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Chapter 20

Psychosocial Care for Patients with Colorectal Cancer

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Additional information is available at the end of the chapter

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1. Introduction

As medical care based on information disclosure has been promoted, the concept of informed consent has also come to be understood in cancer care, and its faithful practice is now required. However, reactions ranging from ordinary psychological reactions (such as discouragement and feelings of isolation, alienation, despair, etc.) to psychological changes requiring the attention of a specialist (i.e., depression) are sometimes seen when information is disclosed, especially after conveying bad news, and healthcare providers must constantly keep the psychological states of their patients in mind. In this chapter, I will first describe the usual psychological reactions that cancer patients exhibit after the disclosure of cancer-related information. Additionally, I will discuss general matters to keep in mind when delivering bad news to cancer patients. Then, I will summarize the diagnosis and management of psychological distress requiring psychiatric attention that healthcare providers in cancer care settings should know.

In addition, healthcare providers are expected to strive for good communication with the patient and the patient's family during the process of conveying bad news about a patient's condition and obtaining informed consent. In reality, however, training in communication skills and support skills is only rarely available, and as a result, many healthcare providers experience stress as a result of having been unable to acquire such skills adequately. With this background in mind, I will describe the need for communication skills in cancer care and review recent literature regarding the effectiveness of training designed to improve such skills.

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2. Typical psychological reactions to information disclosure (especially bad news) (Table 1)

Bad news must be conveyed more often than good news when disclosing information during the clinical course of cancer. Here, the typical psychological reactions displayed by patients after being informed of such bad news will be explained by providing examples of reactions after having been informed of a diagnosis of cancer. First, the initial few days are characterized by not being ready to believe or by temporarily denying what they have been told, saying,: "That can't be…," or by a sense of despair, saying,: "Oh, I've got cancer…." Later, a time is reached when they sometimes say,: "My mind went blank, and it was as though it hadn't happened to me," or "I don't clearly remember what happened after I was told I had cancer. I don't remember how I got home." Thus, it is important for attending physicians to recognize that patients may not clearly remember any subsequent explanations after they have been told that they have cancer, and that even if they describe tests and treatment in great detail, the patients may not understand the explanations adequately.

A. First phase: period of early reaction / within a few days Patients do not believe the information or temporarily deny the facts. Some patients retrospectively describe this period as, 'My mind ceased to function as if these things were not happening to me'. Others experience despair, i.e. 'I was told what I feared'.
B. Second phase: period of distress / after 1–2 weeks Patients repeatedly develop symptoms such as anxiety, depression, insomnia, appetite loss or decreased concentration. Owing to marked anxiety and decreased concentration, patients repeatedly ask the same questions.
C. Third phase: period of adaptation / after 2 weeks–1 month, sometimes 3 months Patients face reality and begin to or try to adapt to the new situation.

Table 1. Psychological reactions to being given a bad news

Then, after a little while, a time comes when symptoms such as a sinking feeling, anxiety, feelings of isolation from their surroundings, difficulty sleeping, or a loss of appetite might occur repeatedly. Symptoms in the form of getting excited or upset over petty matters are also sometimes seen. There are also times when the patient's behavior may take the form of repeatedly asking the same question because patients are very anxious and their ability to concentrate has declined. As a result of these conditions, patients sometimes experience a certain degree of interference with their daily lives, because the things that they were usually able to do have become troublesome or take longer to complete.

After 2 weeks have gone by, however, patients gradually begin to face their real problems and become able to adapt to their new reality. More specifically, they begin to gather information, saying, "There's nothing I can do about having been diagnosed with cancer. From here on, I'm going to think about how best to make things better," or they become capable of an optimistic outlook, saying, "My cancer may get better." Moreover, because they always have the feeling

that, "I have to go about my daily life living with my cancer," although it may be difficult to go about their lives with the same feeling as when they were completely healthy, it does not create a very severe obstacle to their everyday lives, and they are able to return to a living pattern that is almost the same as before.

It is important to have a good understanding of the "typical" psychological reactions described above that cancer patients exhibit.

3. General matters to keep in mind when delivering bad news to cancer patients

1. Basic principles

a. The bad news should first be discussed with the patients themselves whenever possible.

b. The same physician should take charge of the patient from the initial contact until the definitive treatment whenever possible. This allows for true informed consent, during which the patient can calmly decide among several choices of treatment modalities. If a situation arises where a change in the physician-in-charge is necessary, care should be taken not to destroy patient rapport.

c. The location for discussing the bad news must be carefully chosen, providing an environment of privacy where the patients can fully express their feelings, as necessary. On no account should the bad news be communicated via the telephone or while passing in a corridor or in any public place. It was reported that 55% of patients who were told the news by telephone expressed negative feelings [2]. Patients and their families who are given bad news in an inconsiderate manner may never forget the thoughtlessness of the physician.

d. From the initial interview, physicians should try to tell the truth consistently and should provide as much information as they have available at the time. Bad news based on unconfirmed information should not be delivered.

e. Although an accurate explanation is necessary, the patient should not be bombarded with facts with no consideration given to the patient's state. Physicians should be prepared to explain facts as clearly and as simply as necessary. Patients should not be expected to cope with everything by themselves.

f. Patients are sometimes told, "You have advanced cancer and there is nothing I can do. There is no effective treatment in your case." Such cruel attitudes presented by the physician causes a loss of hope, anger, resignation and a sense of alienation in patients. Physicians should recognize that they can generate either hope or despair in patients by their verbal expressions or attitude. Physicians should present other positive features, including supportive care, instead of abandoning a patient with such a statement.

g. Breaking bad news is commonly performed in an outpatient clinic. An adequate amount of time to provide an explanation and subsequent consideration is necessary. When

patients are very anxious, the physician-in-charge should provide a consultation with a psychiatrist. Options such as talking to patients on another occasion after completing all their duties at the outpatient clinic or offering encouragement by talking again on the telephone on the day that the bad news has been divulged can sometimes be very effective.

h. Patients may show reservation towards physicians and sometimes fear them. Therefore, some patients cannot express their feelings when they are given bad news or cannot ask physicians questions, believing that they should do what the physician has told them. However, some patients are able to be more frank when talking to nurses and may ask them questions about the news. Therefore, it is important for physicians to hear the patient's true feelings and complaints through nurses. Cooperation between physicians and nurses is very important in this situation.

i. The physician should not hurry to explain all the details on one occasion. Several interviews with each patient are recommended to discuss the bad news in a step-by-step manner.

j. The physician should put himself or herself in the patient's place and should not judge the patient's reactions prematurely.

2. Approaches to speaking with family members

a. In principle, family members should not be told the bad news before the patient has been told. Families who want the patient to be ignorant of the news may be worried that "… the patient may commit suicide because of fears or shock." However, such a risk is much lower than generally believed [3], though this risk should always be taken into consideration.

b. When a patient is referred to our hospital and only the family has been told the bad news at another hospital and the family strongly opposes telling the patient the truth, the family should be repeatedly encouraged to change their minds, taking as much time as necessary. In such cases, it is important not to blame the initial physicians for their old-fashioned approach, since the rapport between the patient and the physicians may be impaired.

c. Families play a very important role in cancer treatment. When the bad news is told definitively, the explanation should ideally be given to the patient and family together. Although the patient takes priority over the family, it is very important to inform the family of the patient's state as accurately as possible.

d. Families sometimes become more agitