townsville Cancer Centre, psycho-oncologists are occasionally called upon to assist in patients' pain control.
 - c. A social worker is part of some palliative care teams who assists palliative patients and their families with psychosocial issues on a routine basis. Some palliative care services, particularly those in rural areas, are largely delivered through nurses. The extent to which they can offer psychosocial support is probably dependent on their own training.
 - d. Support groups and 1:1 counselling are available through some cancer centres.

9. As with cancer care, there is a limited budget available for health research in Australia. As there is a very robust health research community in Australia, competition for limited funding is intense, and funding bodies must prioritise research. Biomedical research programs and collaboratives are more established hence potentially have more resources and a track record on which to base applications for funding.

Competing successfully in the open market for funds for clinical practice requires a commitment from health professionals and policy leaders to the provision of psycho-oncology. Gold standard psychosocial care must become a priority. At this point, because psycho-oncology is still a developing area of expertise in Australia, there is limited involvement of clinicians in policy development in this area. Furthermore, strong leadership from within the area of clinical psycho-oncology is needed to be developed to help drive the profile and negotiation of services.

Brazil

1. SBPO – Brazilian Psycho-Oncology Society
Rua Itália, 454, Campinas
São Paulo Brasil
Cep: 13070-350
www.sbp.org.br
President: Elisa M. Perina
E-mail: elisaperina@uol.com.br or perina@boldrini.org.br
2. Psychosocial care is incorporated in routine cancer care in specialized cancer centers. Difficulties faced include: Lack of partnership and knowledge about the scope of qualification in psycho-oncology and the specialization in that area, defining the roles among professionals, and respect for the limits and possibilities of multidisciplinary practice.
3. There are no national standard of care. Some screening methods are utilized, but they vary based on need and availability of resources.
4. Graduate, post-graduate, specialization, improvement, continuing education (limited to urban centers and developed regions).
5. There are isolated, institutional academic projects with different approaches. There is however, a growing interest in cooperative multicenter studies on quality of life. Research is also limited by the difficulty in finding instruments that were properly translated and validated, as well as securing appropriate conditions for the development and validation of new techniques.
6. Continuation of IPOS online curriculum through the SBPO website, access to protocols and guidelines, and cooperative multicenter research with local institutions and universities.
7. Publicizing psycho-oncology, including courses for professionals. Exposure of psycho-oncology to the WHO.

8.
 - a. Orientations, lectures, community and professional information, and online courses.
 - b. Follow-up, relaxation and visualization, team and family support.
 - c. Individual and group support for bereavement, formation of healthcare team, acknowledgment of psychosocial intervention and reflection on death as part of the life process.
 - d. Individual and group support for childhood cancer and older patients (breast, gastrointestinal, prostate, etc), rehabilitation, improvement of sexuality during and after treatment, reintegration into school/work, and information for the family, community and team.
9. Lack of knowledge about the importance of psychosocial intervention, lack of investment in research, disconnect between research and clinical practice and lack of motivation for professionals to research.

Canada

1. Canadian Association of Psychosocial Oncology, 296 Jarvis Street, Unit 7, Toronto, Ontario M5B 2C5, Canada. Website: www.capo.ca. President: Esther Green. esther.green@cancercare.on.ca.
2. Psychosocial care is in place in major cancer programs, and in most provinces in Canada, although it may vary in how the program is resourced and supported in each organization. In smaller centres it is more of a challenge...likely related to funding models and absence of leadership support. Primary health care is more of a challenge in Canada because of shortages in family physicians across the country and slow response to address this shortage and place other providers in primary care teams....social work, Nurse Practitioners, dietitians. There is an absence of looking at outcome indicators that would 'trigger' improvement initiatives. In the last 2 years, an Ambulatory Oncology Patient Satisfaction survey has been introduced in several provinces. One of the domains of the patient experience is emotional support. We are now finding that the scores for patient satisfaction are low (50% range), and with these data, the programs are beginning to address improvements and examine the psychosocial program's needs. Secondly CAPO developed Standards for Psychosocial that have been distributed across Canada indicating minimal standards for the programs. We know in some areas that the standards have been used to support improvements, while in other areas, the standards have been ignored. CAPO is taking a lead to examine how the standards can be best utilized.
3. Recently we established Clinical Practice Guideline work and are examining CPG models from other jurisdictions as well as systematically reviewing the literature on screening tools and management of distress. The Canadian Strategy for Cancer Control, Rebalance Focus group recommended that Psychosocial Distress be recognized as the 6th Vital Sign in 2005...and CAPO has promoted this across Canada.
4. There are a number of programs in different provinces, such as a new graduate program at the University of Toronto (Master and PhD studies) in palliative and psychosocial care. Two Chairs were established, one in Calgary in Psychosocial Oncology and one in Toronto at Princess Margaret Hospital in Palliative and Psychosocial Oncology. There are psychosocial programs at the University of Calgary, and U of T, McGill University (Montreal) and courses at other universities such as UBC, Dalhousie University. There is also a major grant to support psychosocial oncology education that is being implemented across the country: PORT...Psychosocial Oncology Research Training

5. There are a number of research studies underway in Canada...too numerous to list here. NCIC has been funding grants specifically for psychosocial oncology as well as the Canadian Institute Healthcare Research (CIHR). We also have a grant of >\$750,000. to study inter-professional education for psychosocial oncology from Health Canada for 2 years. Dr. Deborah McLeod (board member of CAPO) is the PI on this study.
6. Collaboration on multi-centre studies; development and funding of guideline development; inter-professional education programs...learning from what other countries have done successfully.
7. National and international practice guidelines; more interdisciplinary training programs; more research funds directed for psychosocial oncology. Funding within organizations to support psychosocial oncology programs....staff positions, programs for patients and families.
8.
 - a. There are a few psychosocial experts whose work focuses on genetic counselling, such as Dr. Mary Jane Esplen, but for the most part, this area is not well resourced for psychosocial care.
 - b. Strong focus
 - c. Strong focus.
 - d. Minimal work in this area.
9. Limited financial resources...when most of the research funding goes to bench research or clinical trails.

China

1. Chinese Psychosocial Oncology Society
Room 806, Xin Zhou Business Building
No. 58 Fucheng Road
Haiden District, Beijing 100036
P.R. China
Cacamsc@caca.sina.net
President: Dr Zongwei Zhang
Secretary: Dr Lili Tang
2. Psychosocial care is mainly limited to larger cities. The major difficulties encountered are a result of cultural beliefs regarding health and disease; this includes physicians and leaders, as well as patients. In 1990, The Ministry of Health mandated the addition of psychiatric units and psychosocial service for medial patients, which includes cancer patients. However, these services have few professionals and there are limited resources to develop therapies. There is support for group therapy, individual therapy, meditation, message therapy, and psychopharmacology.
3. Some scales have been developed for depression, anxiety and fatigue based on Dr. Jimmie Holland's screening method. The standard of care is based on DSM-IV
4. Since 1978, some medical schools began to train graduate (Master's, PhD and MD) students in psychiatry, clinical and consulting psychology. Some of their research included psychosocial oncology. The early research led to a more specialized psychosocial oncology approach. As well, many Universities began to provide more psychosocial training for medical and psychology students.

In 1985, the medical field in China began to transform from a biomedical model, to biopsychosocial model, although predominantly in theory. Many health care providers continue to practice medicine from a solely biomedical perspective. Nevertheless, in the mid-1990's, hospital sponsored continuing education programs for nurses and doctors began to include psychosocial oncology courses. As well, students of Peking University School of Oncology training in internal medicine and surgery now receive seminars in psychosocial oncology. Smaller community hospitals frequently invite psychosocial oncology experts to give lectures to enhance their physicians' awareness of psychosocial oncology. CACA has now sponsored four National Oncology Congresses, and has set up an assembly room to discuss psychosocial issues about cancer patients at each congress. Many Universities have training and educational programs e.g. post-graduate courses in psychosocial in our country, but only few universities have psycho-oncology training and educational programs in our country now, we are trying to develop it now. Also we are going to have training class in Peking University, medical school students.

5. Approximately fifteen years ago, Dr. Zongwei Zhang, an epidemiologist and some psychologists from the Chinese Scientific Institute began to engage in psychosocial research, following brief education and training in psychiatry and research. At this time, CACA, China Association for Mental Health (CAMH) and Peking University medical school supported the initial research in psycho-oncology. Since then psychologists, psychiatrists and clinical oncologists have increasingly engaged in psychosocial research. This research has included the areas of quality of life, emotional reactions of cancer patients to diagnosis, treatment and survivorship, information needs, and psychosocial interventions such as meditation, massage and group therapy. Funding is provided through the National Natural Science Foundation, CACA, Capital Scientific Research Development Foundation and various hospitals involved in cancer care. We are interested in many issues on cross-cultural collaboration, e.g., cultural factors impact on survivorship, food style and culture, smoke and culture, Traditional Chinese medicine with Psycho-oncology and so on.
6.
 - 1) To translate the website core courses into Chinese.
 - 2) Bring and share some good western concepts and culture on diseases to China.
 - 3) Open training classes or workshop on psycho-oncology in China.
 - 4) Exchange students and professionals.
 - 5) Pay more attention to cross-culture issues in psycho-oncology between the West and the East.
 - 6) Funding support in research and training.
7. Cross-cultural issues should be addressed in 2007.
8. a. Offer more information and health education to the general population in various ways, including pamphlets and videos. In 1995, a World Bank Loan Health VII: China Disease Prevention Project—health promotion component (1996–2002) began in seven cities: Beijing, Tianjin, Shanghai, Chengdu, Luoyang, Liuzhou and Weihai, and some regions of Yunnan province. The program covered about 90 million people. To date, there has been an overall reduction of 15% in the prevalence of male adult cigarette smokers. For example, the project of health eating for life addressed this issue in China by training a team of community health workers and equipping them with the knowledge and resources to inform and educate their communities. Interventions include to train the trainers-health professionals, neighbourhood committees, household representatives and cooks, teachers and schools, workplace committees and cooks; provide health information-newsletters, posters, videos, booklets, television etc

b./c. Clinicians are involved in psychosocial assessments, psychotherapy, palliative care and pain management for cancer patients and their families. We have palliative care groups in psycho-oncology deal with some issues, for example, pain and delirium. In 2001, an enormous donation was provided to 20 hospitals in China and which will continue to provide free pain management medications and support therapy to cancer patients unable to assume the financial costs for care.

d. Patients with cancer are organizing numerous self-help groups nation-wide. CACA assists the organizations in fund-raising through sponsored walks and performances. Every province, municipality and autonomous region has their own self-help organization. In Beijing, one such group is called the Cancer Rehabilitation Society and has approximately 5000 members. They not only provide support to one another, but have also formed choral singing groups and put on fashion shows. Doctors and nutritionists are often involved to give lectures and physical therapists lead qigong, and tai-chi classes. These kinds of organizations aim at advocacy the knowledge of anti-cancer within the groups, support each other in emotion, offer social support each other in the groups, but not have any action for fund raising. This kind of organization adapt the trait of large population in China, we call “population anti-cancer”, all these kind of groups have psycho-oncologists join in.

9. Funding is still a major obstacle in the field and reflective of the little attention that is given to psycho-oncology.

Colombia

1. In Colombia we don't have a national association of psycho-oncology and at this moment, there hasn't been any effort to develop one. The closest experience is a virtual discussion group, with less than 30 members in the country.
2. Most cancer centers in our country don't have a psychosocial care team of their own. Usually, cancer centers are part of a bigger hospital or clinic and receive support from the psychosocial team's hospital.

Cancer centers that do have a psychosocial team, attend to patients and their families with different treatment modalities: psychotherapy, psychoeducational groups, support groups, etc. Psychologists and psychosocial care professionals are not regularly incorporated in hospitals or cancer centers for economic reasons. Our health system doesn't consider psychosocial care in highly specialized health services (but it does in primary care). Also, health professionals are becoming aware of the importance of psychosocial care, but still have difficulties detecting distress and referring patients to psychosocial teams. Most psychosocial personnel have to continuously remind other health professionals of the importance of referrals.

3. In our institution, at the Unit of Oncology Support (Instituto de Cancerología, Medellín – Colombia) we have treatment guidelines and we are conducting a research on suffering assessment in order to establish care standards according to our population needs. However, we don't regularly use other screening methods. We are now promoting the use of distress thermometers for oncologists. In Fundacion Valle de Lily (Cali) the psychosocial team uses regularly the distress thermometer and the MAC as screening methods.
4. We don't have formal psycho-oncology training programs. There have been short (12 – 20 hrs.) and long (100 hrs.) courses developed. We have a formal specialization in Pain and Palliative Care (accepted by the national education ministry) in which students from medicine, psychology, social work and nursing are accepted for interdisciplinary training. They receive basic education in psycho-oncology.

In many universities in Colombia, psychology programs include a curriculum in health psychology, where students have a general approach to psycho-oncology.

5. Usually Universities have research groups in health psychology. The Universidad Nacional de Colombia (Bogotá) has a psycho-oncology research group that has been working for over 5 years. Also, the Pontificia Universidad Javeriana (Bogotá) has research initiatives in psycho-oncology. The Universidad Pontificia Bolivariana (Medellín) has recently initiated research in that area. The group of Dr. Hernan Rincon in Valle de Lily (Cali) Institution has been working for some years in psycho-oncology.
6.
 - 1) By supporting efforts in creating a Colombian psycho-oncology society
 - 2) By translating the IPOS web site into Spanish in order to promote more contact and use of the virtual education programs in it.
 - 3) By receiving support in psychosocial research methodologies to improve quantity and quality of psycho-oncology research projects.
 - 4) By creating research networks with psycho-oncology groups in developed countries (US and Europe)
 - 5) By contributing to funding and scholarship availability for psychosocial care professionals in our country
7.
 - 1) Few professionals with strong experience and /or training in psycho-oncology.
 - 2) Poor knowledge /education regarding research methodologies in psychosocial disciplines.
 - 3) Few psychosocial professionals are regularly incorporated into cancer care.
 - 4) Few screening methods and treatment guidelines culturally adapted or developed considering patients' needs in each country /region
 - 5) Poor knowledge in health professionals and administrative leaders of the importance and benefits of including routine psychosocial care in cancer.
 - 6) Few employment opportunities for psycho-oncologists.
8.
 - a. We have cancer leagues that offer prevention programs. The health system includes a general program on health promotion and prevention that includes early detection of cervical and breast cancer. In our cancer care unit we have group programs oriented to the prevention of long term psychological complications such as sexual dysfunction.
 - b. Symptom control: Palliative care teams usually are committed to detecting and managing emotional symptoms and referring patients to psychosocial care consultation
 - c. Palliative care: Although palliative care is not largely available in our country, institutions that do have a palliative care consultation offer help through individual consultation for cancer patients in advance stages
 - d. Survivorship: In most psychosocial cancer care consultations, help is offered to cancer survivors. In our institution, we also have group therapies available to cancer survivors. It is important to note that cancer mortality rates are higher in our country compared to developed countries.
9. There is no funding available for psychosocial cancer care in any of the areas mentioned (training, research and clinical care).

Ecuador

1. There is no established psycho-oncology society. Work is done at “Instituto de Cancer (Solca-Cuenca).
E-mail: Solca@etapaonline.net.ec
www.solcacuenca.org
Representative to IPOS: Dr. Maria Alvarado
Mariacaridad_alvaradom@yahoo.com
2. At the cancer center, I give assistance to pediatric and Bone Marrow Transplant patients and families. Another psychologist gives assistance to adult patients and their families. The socio-economic problems of most of the patients makes it difficult to make psycho-oncology a priority. Often time is used to solve these problems and little time is left for research.
3. Developing screening methods for Bone Marrow Transplant.
4. There are no educational programs, but IPOS curriculum is used and many professionals train outside the country.
5. Current research is based on following the psychosocial status of patients receiving bone marrow transplants and evaluating the cognitive function of children receiving radiotherapy.
6. IPOS can continue to provide the online curriculum. It should attempt to make more cancer-specific evaluation scales available and begin the expand into pediatrics.
8.
 - a. Community education for early detection, promoting a healthy lifestyle, and promoting diagnostic testing.
 - b. Using psychoeducation and cognitive techniques to deal with symptoms.
 - c. Giving psychological support, teaching families/caregivers how to deal with patient’s symptoms. Adding family support in addition to patient.
 - d. Only when asked by a parent (pediatrics).

Finland

There is no established group in Finland. There is labor market research regarding re-entry into the work force for survivors.

Germany

1. German Association of Psycho-Social Oncology (DAPO)
www.dapo-ev.de
e-mail: dapo-ev@t-online.de
Chairwomen:
PD Dr. Andrea Schumacher
Medizinische Klinik und Poliklinik A
Universitätsklinikum Münster
Albert-Schweizer-Str. 33
48129 Münster
Telefon: ++49 251 -834 -7601; E-Mail: anschum@uni-muenster.de

Working Group/Section Psychosocial Oncology within the German Cancer Society (PSO)

www.pso-ag.de

Speaker:

Prof. Dr. phil. Joachim Weis
Leiter Psychosoziale Abteilung Klinik für Tumorbiologie
Breisacher Straße 117.
D-79106 Freiburg
Tel: ++49 761/206-2220 /-2218
Fax: ++49 761/206-2258
E-Mail: weis@tumorbio.uni-freiburg.de

Furthermore, there exist quite a few working groups on “Psycho-Oncology“ or “Psychosocial Oncology“ within other Scientific Societies such as:

German Society for Medical Psychology (DGMP): www.dgmp-online.de
German Society for Hematology and Oncology: www.dgho.de
German Society for Rehabilitation Sciences: www.dgrw-online.de

2) In routine inpatient cancer care: occasionally

In routine ambulant/outpatients/primary health care settings: rarely to never

In cancer centers: often

In breast cancer centers: regularly (otherwise breast cancer centers loose their certification)

In Germany, there are political attempts to implement Comprehensive Cancer Centers where psychosocial care is mandatory as it is currently for breast cancer centers.

We also have a very common system for oncological rehabilitation paid by the pension insurance. Within an oncological rehabilitation program (which can last approx. 3 weeks) psychosocial care is regularly implemented.

3) Professional rating system for psychosocial oncology: The basic documentation for psycho-oncology (PO-Bado) developed by Peter Herschbach and colleagues

www.po-bado.med.tu-muenchen.de/engl/home.html

Cancer-specific distress questionnaire

Herschbach P, Keller M, Knight L, Brandl T, Huber B, Henrich G, Marten-Mittag B. Psychological problems of cancer patients: a cancer distress screening with a cancer-specific questionnaire. *Br J Cancer*. 2004 Aug 2;91(3):504-11.

Hornheider Questionnaire developed by Gerhard Strittmatter and colleagues

Strittmatter G, Tilkorn M, Mawick R. How to identify patients in need of psychological intervention. *Recent Results Cancer Res*. 2002; 160:353-61.

German Version of the NCCN Distress Thermometer

We have translated and implemented the NCCN Distress Thermometer:

Mehnert A, Müller D, Lehmann C, Koch U (2006) Die deutsche Version des NCCN Distress-Thermometers -Empirische Prüfung eines Screening-Instruments zur Erfassung psychosozialer Belastung bei Krebspatienten. Zeitschrift für Psychiatrie, Psychologie und Psychotherapie, 54 (3), 213-223.

Mehnert A, Lehmann C, Koch U (in prep) The German Version of the NCCN Distress-Thermometers.

- 4) There is a 2 years curriculum „Psychosocial Oncology“ (initiated by the German Association of Psycho-Social Oncology) with a basic class and an advanced training course. The curriculum is a post-graduate course for psychologists, psychotherapists, doctors, social workers, social pedagogues, pastors, counselors), among others.
see: www.dapo-ev.de/wpo.html

- 5) Hamburg: Uwe Koch et al.

Projects:

- 1) Neuropsychological functioning in the course of treatment in patients with malignant hematological diseases. A prospective multicenter study.
- 2) The role of specific psycho-oncological interventions during inpatient oncologic rehabilitation for occupational reintegration
- 3) Need for psychosocial care and use of psychosocial support in cancer patients.
- 4) Acute and Posttraumatic Stress Disorder in cancer patients.
- 5) Distress and use of psychosocial care in breast/prostate cancer patients.
- 6) Development of a screening instrument for systematic evaluation of neuropsychological deficits in cancer patients.
- 7) Promotion of the qualification of doctors and nurses in palliative care
- 8) Cognitive deficits and quality of life after high-dose and standard adjuvant chemotherapy for advanced breast cancer.
- 9) Efficacy and efficiency of a psycho-oncological consultation liaison service at municipal hospitals /Development of guidelines for psychosocial care
- 10) Development and evaluation of a manual for genetic counseling for hereditary breast and ovarian cancer susceptibility.
- 11) Processes of using predictive genetic testing for breast cancer. German Ministry of Health

In the Hamburg research group, we are very interested in cross-cultural collaboration, and already have some international cooperations:

Shim EJ, Mehnert A, Koyama A, Cho SJ, Inui H, Paik NS, Koch U. Health-related quality of life in breast cancer: A cross-cultural survey of German, Japanese, and South Korean patients. Breast Cancer Res Treat. 2006 Jun 24; [Epub ahead of print]

München: Peter Herschbach et al.

Projects:

- 1) Computerized screening for psychosocial care
- 2) Predictors of adaptation in partners of cancer patients
- 3) Development and testing of the basic documentation for psycho-oncology (PO-Bado)
- 4) Fear of progression in cancer patients
- 5) Development and evaluation of new psychosocial interventions
- 6) Psycho education in cancer patients

Freiburg: Joachim Weis, Martin Härter et al.

Projects:

- 1) effects of psychosocial intervention/music therapy
- 2) Neuropsychological functioning in the course of treatment in patients with malignant hematological diseases and breast cancer
- 3) Improvement of neuropsychological functioning during rehabilitation
- 4) psychosocial distress in cancer patients
- 5) shared decision making

Heidelberg: Monika Keller et al.

Projects:

- 1) psychosocial aspects of predictive genetic testing for colorectal cancer
- 2) implementation of psychosocial care into routine care
- 3) Psychosocial distress in cancer patients
- 4) doctor patient communication

Leipzig: Reinhold Schwarz et al.

Projects:

- 1) quality of life in cancer
- 2) psychosocial distress in prostate cancer patients
- 3) patient children communication
- 4) shared decision making

6) Provision of “International Guidelines” such as basic guidelines what is essential in psychosocial care...

Scientific/Clinical exchange (e.g. such as the online curriculum)

Cross-cultural Research

7) Providing knowledge and support for people in low income countries to build psychosocial care services, at least at a very basic level. In many countries like in eastern European countries, there is little money for an adequate oncological care and no money for psychosocial care. Sometimes people want to improve that situation but don't know how. I think this would be one opportunity for an international society to help providing knowledge (how to implement a program etc...)

- IPOS could provide one week summer schools for young researchers or/and clinicians. People from low income countries could have a fee reduction
- Research: Improving psychosocial care in palliative patients, e.g. in rare tumors such as glioblastoma, or decision making in the end of life
- Research: evaluating new technologies in cancer care and its impact on psychological well being (e.g. telemedicine)
- Research: evaluating the impact of new cancer drugs on psychological well being etc...
- Development psychosocial interventions for the elderly

8) a. Prevention/Early detection frequently during genetic counseling for hereditary breast or colorectal cancer, prevention very rarely

b. Symptom control in university hospitals/cancer centers in liaison services, consultation services, rarely psycho-oncologists are a member of the staff of a unit

c. Palliative care in hospice care and palliative care units regularly, providing support for patients and family

d. Survivorship mostly only in ambulant psychotherapy

9) Like all the psychosocial or social sciences, it's not seen as important as the „truly“ scientific disciplines such as medicine etc... Furthermore, it's hard to earn money with psychosocial oncology. Many people don't want to invest their money without having a clear benefit. In my opinion, psycho-oncologists must learn to better and more clearer communicate their work and results to all, the scientific community as well as patients and the public.

Hong Kong

1. HK doesn't have a country society but China does. I'm not sure who is currently running that, not being Chinese myself I'm somewhat "out of the loop".
2. Each government hospital has a dedicated Cancer Patients' Resource Centre funded by a local NGO. This is staffed by a social worker. Several, but not all hospitals have clinical psychology support. There are good and widespread patient support groups for specialist cancers, such as the New Voice Club and Stoma Association. Primary health care provides almost no psychosocial care. Attitudes of practitioners and institutional routines are the biggest barrier. However, we have recently noticed that within the past three years as more younger oncologists emerge, that there is more desire to address issues such as QoL and to provide more comprehensive care. Most centres would like to provide dedicated service but being mostly government funded, lack the resources to do so. Attitudes are also a problem in private care where the focus is on almost pure biomedical issues.
3. Yes, we have been working for over 10 years to raise awareness of this issue and have produced data illustrating how distress is linked to consultation practice. We are working with two major hospital oncology centres to optimise surgeon consultation training to facilitate treatment decision making and hope to shortly demonstrate that this results in less distress among women facing treatment for breast cancer. We have validated a number of instruments for use in the local population, including the MISS, CHQ-12, ChSAS, and BCTDS. We are currently using the HADS to validate that among this population.
4. Until recently there were none in HKSAR. We ran a master's programme in psycho-oncology for two years but were forced to abandon it due to lack of interest. There are no positions open for psycho-oncologists within the health system and nursing staff in particular still resist seeing psychosocial care as part of their role.
5. We are the Centre for Psycho-Oncology Research & Training, at the University of Hong Kong. We are carrying out three major projects. First, a qualitative study of delays in symptom presentation among Chinese women with breast symptoms. Second, we are running an intervention training programme for surgeons to better help women decide on treatment for breast cancer. Third we have a study running on Chinese colorectal cancer and coping dynamics with particular emphasis on social resources in coping. Fourth, we are developing a de novo quality of life assessment suitable for use among young children aged 3-5 who have cancer. As existing QoL measures for kids of this age rely on proxy assessment they are prone to bias and distortion. Our instrument will not rely on proxy assessment but is age-appropriate and we hope to demonstrate also valid and reliable. Finally, we are planning a study to examine the role of decision boards for Chinese women facing breast cancer treatment decisions. The Centre on Behavioural Health is carrying out some studies but we have almost no interaction as they tend to provide training more than research.
6. The international training curriculum is great.

8.
 - a. CePORT is based in the HKU school of public health. We are involved in smoking control and anti-tobacco advocacy, dietary policy and exercise promotion. We have researched screening issues and regularly contribute to policy debates with research (e.g. is opportunistic mammography justified for use in screening in HK? Should all patients be screened for CRC using either FOB or colonoscopy?)
 - b. We have close contact with palliative physicians. We work with oncologists to validate the EORTC CRC module for use in local contexts.
 - c. See b
 - d. We currently provide support to both volunteers and group leaders of local NGO support groups for survivors of breast cancer and a local Cansurvive support group. Much of our work is focused on minimizing collateral damage from disease and treatment trajectory.
9. There is no funding for training. Research funding is pretty good, though recently focus on genomics has pulled money away from research on clinical care.

Hungary

1. Hungarian Psycho-oncology Society (MPOT)
Budapest, 1096, Gyali ut 5-7, Szent Laszlo Korhaz, Onkologia
President: Magdolna Rohanszky, Clinical Psychologist
mrohanszky@laszlokorhaz.hu
www.MPOT.hu
2. Currently we only have a few psychologists working in cancer care centers and in the primary health care. The main difficulties are lack of financial conditions.
3. We don't have a common screening method, but the most commonly used are the Beck, Spielberger and the Distress Thermometer (J. Holland).
4. We have post-graduate courses for physicians and clinical psychologists.
MPOT will commence in September a one year basic psycho-oncology course for health professionals working in cancer care.
6. The patient-doctor relationship is changing in Hungary. This is a very long and difficult process. The MPOT would like to help both parties -doctors and patients in this transformation. We would benefit from other's experience and would be glad to participate in cross-cultural research and communicational training in this field.

Iceland

1. Currently there is no such society in Iceland. There is, however, much interest in founding a psychosocial society in Iceland. An interdisciplinary group at the Landspítali-University Hospital in Iceland is currently working on implementing the NCCN distress management guidelines and screening. A conference and workshop will be held in the spring of 2007 as part of implementing these guidelines. Our plan is to concurrently found a psychosocial society in Iceland. The members of the interdisciplinary group are the following:

Barbel Schmid Social worker barbels@landspitali.is
Bragi Skulason Chaplain bragi@landspitali.is
Fridbjorn Sigurdsson MD-oncologist fridbjor@landspitali.is
Halla Thorvaldsdottir psychologist hallath@landspitali.is (will attend the IPOS meeting in Venice)
Nanna Fridriksdottir RN nannafri@landspitali.is
Sigridur Gunnarsdottir RN (chair) sigridgu@landspitali.is

2. Psychosocial care is incorporated into routine care at Medical Cancer Center at the Landspítali-University Hospital in Iceland, which is the primary Cancer Center in Iceland. Cancer patients have access to psychologists, psychiatrists, social workers and chaplains. The primary difficulties encountered are lack of coordination of these resources as well as availability of such resources at every stage, including surgery and primary care.
3. Preparation is currently in its final stages for implementing the NCCN clinical practice guidelines for distress management, including the distress thermometer at the Landspítali-University Hospital in Iceland.
4. None
5. To my knowledge two groups are currently working on research projects in psycho oncology in Iceland. One group at the University Hospital has already been mentioned. This multidisciplinary group (nurses, psychologist, social worker, oncologist, and a chaplain) has been working on research projects concurrent with preparing to implement the NCCN clinical practice guidelines and the DT. This group has conducted a validation study on the DT and is currently designing a study to evaluate the effects of the clinical practice guidelines. Another group at the Cancer Research Center at the University Hospital in Iceland has been working on some descriptive studies on prevalence of psychiatric co-morbidities in Icelandic cancer patients. Isolated, smaller projects have been carried out by psychologists and nurses associated with the University of Iceland.

In addition, preparation is currently on its way for a new program in integrative medicine at the Cancer Center at the University Hospital in Iceland. One of the goals of this program is to address psychosocial issues.

The group that I am the spokesperson for is very keen to participate in cross-cultural collaboration to enhance psychosocial care of cancer patients, including cross-cultural research programs.

6. One of the ways IPOS could be helpful to our country's efforts is to provide us with information that could help us when founding our national psycho-social society. It would also be helpful if a representative from IPOS could visit us and participate in a conference when we found our psycho-social society. It would be beneficial to us if we could participate in collaborative research projects.
7. Integration of psycho-social care into routine care of cancer patients.
8. In Iceland there is only one physician who is trained as both an oncologist and psychiatrist and he works in private practice. No Icelandic physician is specially trained in psycho-oncology. There are, however, a number of other health care professionals who specialize in psychosocial care of cancer patients, including both social-workers and psychologists.
9. Lack of available funds.

India

1. India used to have a psycho-oncology society however I am unable to find its office bearers or any information on its activity after 1997. The society was called the Indian Psycho-oncology Society. I will try to find out more information.

We do have an Indian Association of Palliative Care <http://www.jpalliativecare.com/iapc.asp> which is regular in its meeting and has a journal called *Indian Journal of Palliative Care*. The society deals mainly with pain and palliative care rather than psycho-oncology.

2. Apart from a few major cancer centres like Tata memorial, Mumbai, RCC, Trivandrum and Kidwai Bangalore, the concept of psychosocial care is almost negligible even in these centres. There are many more patients in need of care than psychologist to treat them. In primary health care psycho-oncology is nonexistent.

One of the main problems is lack of awareness that there is such a great need. Second is lack of trained professionals. I would like to host next IPOS in Varanasi, India so as to increase the awareness in this continent.

3. We have developed a tool to measure distress, we will be presenting the findings at IPOS this year in Venice. The tool is called the Distress Inventory for Cancer Version 2. We have also published a few papers in psycho-oncology on this issue and on development process.
4. There are no structured training programs in psycho oncology or psychosocial oncology. The programs in pain and palliative care are available. The PhD program in psycho-oncology is being offered in my unit. We also guide students for their MA and M Phil programs as well. I have so far trained 3 MA, 1 M Phil and 1 PhD (total 5 students) another one is currently doing her PhD at present.
5. Our group is the only group involved in psycho-oncology research at present in India. The group can be contacted at Dr. Manoj Pandey, Surgical Oncology, Institute of Medical Sciences, Banaras Hindu University, Varanasi 221 005, manojpandey@vsnl.com. We are in position to take on short term and long term research in areas of cross-cultural studies. Please see: *Quality of life of patients with cancer in India: challenges and hurdles in putting theory into practice*. Psycho-oncology. 2004 Jun;13(6):429-33. Besides this there are only 4 reports on psycho-oncology; three of these on translation and validation and one cross sectional study.
6. IPOS can play a big role by increasing the awareness of psycho-oncology among cancer specialists. It can start by hosting the next IPOS in India and from there it can take off. Bringing international collaborations to India can bring the country in the mainstream of psycho-social oncology research. IPOS can also sponsor a few members to its conferences to reduce some financial burden.
7. Awareness of the need for psychological help. This should not be regarded as taboo as it is. IPOS needs to expand beyond developed countries of Europe, US and UK to other underdeveloped or less developed countries. It needs to encourage more collaboration and understanding of cultural differences in the psyche of people in order to address their needs.
8.
 - a. None so far, except perhaps tobacco cessation
 - b. Yes and only few
 - c. Maximum effort is being put at this aspect

- d. None so far, a study has been proposed but we wait its funding
9. Not a priority area for the government and research funding is limited. Need canvassing

Ireland

1. Presently, there is no formal Psycho-Oncology society in Ireland. However, a steering committee has been formed to develop the Irish Psycho-Oncology Group (IPOG). Representatives (interdisciplinary) from Northern Ireland and the Republic of Ireland have met on a number of occasions and a draft constitution is in development. We will have the official launch of IPOG in April 2007. You have kindly agreed to attend the conference where IPOG will have its inaugural meeting. For further information on IPOG, please contact me, Dr. Shawn Steggles, Research Fellow, School of Psychology, University College Dublin, Principal Clinical Psychologist, Psycho-Oncology Services: Education, Clinical and Research, St. Luke's Hospital, Highfield Road, Rathgar, Dublin 6, Republic of Ireland.

2. In a mailed survey that I conducted in 2003, only approx. 20% of health care institutions in the Republic of Ireland indicated that psychosocial care was incorporated into routine cancer care. Of this 20% the service was predominantly offered by the professional discipline of Social Work.

At the largest public radiation treatment facility for cancer patients in the Republic of Ireland (St. Luke's Hospital), Medical Social Work services have been available for many years. The first Clinical Psychologist was hired in 2003 with the second one being hired in early 2006.

To my knowledge there are approximately 5 full time Psychologists working in the Psycho-Oncology field in the Republic of Ireland.

- 3. To my knowledge there are no formal screening methods for psychological distress utilized in any of the cancer treatment facilities in the Republic of Ireland.
- 4. In terms of training in Psycho-Oncology I can only speak for our cancer centre (St. Luke's Hospital). We have taken a doctoral level Clinical Psychology Intern each year that I have been at St. Luke's Hospital.
- 6. Funding would be the greatest barrier to the development of the Psycho-Oncology field in the Republic of Ireland.

Israel

1. Israel Association of Psycho-Social Oncology (IPAS)

The society maintains an active forum where roles are integrated and interchanged.

Contact:

Dr. Shlomit Perry, Ph.D., perrys@clalit.org.il

Professor Lea Baider, Ph.D., baider@cc.huji.ac.il

2. Israel currently has six comprehensive cancer centers, which include diagnosis, treatment, surgery, radiotherapy, chemotherapy and genetic testing. Most of the centers have established a psycho-social oncology unit. Israel also has many oncology clinics with limited psycho-oncology services.

3. Each comprehensive cancer center has its own screening method. There is no national method that is imposed on the individual centers.
4. The Israel Cancer Association serves as the hub for developing post-training courses. An average of 5 to 6 psycho-oncology curricula are prepared annually for psychologists, social workers, nurses, radiotherapists, art therapists, school teachers working in pediatric oncology, volunteers from "Reach to Recovery," etc.
5. Each cancer center works in different areas of research, which are too extensive to describe here. In general, there is a great interest in cross-cultural collaboration.
6. IPOS could be helpful in improving our training, research and clinical care by sending professional experts here to teach and share their knowledge.
7. Each cancer center has its own agenda and needs. Nevertheless, on a national level, Israel does not provide adequate funding for research, training and teaching. One of the most beneficial options would be the possibility of collaborating on cross-cultural research and workshops.
8. All the cancer centers are involved in the four areas of care to varying extents, based on human resource limitations:
 - a. The Israel Cancer Association, in conjunction with the professional staff from the cancer centers, arranges educational meetings several times a year targeted to different audiences (e.g., patients with various cancer diagnoses, healthy and high risk populations).
 - b. The psycho-oncology unit of the Israel Cancer Association conducts group interventions and special programs on a national basis for young adults, offers monthly meetings for prostate and colon cancer patients and maintains a hotline for inquiries from the public.
 - c. Palliative care is well recognized as a vital service which, according to a recently passed law regarding dying patients, must be implemented in Israel by the end of 2006. Psycho-oncology professionals served on the committee to formulate the law. Its aim is to make palliative care an integral part of the medical system and to provide comprehensive treatment for patients near death and their families.

Several centers are developing palliative care units, including pain control, symptom control and end of life issues. Psycho-oncology is also part of the in-patient hospices and homecare services. Several centers offer complementary medicine in cooperation with the oncology teams.
 - d. A number of educational programs and services for survivorship include the Wellness Community and nationwide organizations whose focus is on daily survivorship activities.
9. The major obstacles for training, research and clinical care are finding adequate financial resources to fund these activities.

Italy

1. Società Italiana di Psico-Oncologia (SIPO) (Italian Society of Psycho-Oncology) (founded in 1985)
e-mail: segreteria@avenuemedia.it; avenuemedia@avenuemedia.it
website: www.siponazionale.it
President (2003-2007): Luigi Grassi, MD, Professor of Psychiatry, University of Ferrara, IT (e-mail luigi.grassi@unife.it; psichiatria@unife.it)
2. Not routinely incorporated in cancer care.
However:
 - most, if not all, National Cancer Institutes have psycho-oncology services
 - Many University Hospitals have Psycho-Oncology services as well as some general hospital in the community.
 - A survey done by the Italian Association of Medical Oncology provides data indicating that the rate of “psychologists” (including fellows, volunteer etc.) is increasing in oncology divisions in the country with an average of 1.3 psychologist per division.
 - A National survey promoted by the Italian Health Institute and conducted by the Italian Society of Psycho-Oncology and the Italian Federation of Volunteer inn Oncology in 2005-2006 indicated the existence of 96 psycho-oncology centers in the National Health Service, 98 centers run by Volunteer Association and around 30 centers run by the Italian League Against cancer
 - Local experience of networks between hospital and primary health care, not standardized at a national level
3. A short questionnaire to assess Psychological Distress was developed some years ago (Morasso et al., Oncology, 1996 Jul-Aug;53:295-302.) and applied mostly in research setting
 - Most centers are using the Italian versions of psychometric instruments developed in English-speaking countries (e.g. HADS, BSI, BDI, STAI, Mini-MAC)
 - The Distress Thermometer is used now in several centers even if not as a routine instrument at the moment (see below # 5)
 - “Standards, options and recommendations for psychosocial care in cancer” were developed in 1998 by the Italian Society of Psycho-Oncology and are available and downloadable from the SIPO website. The development of more detailed guide-lines is in progress (2006-2007)
4. Specific Psycho-Oncology courses in School of Medicine and post-graduate schools (residency programs) in Oncology, according to the local interest of the University (or psycho-oncologists working in that context). However not specifically indicated by the Ministry of the University as a prerequisite or basic course in Italian Medical Schools
 - Prerequisite for setting-up post-graduate courses (Medical School residency programs) in Clinical Psychology and, in part, Psychiatry: “to perform at least (number of intervention / number of residents) clinical intervention in cancer settings”
 - 2nd level Master (postgraduate – 800 hours a year – 2 years) in Psycho-oncology in several University centers (e.g. Rome, Naples, Turin).
 - 2-year Training Courses in Psychosocial Oncology organized by Cancer Institutes (e.g. Milan, Rome)
 - Several courses on different psycho-oncology topics organized by Health Agencies throughout the country n (difficult to follow all the initiatives – possible risk of poor quality courses – lack of specific criteria of selection when evaluating psycho-oncology courses receiving CMEs)
 - No specific post-graduate course (e.g. 4-year residency program) in psycho-oncology

5. The Italian Association of Pediatric Onco-Hematology is currently carrying out a multicenter BMT study involving patients and families in order to evaluate post-traumatic stress
 - The Distress Thermometer, as a golden standard, is about to be validated in a nation-wide research under the auspices of the Italian Society of Psycho-Oncology
 - Multicenter study on Palliative Care regarding the burden of caregivers
 - Extreme interest in cross-cultural studies, as already shown by some studies carried out by the EORTC and involving several European countries, including Italy or the Southern European Psycho-Oncology Study involving Italy, Portugal and Spain.

6. To facilitate links and synergies between the different societies of different countries;
 - To promote the development of a common document or statement position to be presented to the national government and institutions, under the auspices of IPOS as an NGO linked to the WHO programs
 - To promote cross-cultural research studies
 - To improve the quality of core-curricula for psycho-oncology training through a supervision of programmes developed by national societies or health agencies
 - To maintain and continue the promotion of educational material
 - To promote residential training courses in different languages (same core-curriculum adapted according to the cultural context)

7. See # 9.

8.
 - a. Anti-tobacco campaigns involving psycho-oncologists, especially within the Italian League Against Cancer; genetic counsellors and psycho-oncologists involved in screening programs in several centers;

 - b. Psycho-oncologists involved both in Oncology Department or specific Psycho-Oncology service on consultation basis or routine intervention for evaluation and treatment of psychosocial problems secondary to cancer

 - c. Psycho-oncologists involved in home and hospice care in most towns

 - d. not many psycho-oncologists involved in survivorship programs in the country

9. Lack of funds due to reduction of investment in research (as a chronic problem in the country)
 - Lack of funds due to reduction of investment in training (many mandatory training courses of Health Agencies consisting in congresses and/or seminars rather than more articulated training in small groups – communication skills course etc.)
 - Consideration of biological issues, especially genetic and molecular mechanisms, as the center of research in oncology settings (most funds diverted to these areas rather than psych-oncology)
 - However, the 2006-2008 National Plan for Health in Oncology (chapter 7) states that “Psycho-Oncology centers or activities should be mandatory in Departments of Oncology” and “priority actions in psychological support in cancer care are: 1) promoting the development of specific services and psychological support centers through trained health care professionals; 2) evaluating the efficacy of psychological intervention through specific outcome measures”

Japan

1. JAPAN PSYCHO-ONCOLOGY SOCIETY (JPOS)

e-mail address: nakamura@kobunsysa.co.jp

website: <http://www.jpos-society.org/>

President: Yosuke Uchitomi, MD, PhD, yuchitom@east.ncc.go.jp

IPOS liaison: Takashi Hosaka, MD, PhD, hosaka@is.icc.u-tokai.ac.jp

2. Psychosocial care is not incorporated in routine cancer care well. Usually, physicians in charge and nurses have to respond to psychosocial needs, but not sufficiently. Twenty out of 30 cancer center hospitals in Japan have full-time psychiatrists. In primary health care, psychiatric consultation access has been improving. Difficulties are as follows; a low reimbursement of psychiatric consultation, a low incentive to psychiatric consultation for such an economical reason; and few educational/training systems in psycho-oncology at University Hospitals.
3. No nationwide screening methods.
4. JPOS started the following training programs;
 - 1) One-day Workshop on basic psycho-oncology.
 - 2) Two-day Workshop on communication skill training for oncologists.Others;
 - 1) Three-year residency program for post-graduate physicians, National Cancer Center Hospitals, Japan
 - 2) Two-year fellow program for post-graduate physicians, National Cancer Center Hospitals, Japan
5. Nationwide Psycho-oncology research groups have promoted screening/treatment for depression among cancer patients.
6. The IPOS Academy, especially its pre-congress workshop, would be helpful if it was held in Asia, every year!
7. The WHO authorization should be required for encouraging psycho-oncology development.
8.
 - a. None
 - b. a little
 - c. a little
 - d. a little
9. Low publicity, low reimbursement for psychiatric care

Korea

1. Korean Psycho-oncology Society (a tentative name)

Email: Dr. Seong-Jin Cho lawdoc@kcch.re.kr

Website: <http://cafe.daum.net/psychoncology>

2. In many institutes, psychosocial care is actively incorporated into routine cancer care. Specific cultural values, society norms and other limitations
3. Translating and validating international screening tools into Korean version. Getting ready for developing Korean assessment tools.

4. Psycho-oncology Fellowship (National Cancer Center, Several University Hospitals...)
5. Group Program for children and adolescents with cancer. Art therapy for children and adolescents with cancer. Humor therapy for families of patients with cancer. Specific Cognitive-behavioral intervention. Undergoing cross-cultural study... collaboration with other countries.
6. Psycho-oncology fellowship. Delegation and common curriculum.
- 7.
8.
 - a. Prevention/ Early detection
Early screening and detection.
Lifestyle change strategies
 - b. Symptom control
Methods for reducing aversive reactions to biological treatment
Practical Techniques for treating adjustment problems
Coping with and managing treatment side effects
 - c. Palliative care
The 6th Asia Pacific Hospice Conference was held in Seoul, Korea, 2005. and hosted by Korean Society for Hospice and Palliative Care.
 - d. Survivorship
Practical interventions for cancer survivors and their families
- 9.

Netherlands

1. Netherlands Psychosocial Oncology Society (NVPO)
p/a Netherlands Cancer Institute
Plesmanlaan 121
1066 CX Amsterdam, The Netherlands
Email: nvposecr@nvpo.nl
Website: www.nvpo.nl

Current president of the NVPO:
Dr. Eveline M.A. Bleiker
Netherlands Cancer Institute
Plesmanlaan 121
1066 CX Amsterdam, The Netherlands
Email: e.bleiker@nki.nl
2. All cancer centers have social workers, psychologists and psychiatrist(s) employed. General hospitals usually have one or two social workers or one psychologist employed for the whole hospital. These psychosocial workers are not specifically trained in oncology, but their expertise should cover the whole patient population of the hospital.

One problem in general health care is the coverage of the costs that are not covered by health insurers. Not all health insurance companies include psychosocial care for cancer patients on a standard basis.

3. In 2005, our Society has initiated a National working group, which has made an overview of screening tools. Currently the members of the Working group are developing and testing the screening tools in various sites (hospitals, but also 'home-care') and moments in time 'along the road of the cancer patient'.
4. Our Society has developed two post-graduate courses in psycho-oncology: one for psychologists and one for social workers. Furthermore, we are working on a psycho-oncology educational track for physicians who want to be specialist in Medical Oncology. Their training must incorporate psychosocial issues.
5. Please, find below an overview of the studies that are financially supported by the Dutch Cancer Society. I am sure that there will interest in cross-cultural collaboration, however, the PI's should speak for themselves.

Current Cancer Research

EMCR 2003-2775	The health-related quality of life effects of the Dutch cervical cancer screening program (KWALIBOB)
Projectleader(s)	Prof. J.D.F. Habbema Dr. M. van Ballegooijen Dr. M.L. Essink-Bot
HDI 2004-3177	SPIRITUALITY IN PATIENTS WITH CANCER - the development of a spirituality questionnaire
Projectleader(s)	Dr. A. Garssen Dr. A.P. Visser
KUN 2005-3206	Evaluation of intervention strategies to manage fatigue during active treatment and to prevent persistent fatigue after curative treatment for cancer
Projectleader(s)	Prof. dr. G. Bleijenberg Dr. C.A.H.H.V.M. Verhagen
NKI 2002-2771	The incidence, nature and etiology of cognitive problems following chemotherapy for cancer
Projectleader(s)	Drs. S.B. Schagen
RUG 1998-1737	Cognitive functioning of children treated for acute lymphoblastic leukemia with chemotherapy only, according to SNWLK ALL-9 protocol; a prospective longitudinal and nationwide study
Projectleader(s)	Prof.dr. W.A. Kamps Dr. R.I. van Dommelen
RUG 2004-3184	Samen leven met kanker. Een review en meta-analyse van empirische studies over het welbevinden van kankerpatiënten en hun partners
Projectleader(s)	Dr. M. Hagedoorn Dr. J. Tuinstra Prof.dr. R. Sanderman
RUG 2006-3640	Evidence based development of patient education information to be provided through different media to increase quality of life in cancer patients
Projectleader(s)	Dr. A. Dijkstra Prof.dr. A.P. Buunk
UVA 1999-2132	Quality of life, course of life and coping in childhood cancer survivors
Projectleader(s)	Dr. B.F. Last Dr. M.A. Grootenhuis

- UVA 2002-2580** **Assessing response shift in cancer patients quality of life over time: A secondary data analysis**
Projectleader(s) Dr. M.A.G. Sprangers
 Dr. F.J. Oort
 Prof.dr. G.J. Mellenbergh
- UVA 2005-3196** **HRQL assessment in daily pediatric oncology practice**
Projectleader(s) Dr. M.A. Grootenhuis
 Dr. S.B. Detmar
 Dr. H.M. Koopman
- UVA 2005-3197** **Understanding changes in quality of life in cancer patients. A cognitive interview approach**
Projectleader(s) Dr. M.A.G. Sprangers
 Dr. M.R.M. Visser
 Prof. dr. C.C.E. Koning

Current Cancer Research

- RUG 2000-2355** **Meaning in life as a response to the trauma of cancer - an integration of coping theory, trauma theory and existential theory**
Projectleader(s) Prof.dr. R. Sanderman
 Dr. G. Jonker-Pool
- RUG 2002-2581** **The interactive process of coping with curative colorectal cancer in intimate relationships: Support interaction patterns and psychological adjustment**
Projectleader(s) Dr. M. Hagedoorn
 Prof.dr. R. Sanderman
- RUG 2004-2989** **Perceived control and well-being in breast cancer patients**
Projectleader(s) Dr. A.V. Ranchor
 Prof.dr. R. Sanderman
- UL 2005-3214** **The disclosure process and support needs of women with breast cancer who receive a variant of uncertain clinical significance (VUCS)**
Projectleader(s) Prof.dr. A. Tibben
 Dr. W. Otten
 Dr. C.J. van Asperen
- UU 2004-2992** **Experiences, needs and coping strategies of parents caring at home for their child with cancer in the palliative phase**
Projectleader(s) Prof.dr. J.J.M. van Delden
 Prof.dr. M.H.F. Grypdonck
 Prof.dr. M.A. Verkerk
- KUN 2006-3464** **Shared and Nonshared Familial Influences on Regular Smoking in Late Adolescence**
Projectleader(s) Dr. R.C.M.E. Engels
 Dr. R.H.J. Scholte
- NKI 2003-2977** **Psychological and behavioral issues in cancer genetics**
Projectleader(s) Dr. E.M.A. Bleiker

- NKI 2004-2987 Long-term psychosocial impact of genetic testing among familial adenomatous polyposis (fap) families
Projectleader(s) Dr. E.M.A. Bleiker
 Prof.dr. N.K. Aaronson
 Dr. H.F.A. Vasen
- NKI 2005-3209 Psychosocial aspects of genetic testing in families at high risk of multiple tumors at various sites and ages
Projectleader(s) Dr. E.M.A. Bleiker
 Prof.dr. N.K. Aaronson
 Dr. S. Verhoef
- RUG 2004-3165 Discovery of new Biomarkers for Cervical Cancer
Projectleader(s) Prof.dr. R.P.H. Bischoff
 Prof.dr. A.G.J. van der Zee
 Prof.dr. J. van der Greef
- RUG 2005-3361 RhTRAIL and NSAIDs for chemoprevention in hereditary forms of colorectal cancer.
Projectleader(s) Prof.dr. E.G.E. de Vries
 Dr. S. de Jong
 Prof.dr. J.H. Kleibeuker

Current Cancer Research

- UL 2003-2780 Long-term effects of genetic counseling for familial breast cancer focusing on women with uninformative DNA test results: risk management strategies, perceived risk and psychological well-being
Projectleader(s) Dr. W. Otten
 Prof.dr. A. Tibben
 Dr. R.A.E.M. Tollenaar
- UM 2005-3218 Message framing for cancer prevention
Projectleader(s) Dr. R.A.C. Ruiter
 Prof.dr. H. de Vries
- UU 2001-2386 Breaking the rule of nondirectiveness: psychosocial consequences of bringing breast cancer patients in a genetic counselling procedure
Projectleader(s) Dr. H.F.J. ten Kroode
 Dr. C.C. Wárlám-Rodenhuis
 Dr. M.G.E.M. Ausems
- KUN 2001-2379 Patient involvement in prostate cancer treatment decisions
Projectleader(s) Prof.dr. W.A.J. van Daal
 Prof.dr. J.W.H. Leer
 Dr. H. Huizenga
- KUN 2005-3457 Shared decision making in oncology
Projectleader(s) Dr. P. Stalmeier
- KUN 2006-3465 Patient informed choice between palliative chemotherapy and best supportive care
Projectleader(s) Dr. P.F.M. Stalmeier
 Drs. P.B. Ottevanger
 Prof.dr. P.H.M. De Mulder

[NIVEL 2003-2973](#) [Communication with elderly patients during nursing encounters preceding chemotherapy](#)

Projectleader(s) Prof.dr. J.M. Bensing
Dr. W.M.C.M. Caris-Verhallen

[NKI 2006-3470](#) [Cognitive behavioral therapy \(CBT\) and physical exercise for climacteric symptoms in breast cancer patients experiencing treatment-induced menopause](#)

Projectleader(s) Prof.dr. N.K. Aaronson
Dr. M. van Beurden
Dr. H.S.A. Oldenburg

[UL 2005-3213](#) [Decision making in rectal cancer: the costs and benefits of preoperative radiotherapy](#)

Projectleader(s) Dr.ir. A.M. Stiggelbout
Dr. C.A.M. Marijnen
Prof.dr. C.J.H. van de Velde

[UU 2002-2585](#) [Effects of a multi-disciplinary rehabilitation program for cancer patients, combining physical exercise with psycho-education: a randomised, controlled study](#)

Projectleader(s) Dr. W.J.G. Ros
Prof.dr. B. van den Borne
Prof.dr. R.W. Trijsburg

Current Cancer Research

[UU 2003-2782](#) The effect of comprehensive counseling by a nurse specialist on depressive symptoms and quality of life: A prospective randomized study in patients with head and neck cancer

Projectleader(s) Dr. J.R.J. de Leeuw
Dr. W.J.G. Ros

[UU 2003-2783](#) Cognitive rehabilitation of glioma patients: A prospective, randomized study

Projectleader(s) Dr. M.J.B. Taphoorn
Dr. M.M. Sitskoorn
Prof.dr. N.K. Aaronson

[UU 2004-3189](#) Ondersteuning door verpleegkundigen van symptoommanagement bij chemotherapie- en radiotherapiepatiënten

Projectleader(s) Prof.dr. M.H.F. Grypdonck
Dr. C.J. Gamel
Dr. J. van der Bijl

[UVA 2003-2785](#) [Ethical aspects of palliative cancer chemotherapy](#)

Projectleader(s) Dr. D.L. Willems
Prof.dr. D.J. Richel

[UVA 2005-3199](#) [Cancer patients' wish not to know and tailored information giving, a prospective study](#)

Projectleader(s) Prof.dr. J.C.J.M. de Haes
Prof.dr. C.C.E. Koning
Dr. E.M.A. Elshuis-Smets

<u>KUN 2005-3207</u>	<u>Development and validation of a set of quality indicators for the evaluation and monitoring of quality of care in oncology</u>
Projectleader(s)	Prof.dr. R.P.T.M. Grol Prof.dr. P.H.M. De Mulder
<hr/>	
<u>NIVEL 2004-3192</u>	<u>Communication and role delineation in paediatric oncology: A multi-perspective view on policies, preferences, and practices</u>
Projectleader(s)	Prof.dr. J.M. Bensing H Tates
<hr/>	
<u>VU 2001-2390</u>	<u>Effects of chemotherapy on attention and information processing in survivors of childhood cancer</u>
Projectleader(s)	Dr. ir. L.M.J. de Sonnevile Prof.dr. A.J.P. Veerman
<hr/>	
<u>VU 2004-2994</u>	<u>Communicating breast cancer risks: a genetic counsellor's role in improving patient understanding to increase informed decision-making</u>
Projectleader(s)	Dr. D.R.M. Timmermans L Henneman Dr. F.H. Menko

6. IPOS would be helpful in improving the collaboration between countries, e.g. by developing and testing screening tools for 'cancer distress', which can be adapted for use in different languages and countries. Exchange of experience with training programs, guidelines for clinical care, and training in these issues would be very helpful (it also takes place at the IPOS conferences).
7. The most important barrier for carrying out all the ideas we have is 'time and money'. Problem in our Dutch society is that we have great ideas; however, all members work on a voluntary basis and have their priorities not always at the society. However, recently we got funding to have an expert in psycho-oncology working for the Society. This will certainly help in getting things started.
8. a. Prevention/ Early detection:
psycho-oncologists are involved in the field of prevention / early detection mainly by means of research projects (e.g. stop smoking study)
- b. Symptom control:
clinical psychologists and psychiatrist in (cancer-) hospitals are involved in symptom control
- c. Palliative care:
clinical psychologists and psychiatrist in (cancer-)hospitals are involved in palliative care in hospitals; special trained nurses are involved in the palliative care in the home-situation
- d. Survivorship:
we have national programs named "recovery and balance" for survivors to get 'back on track'. Roughly, it consists of training in psychological as well as physical abilities.
9. Major obstacle is that we have only one Cancer Fund (the Dutch Cancer Society) that provides the funding for research grants. They have changed their policy in a way that clinical work and education does not receive funding anymore (the focus is on research only).

Philippines

1. There is no Psychosocial or Psycho-Oncology Society. Presently there are no plans of organizing a society.
2. Psychosocial care is not incorporated in routine cancer care even in cancer centers. There are existing cancer support groups in the different tertiary hospitals.
Medical insurance for oncology is limited.
3. There are no screening tools used. Referral to a psychiatrist is done in the private and training centers. Often due to behavioral changes, suicidal behaviors or delirium.
4. There are no existing post-graduate courses in psychosocial and psycho-oncology in the Philippines.
5. There are no current research groups in psycho-oncology. I am personally interested in cross-cultural collaboration.
6. I would be interested to hear about experiences of providing psychosocial care in countries with limited medical resources.
7. In my opinion there is no specific individual who would have time to spearhead training, research and clinical care.
8.
 - a. Psychological issues of cancer patients are referred to a psychiatrist. In some areas there are no psychiatrists and therefore these issues are not addressed.
 - b. Psychologists are not part of the hospital staff and may be involved in ambulatory care.
 - c. Patients may join cancer support groups however, these are mainly in tertiary care institutions and in MetroManila.
9. I think the major obstacle is that no one is interested to take the major responsibility of focusing on developing psycho-oncology.

Portugal

1. Sociedade Portuguesa de Psico-oncologia -António Barbosa, MD, PhD
Academia Portuguesa de Psico-oncologia -Emília Albuquerque, MD
2. The psychosocial care still not part of routine cancer care. We have some teams that have incorporated psychologists, but in the most cases, patients are seen by the medical staff when the patient present visible symptoms of distress and adjustment difficulties. Only few patients are screened for distress.
In primary health care they don't have specific consultations for cancer patients.
There is a lack of well trained professionals in psychological care. It is difficult to prove to the government that there is a need for more mental health professionals. The biggest cancer centre in Lisbon has one psychiatrist and 4 psychologists for 250 beds and all outpatients (including pediatrics) from diagnosis on.
3. No. We use international measures and standards - distress management guidelines from NCCN.

4. Small under graduate courses -30 to 45 hours - between 2 and 4 a year in different places some of them not linked to universities

Post graduate courses in faculties and nurses schools -more than 300 hours -most of them in Palliative care, and specific for medical doctors or nurses -between 4 and 6 a year in different places

5. I have no knowledge of collaborative research or current groups, but would like to be involved in cross-cultural research.
6. Training: promote psycho social academies; and translation into Portuguese of the core curriculum

Research: creating groups of research that can involve the participation of individuals with particular interest -for example helping them to translate and adapt the most important evaluation instruments

Clinical care: we need the Portuguese societies or groups to use their influence to change the policies in the health care systems. Using the experience of Pain societies and groups, for example, and turn the distress evaluation in a vital sign as it happened with pain. Creating guidelines that can be extended to different hospitals and care services to improve clinical care

7. Establishing Definitions: what is a psycho-oncologist and what is the role of the different specialities with psycho-oncology training? Who one is responsible for psychological care, support and for psychotherapy? And why is so important that those who are not responsible for psychotherapy have the knowledge of psychological aspects related to cancer coping, just as it is for psychologists to know the basics of cancer physiology, treatment and prognosis.
8. Most of the psycho-oncologist are involved in symptom control (integrated in multidisciplinary teams for pain control) and in palliative care.
9. In training and research since almost our hospital belong to the public health system the funding came from the industry and they are more interested in fields that can promote their profits.

Spain

1. In Spain there are some different realities, since the different autonomous communities have their own associations. There is the national society (SEPO, which last congress was in November 2005) but, at the present, it has no web. In my own Autonomous Community (Catalonia) there are two working groups in Psycho-oncology: one is inside the Clinical and health Psychologist Section in the Catalan College of Psychologists, coordinated by myself (Tania Estapé, Ph.D., c/Enric Granados, 111, 2^o, 2^a, 08008 Barcelona, Spain, fefoc@fefoc.org, this is my professional address, being the College one: seccio@copc.es, but they will send any information concerning psycho-oncology to me). The other group is The Psycho-oncology Working Group, belonging to the Oncology Society Catalano Balearic Academy of Medicine, its website is: www.acmcb.es, the coordinator at the present moment is Ms. Cristina Bierge. Although I belong to this group I only know her e-mail address: cristina.bierge@sanitatintegral.org. There are some other autonomous groups (Madrid, Valencia).
2. I must talk again about Catalonia, since health care is transferred to our autonomous government and I do not know the reality of other areas of the country. There are psycho-oncologists working in some huge hospitals, and also in non-profit foundations and patient groups. Personally, I am attending a psycho-oncology consultation in a primary health care center once a week, being paid by the non-profit foundation, where I work, but this is not the usual. The difficulties are mainly the lack of resources. Psycho-oncology is still underestimated as an essential field in the care of cancer patients

and their relatives.

3. Some colleagues have done so. In my personal case, since I am working for a non-profit institution, we are open to people who need our services: by support groups, by telephone or by our web (www.fefoc.org), which is growing fast. We have now some projects to widen this field of our work. At the moment we do not use a standard screening method for distress, since we are funded by different institutions whose aim is to offer help to whoever need it. Now, in our projects, we will include some tools on-line (with sound questionnaires) to try to have some form of measurement.
4. Now there are is a Master's in psycho-oncology in Madrid (Universidad Complutense). We are doing some courses, like workshops with different goals (for volunteer in cancer, for psycho-oncologists...). In the past we were the ESO branch in Spain and have done a psycho-oncology course every year.
5. There are some research on going in some universities, hospitals and some foundations.
6. IPOS could help us by helping to spread information on our work. I have sent several times information, for instance, to be included in the resources offered by the IPOS web, and nobody answered!! We have a sound work online in Spanish, used by Latin Americans as well. Since IPOS is international, my humble point of view is they must give voice to all the members. Also I have the same impression with research. It is very difficult for us to publish and disseminate our work internationally, since it is very difficult, and expensive, to express some topics in English. Some people, including our group, have tried to publish in Psycho-oncology Journal, but is very difficult, and for the comments of the reviewers we see it is a problem of communication. We are in clear disadvantage in front of English speaking professionals. Also I ask to IPOS to be more next to every country. Sometimes it seems to some colleagues that internationally IPOS only give attention to one or two professionals in some countries, and there are more people working hard, even if we do not succeed in publishing sound articles. Also about cross-cultural research, IPOS may set up a bank data to share with some professionals.

Last, I participate in some working groups and all of them say that one IPOS congress every year is too much. In Spain psycho-oncologist have great difficulties to have the whole or part of the congress (registration, travel, hotel accommodations) paid. Some of us do an enormous effort to pay (some people by they own resources) one congress every two years, then if it is annual, some people will not be able to afford it. This is another way to help to our country: the chance of having some funding to go to IPOS congresses!

7. Give a voice to members of countries not as rich as others, who could have all the resources. In Spain resources for research are limited.
8.
 - a. some professionals in breast cancer screening campaigns, but mainly doing research. Some non-for profit foundations are doing some public activities to provide information to specific groups (for instance we are doing a campaign for the elderly).
 - b. Symptom control: mainly in hospitals
 - c. this is one of the most developed parts in our autonomous community, with units devoted to palliative care, most with a psychologist.

d. one of the parts we are working most. It is treated in non-for profit foundations or privately, because hospitals are so crowded that, generally speaking, they are obliged to offer psychosocial support during treatment phases only.

9. The lack of consciousness of the importance of psychosocial care for cancer patients.

Switzerland

1. Schweizerische Gesellschaft für Psychoonkologie SGPO

c/o its president:

Prof.Dr.med.Christoph Hüerly

Chefarzt Bürgerspital

CH-9000 St.Gallen

Tel 0041 71 243 88 78

Fax 0041 71 243 81 13

e-mail: christoph.huerny@buergerspital.ch

2. Since the Swiss healthcare system is organized regionally (each of the 26 cantons having one of their own) there are many different models:

In cancer centres and hospitals the degree of incorporation ranges from no psycho-oncologist at all to: One or more psycho-oncologists integrated in a multidisciplinary team or psycho-oncology as part of the psychiatric or psychosomatic unit of the hospital or a psycho-oncologist that gets the cases sent from the medical-care-staff.

To my knowledge there is no systematic integration of psycho-oncology in primary care. Some regional cancer leagues send their patients to a psycho-oncologist.

Difficulties in improving care:

- Financial issues (budget restrictions)
- Healthcare system is dominated by biomedicine, biopsychosocial model of medicine not established
- Physicians impression, that psycho-oncology wouldn't be necessary if there just were more doctors (same goes for nurses).
- Competition between professions instead of multidisciplinary cooperation, lack of knowledge about and respect for each others work.
- Lack of attention toward psychosocial needs of patients (problems get overlooked)

3. Screening tools:

Swiss Psycho-oncology Society and Swiss Cancer League: No.

But there are teams in some hospitals experimenting with some tools of their own (or at least they did so in the past).

Standards: no

4. The Swiss Cancer League offers in cooperation with the university of Basle an interdisciplinary postgraduate two year educational program: 200 hours, content: medical, psychological/psychiatric and social work basics as well as supervision and self reflexion. It is open to physicians, psychologists, nurses, radio-oncology technicians and social workers working in oncology.

In addition a communication skills training for physicians and nurses of 2,5 days with 4-6 telephone supervisions and half a day follow up is offered. The course is mandatory for obtaining board certification in oncology.

5. The main research projects are within the SAKK Swiss Group for Clinical Cancer Research: Quality of Life Office (PD Dr Jürg Bernhard) and the IBCSG International Breast Cancer Study Group. The Focus in both groups is Quality of Life as an additional endpoint in clinical trials. An ongoing international IBCSG trial is a randomized intervention trial of a consultation skills training package for physicians.
6. 1) Promotion: it is necessary to publicise information about this topic widely: information about the range of psychosocial services on offer, the needs that are being met by these services, and the existing scientific documentation about the effectiveness and medical cost offset of such services.

2) Regional and national networking of providers of psychosocial services. Make the available services more clearly visible and accessible to those who need them, and give patients/relatives and professionals an instant overview over what is available regionally. Exchange of experience and expertise between professionals.

3) Professionalism: Development and especially implementation of national standards for education and treatment. Any help would be welcome: Examples of best practice, guidelines, and especially proof of medical cost offset and advice about how to influence decision makers
7. See answers to question 6
8. a. no systematic involvement

b. no systematic involvement

c. in 2005 common Symposium "Depression in Palliative Care of the SGPO and the Swiss Society for Palliative Care

d. no systematic involvement
9. The actual political trend is cutting healthcare costs. Psychosocial issues are sometimes considered as nice to have /wellness /or questions of low priority.

Turkey

1. Turkish Association of Social Psychiatry
Derya Iren Akbiyik, MD (Executive Committee Member)
deryaakbiyik@yahoo.com

Ankara Oncology Research and Training Hospital
Psycho-Oncology Unit
Haldun Soygur, MD, PhD (Chief)
Soygur.haldun@isbank.net.tr

2. There are usually an appropriate number of psychologists in cancer centers depending on the number of inpatients. The general practitioners usually carry the responsibility for psychosocial care of cancer patients in primary health care centers where mental health specialists are usually unavailable. The only specific psycho-oncology clinic among state hospitals was established at the Ankara Oncology Research and Training Hospital 3 years ago. Primarily financial, and secondly, organizational difficulties are difficulties faced by many of the professionals.
3. In Ankara Oncology Research and Training Hospital, except for the breast cancer patients, the psychiatrists were called for consultation by the oncologists as needed by the patients. For breast cancer, every patient is referred to the Psychiatry Clinic of the aforementioned hospital as soon as they are admitted to the oncology clinic (just after confirmation of diagnosis).
4. Three main centres are responsible for the training:
 - 1) Istanbul University, Capa Medical School, Institute of Psycho-Oncology, Istanbul.
-Master's degree for mental health professionals.
 - 2) Ege University, Medical School, Department of Consultation-Liason Psychiatry, Izmir
 - 3) Ankara Oncology Research and Training Hospital (AORTH), Psycho-Oncology unit.
-Psycho-oncology training for professionals in oncology clinics in the hospital
-Courses for "coping with stress at work" for the staff working with cancer patients.
-Staff training for psycho-oncology team of the hospital.
5.
 - 1) Screening for psychosocial distress: Distress Thermometer. (Psycho-oncology team - AORTH).
 - 2) Screening for burn-out levels of staff working with cancer patients (Psycho-oncology team - AORTH).
 - 3) Psycho-immunology and cancer (Psycho-oncology team-AORTH).
 - 4) The effect of group therapies for cancer patients (Psycho-oncology team-AORTH).
6.
 - 1) Participating in the major international projects conducted by IPOS would improve our collaborative research experiences.
 - 2) The staff training programs directed by IPOS could be organized for Turkey.
 - 3) Collaboration for further psycho-oncology meetings.
7. Handling issues related to health economics and policy, creating social networks for patients and their families, increasing specialized staff training and changing attitudes regarding psycho-oncology.
8.
 - a. N/A
 - b. Follow up with outpatients
 - c. Helping patients with acceptance of and cooperation with treatment plan
 - d. Guiding patients to establish new life goals after treatment
9. In a developing country such as Turkey, the governmental funding is usually inadequate for specialized areas such as psycho-oncology. As a result, any funding for psycho-oncology must come from general psychiatry sources. There are not enough NGOs to support this area.

United Kingdom

1. The British Psychosocial Oncology Society (BPOS) www.bpos.org

Prof. Karen Cox Chair. BPOS

Professor in Cancer and Palliative Care

School of Nursing

Faculty of Medicine and Health Sciences

University of Nottingham

Nottingham

NG7 2UH

Chair

Tel: 0115 970 9265 Ext 430567

Fax: 0115 970 9955

E-mail: Karen.Cox@nottingham.ac.uk

2. In the UK, guidelines have recently been developed nationally under the auspices of the National Institute of Health and Clinical Excellence (NICE). The National Institute for Health and Clinical Excellence works on behalf of the National Health Service and the people who use it. The function of the organisation is to make recommendations on treatments and care by reviewing the best available evidence. This process led to the publication in March 2004 of the document "Guidance on Cancer Services: Improving Supportive and Palliative care for Adults with Cancer" (available at www.nice.org.uk/page.aspx?o=110005). The aim of this 200 page document is to define a service model to ensure that patients with cancer, their families, and other carers receive support to help them cope with the diagnosis of cancer and its treatment.

The key recommendations of these guidelines are:

- People affected by cancer should be involved in developing cancer services
- There should be good communication, and people affected by cancer should be involved in decision making
- Information should be available free of charge
- People affected by cancer should be offered a range of physical, emotional, spiritual and social support
- There should be services to help people living with the after-effects of cancer manage these for themselves
- People with advanced cancer should have access to a range of services to improve their quality of life
- There should be support for people dying from cancer
- The needs of family and other carers of people with cancer should be met
- There should be a trained workforce to provide services

The Guidance discusses the co-ordination of care, communication, information and the provision of a range of services for cancer patients and their families and carers. The services discussed are, psychological support services, social support services, spiritual support services, general palliative care services, specialist palliative care services, rehabilitation services, complimentary therapy services, and services for families and carers including bereavement care. All NICE guidelines are intended to be adopted as national standards. The first stage of the process of implementing the Supportive and Palliative Care Guidelines is a fact finding exercise regarding existing provision of psychosocial care nationally. In addition, an assessment of the workforce implications of the Guidelines is required. The implications of the NICE Guidance recommendations for both the number, and type, of health care professionals required, and the organisation and co-ordination of service delivery, is being considered at a national level by the Department of Health Workforce

Planning Group with responsibility for cancer along with the Workforce Development Confederations in England and Wales. (The Scottish Healthcare system is functionally independent of that of England and Wales). The NICE guidance also recommends the establishment of a National Supportive and Palliative Care Co-ordinating Group for England. Regionally in England, the implications of the Guidelines, and the current status of psychosocial care provision is being assessed by the Regional Cancer Networks. Cancer Networks work in partnership with Strategic Health Authorities and their associated Workforce Development Confederations. They comprise a partnership involving primary care organisations, NHS trusts, hospices and other voluntary sector organisations, local government councils with social service responsibilities, health and social care professionals and patient and carers. These regional and national bodies have the power to recommend levels of service delivery and workforce planning recommendations. However, the responsibility for financing any recommendations rests with Strategic Health Authorities and Primary Care Trusts. These bodies are not bound fiscally to underwrite the recommendations of the Networks.

3. National guidelines for the management of psychosocial distress have been developed and published by the National Institute of Health and Clinical Excellence (NICE) described in 2. above. The guidelines make recommendations for the appropriate structuring of psychosocial oncology services, and recommend that cancer patients should be regularly screened for the presence of clinically significant psychosocial distress at regular and pertinent stages throughout their cancer journey. However, the guidelines make no recommendations as regards appropriate screening instruments or methods. This is a subject of considerable discussion and debate
4. There is, as yet, no central coordination of training and educational programs in psychosocial oncology in the UK. However a number of institutions such as research funding organizations (Cancer Research UK), Universities, and others provide postgraduate courses (MSc), or diploma level courses on various aspects of psychosocial oncology such as communication skills. The British Psychosocial Oncology society (BPOS www.bpos.org) is currently conducting a survey to establish the range of psychosocial oncology training courses and opportunities in the UK.
5. There is considerable research effort and a notable psychosocial research history in the UK. There has been a recent drive to organise research effort. This has led to the formation of the National Cancer Research Institute (NCRI www.ncri.org.uk).

The NCRI is a partnership between the Government and charity sectors and exists to promote co-operation between the member organisations for the benefit of the cancer research community. The activities of NCRI are overseen by the NCRI Board, at which the Government and charity sectors are represented at the highest level.

NCRI was set up in 2001 to help its members to develop common plans for cancer research and avoid unnecessary duplication of effort. All the major organisations that fund cancer research are involved. There are 19 Government and Charity [partners](#) which between them fund more than £330m pa of cancer research in the UK. Pharmaceutical companies also do research on cancer and in recognition of this the Association of British Pharmaceutical Industry is also a member.

Until NCRI came together there was no joint planning or management of cancer research, and collaborations were patchy. There was no single source of information about the research being carried out, so it was difficult to assess needs for new work.

The NCRI supports 23 Clinical Studies Groups which oversee research work across the range of cancer research. Whilst many of these groups are cancer site specific, a number are more directly relevant to psychosocial oncology. The Psychosocial Oncology Group, the Palliative Care Group and the Complimentary Therapies Development Group are examples.

More detail of the organization of the NCRI and details of ongoing research sponsored by the organization can be found at www.ncri.org.uk

6. The IPOS Mission Statement -

“.....to be the international multi-disciplinary organization dedicated to fostering the science of psychosocial and behavioral oncology and improving the care of cancer patients and their families throughout the world.”

encapsulates the major role that IPOS can play in the further development of psychosocial oncology services in the UK. By providing a forum for the coordination and dissemination of worldwide research and clinical practice and developing the Core Curriculum in Psycho-Oncology in association with the European School of Oncology, IPOS is well placed to drive forward the psychosocial oncology agenda worldwide.

7. a. Training

(i) Previous research has shown that much psychological distress in cancer patients goes unidentified in the clinic. It is clear therefore that health care professionals would benefit from more extensive training in identifying and eliciting psychological concerns from their patients. Training would, of course, be required in the appropriate response to such concerns should they emerge, and in appropriate management.

(ii) The NICE Guidelines in the UK give targeted personnel the responsibility for screening cancer patients for the presence of psychological distress at given points throughout their cancer journey. There is a need for extensive training on methods of identifying psychological distress and their relative strengths and weaknesses. It would be unfortunate if an unsubstantiated assumption that simple screening of a population represented high level care without a deeper understanding of the clinical complexities of identifying and responding to clinically significant distress.

(iii) An area related to training is clinical supervision and support. It is clear that there will be an increasing need for supervision and support of the health care personnel tasked with the identification and in some cases triage of clinically significant distress. The design, organisation, and provision of adequate supervision and support of other health care professionals will be a major task for psychosocial services in the future

b. Research

Previously research has focussed on the prevalence of psychological distress and psychiatric disorder amongst cancer patients. Much research attention has also focussed on communication skills of health care professionals. The current consensus is that there is little need for further intensive research in the above areas and that a change of focus of research efforts is warranted.

(i) Future research could most usefully focus on the interventions which are provided to ameliorate psychological distress in cancer patients. Whilst some work has been conducted on this, there is a need for rigorous scientifically controlled research on the efficacy, effectiveness, and cost effectiveness of psychosocial treatment interventions. This also applies to the area of complementary

interventions where there are, as yet, very few scientifically controlled investigations of CAM interventions with cancer patients. Given the increasing provision of psychosocial services, there is a pressing need to establish the efficacy, effectiveness, and safety of the interventions provided within them. The methodology of such treatment outcome research might also warrant investigation as to the relative benefits and costs of gold standard methodologies such as the randomised controlled trial and other methods such as case series and qualitative designs.

(ii) Further, it is clear from studies conducted to date that more attention should be paid in future research to the population under study. The evidence base would benefit from research on a wider range of cancer types and stages of illness and also from clearer definition of study populations than has hitherto been the case. This will significantly improve the interpretation, and generalisability of research findings.

(iii) Section (c) below on Clinical Care, highlighted several areas of contention, and potential importance, with regard to the organisation of clinical services. This is an important and potentially fertile area for future research.

c. Clinical Care

(i) If one considers the research evidence on the point prevalence of psychiatric and psychological distress in patients with a cancer diagnosis in the UK, it is clear the prevalence rates (circa 25% -50%) have remained remarkably stable over the past 20 years. The fact that this constancy exists despite considerable investment in provision of personnel tasked with providing psychosocial support, such as Clinical Nurse Specialists begs the question; why has this investment in personnel apparently failed to make an impact on the prevalence of clinically significant distress? It has been argued that if further attention is paid to the training, support and service organisation of these health care professionals, clinically significant benefits may be gained. This requires urgent research attention.

(ii) A further area of importance in clinical care is equity of access. Cancer is an illness which crosses social and cultural boundaries. However in the UK and Europe the available research evidence has shown that psychosocial support services tend to be accessed preferentially by female, breast cancer patients of higher socio-economic status. This finding represents a major challenge to attempts to provide an equitable, and by that token, more broadly clinically effective service. There is evidence, however, that services which are functionally and geographically integrated with wider oncology provision are accessed by patients with a wider range of cancer diagnoses and with a significantly broader range of socio-economic backgrounds. Such services tend to be located within mainstream oncology hospitals and clinics and to be seamlessly integrated functionally and organisationally with wider oncology services. They are therefore more readily available to, and accessed by, a much wider range of patients.

(iii) A third area of significance for clinical care relates to the philosophy of care. The NICE guidelines and much other discussion of psychosocial care, both nationally and internationally, outline services which are designed to react to psychological distress when it is identified. In other words clinical care is provided as a reactive service. In such a model varying intensities of intervention can be provided, with the type of intervention given being determined by the level of distress identified in the patient. There is little room in such models of care for notions such as the prevention of psychological distress in cancer patients. Once again research evidence suggests that if psychosocial services are appropriately organised and delivered then much psychological distress and psychiatric disorder is preventable. This principle of psychoprophylaxis rests on a simple reorientation of thinking regarding clinical services, namely that the type of service and intervention provided may, in fact, be a

significant determinant of the level of distress that patients experience. The provision of psychosocial care within the context of a service designed to prevent the occurrence of distress wherever possible represents an efficient use of clinical resources. This is an area worthy of rigorous research effort.

(iv) The application of the principles of psychosocial oncology research also has a valuable contribution to make to wider oncology research. The inclusion of assessments of quality of life, mood state, and psychological coping in studies of new and existing medical, clinical and surgical oncological interventions would provide a more comprehensive understanding of the effectiveness, and acceptability, of such treatments.

8. The exercise to survey the provision of psycho-oncology services being conducted by Regional Cancer Networks (see 2. above) is ongoing therefore detail on the exact numbers of staff working in the four areas listed is lacking at present. However it is known that in the UK psycho-oncologists are involved at all levels in these areas in the conduct of research, the design and provision of direct and supervised clinical services and in training and education.

9. There are several challenges in the provision of psychosocial services and conduct of psychosocial research which may operate as barriers to the development and delivery of an adequate service. The need for, and potential contribution of, psychosocial services is still under recognised in some areas. A significant and perennial problem is availability of financial resources in a rapidly developing area such as oncology where there can be strong competition for available funding. There is also a dearth of appropriately qualified and trained personnel, such as clinical psychologists and psychiatrists, which leads to recruitment difficulties once posts are funded and advertised.

United States

1. American Psychosocial Oncology Society

2365 Hunter's Way

Charlottesville, VA 22911

434.293.5350

www.apos-society.org

President: Matthew Loscalzo, MSW

mloscaszo@ucsd.edu

History and Purpose of the American Psychosocial Oncology Society

The American Psychosocial Oncology Society (APOS) is the only multidisciplinary professional society in the U.S. dedicated to the psychosocial aspects of cancer treatment. APOS was formed in 1986 to provide the opportunity for networking, education and professional development among the small numbers of professionals working in the psychosocial aspects of cancer and AIDS. Jimmie Holland MD, Chief of Psychiatric Services at Memorial Sloan-Kettering was elected the Founding President.

The need was clear, however, for a national organization that could bring together all the disciplines of psychosocial oncology to stimulate collaboration and dialogue across professions; prior to APOS' formation, most working in the field were limited to presenting their work at discipline-specific meetings. Over time, APOS developed a constitution that provided independence for the organization, encouraging multidisciplinary membership and firmly establishing itself as the single national organization devoted solely to psychosocial care in cancer. Members come to work together from the fields of oncology, psychiatry, psychology, social work, nursing, counseling, therapy and patient advocacy.

APOS Mission

To advance the science and practice of psychosocial care for people with cancer

APOS Vision

To ensure that all people with cancer have access to psychosocial services as part of quality cancer care

APOS Institute of Research and Education

Psychosocial Oncology Handbook The APOS Institute of Research and Education (AIRE) published its first handbook, *Quick Reference for Oncology Clinicians: The Psychiatric and Psychological Dimensions of Cancer Symptom Management*, debuted in June 2006. The pocket-size handbook is a tool clinicians can use to help them respond effectively with appropriate interventions to cancer patients in distress and their caregivers. The response to the Handbook has been overwhelmingly positive. APOS has sold almost 200 copies of the book in its first month. With grant support, APOS has distributed almost 1,000 additional copies, free of charge, to its members and to psychosocial oncology professionals in developing countries.

A second handbook, focusing on pediatric psychosocial oncology, is planned, contingent on funding, as AIRE's next project. The Pediatrics SIG of APOS has compiled a table of contents and is identifying chapter authors.

Online Education AIRE offers a number of professional education opportunities online, free of charge. Continuing education certificates are available for certain curricula through the University of South Florida. Following is a selection of AIRE online education programs:

- Multidisciplinary Training in Psycho-Oncology (15 webcast lectures)
- Distress Management Training for Oncology Nurses (four webcast lectures)
- Cancer 101 for Mental Health Professionals (four webcast lectures)
- Psychosocial Aspects of Cancer Survivorship (four webcast lectures)

Toll-Free Helpline: 1-866-APOS-4-HELP (276-7443)

The APOS Toll-Free Helpline is a resource for people with cancer, their caregivers and patient advocates to obtain local referrals for counseling. The referral program connects patients and patient advocates to professionals skilled in managing cancer-related distress. APOS reconfigured its Helpline in 2006. Staff now answers the Helpline directly during normal business hours; prior to this year calls were answered by voice-mail and transcribed. This change has had a tremendous effect — that first contact with a caring human voice offering assistance makes a huge difference in the lives of our callers. Also added this year is counseling via telephone for callers in crisis who have no identified local resources for psychosocial care.

Annual Conference

APOS hosts an annual conference in the latter part of February or early March, chaired by the First Vice President. A full day of training workshops is followed by two-days of concurrent, plenary and symposia sessions. Starting with the 2006 conference, APOS added postconference training opportunities to the schedule on the day following the conference.

The APOS Annual Conference brings together researchers and practitioners to develop, test and implement innovative approaches to psychosocial supportive care for people with cancer who are undergoing treatment and as they move into survivorship. The APOS conference, with its emphasis on exchange between researchers and practitioners, is uniquely designed to improve translation of research to practice in psychosocial oncology.

To give all members and their colleagues the opportunity to attend this conference, locations are selected based on a three-year cycle from East coast to Central to West coast venues. Annual Conferences include the following:

- 1st Annual Conference, 29 January – 1 February 2004, Orlando, Florida
- 2nd Annual Conference, 27 – 29 January 2005, Phoenix, Arizona
- 3rd Annual Conference, 16 – 19 February 2006, Amelia Island, Florida
- 4th Annual Conference, 1 – 4 March 2007, Austin, Texas
- 5th Annual Conference, 28 February – 2 March 2008, Irvine, California

Members-only Website

The APOS Members-only website is an important benefit of membership. Through this website, members have access to a directory of their colleagues, searchable by name, discipline and location. The website also features back issues of the Clinical Update, a valuable members-only e-mail publication that highlights current research in the field. Presentations from the APOS Annual Conference are available to members (and to registrants) via a link from the members-only website. Recently, APOS has introduced a member newsletter to draw attention to all the resources available to members on the website.

Membership

Membership is open to individuals with diverse clinical and research backgrounds. APOS members represent the following disciplines, among others: psychiatrists, psychologists, oncologists, nurses, social workers, clergy, mental health counselors, music and art therapists, epidemiologists, social scientists and educators. Currently, there are nearly 450 members representing 14 countries and 42 states in the U.S., including Washington, DC.

Organization and Infrastructure

APOS established its current administrative infrastructure in 2002 by contracting with an association management firm, Custom Management Group (CMG). CMG President, Ms. Elliott Graham, was contracted to serve as Executive Director and headquarters were established in Charlottesville, VA. In 2004, the Board of Directors developed a strategic plan to direct the activities of the Society.

The Board of Directors, led by the President, governs the Society. Officers of the Board also include the Past President, First and Second Vice-Presidents, Secretary and Treasurer. Five elected Members-at-Large and three invited members serve on the Board as Directors.

APOS has three levels of membership: Full, Associate and Member-in-Training. Full membership is open to individuals with training or experience in the psychosocial, social, emotional, behavioral, spiritual and physical aspects of cancer, and those who are actively engaged in research or clinical aspects of care for patients with cancer. Full members are eligible to hold office and vote in Society elections.

Associate membership is open to any individual with an interest in psychosocial oncology. Members-in-Training must be enrolled in programs that would lead to appropriate degrees or certificates in subjects relating to psychosocial oncology. Neither Associate Members nor Members-in-Training are eligible to hold office or vote.

All members are welcome to join one or more of APOS' six Special Interest Groups (SIGs) to serve its membership. The Bereavement/Spirituality, Genetics, Health Disparities, Pediatrics, Sexual and Reproductive Health, and Survivorship SIGs provide APOS members with forums for focused discussion and professional networking. APOS hosts webpages for each of the SIGs on its Members-only website to facilitate information sharing and interaction.

Impact of Psychosocial Oncology

Psychosocial distress that indicates trouble coping with illness is seen in as many as 44% of patients with cancer.¹ It is a significant problem for these patients and their families. The word “distress” applies equally to concerns of a psychological, social and/or spiritual nature. It also suggests that a diagnosis of cancer results in normal feelings of vulnerability, sadness and fear. However, when distress becomes severe, it represents depression, anxiety, panic, social isolation or a spiritual crisis.² There is a growing body of research that shows a reduction of distress and improved quality of life when psychosocial interventions are applied during cancer treatment.³ Several Canadian studies have even shown cost savings associated with psychosocial care.^{4,5,6} With the burden of cancer increasing globally no one can afford to ignore the psychosocial distress of cancer patients and their families. It should be noted that Canada (the Canadian Strategy for Cancer Control-Public Health Agency of Canada and the Canadian Association of Provincial Cancer Agencies) has taken the first step in endorsing Emotional Distress as the 6th Vital Sign in Cancer.^{7,8} APOS, too, is working to ensure that screening for emotional distress is as common in doctor visits as recording the patient’s temperature, respiratory rate, pulse rate, blood pressure and pain.

Uruguay

1. There is no organization.
2. As Gerge Engel would say, there is a lot of “lip service” towards the “human care”, but no actually policies regarding psychosocial care.
3. We use the Distress Thermometer at our hospital
4. In our unit, Residents have a rotation on psycho-oncology and care of the terminally ill. We also participate in the Tumor Committee and the Ethics Committee.
6. The impact of IPOS would be great since international information is usually well received. IPOS should start regional research that includes Uruguay, Argentina, Brazil and other countries (There is a Latin American Psycho-Oncology Society that was born last May at Sao Paulo). Having a common protocol will help. Doing research will also educate people and would hopefully result in a regional paper. This should be reinforced with regional courses and standards.

¹ Zabora J, BrintzenhofeSzoc K, Curbow B, Hooker C, Piantadosi S. (2001). The prevalence of psychological distress by cancer site. *Psycho-Oncology*, 10(1), 19–28.

² Holland JC, Andersen B, et al. (2003). Distress management clinical practice guidelines in oncology. *Journal of the National Comprehensive Cancer Network*, 1, 344–374.

³ Meyer TJ, Mark MM. (1995). Effects of psychosocial interventions with adult cancer patients: A meta-analysis of randomized experiments. *Health Psychology*, 14, 101–108.

⁴ Carlson LE, Bultz BD. (2003). Benefits of psychosocial oncology care: Improved quality of life and medical cost offset. *Health Quality Life Outcomes*, 1, 8.

⁵ Chiles JA, Lambert MJ, Hatch AL. (1999). The impact of psychological interventions on medical cost offset: A meta-analytic review. *Clinical Psychology: Science Practice*, 6, 204–220.

⁶ Simpson S, Carlson L, Trew M. (2001). Impact of a group psychosocial intervention on health care utilization by breast cancer patients. *Cancer Practice*, 9, 19–26.

⁷ Bultz, BD & Carlson, LE. (2006). Emotional distress: The 6th vital sign in cancer care. *Psycho-Oncology*, 15, 93–95.

⁸ Bultz, BD & Holland, JC. (2006). Emotional distress in patients with cancer: The 6th vital sign. *Community Oncology*, 3, 311–314.

7. IPOS should have a core curriculum of courses that would be considered a standard part of international psycho-oncology education.
8. At our Unit we provide all levels of care.
9. There is no national policy on Psycho-Oncology. There is no C/L Psychiatry in Uruguay and psychoanalysis is the most prevalent model used. This results in resistance from the many medical doctors.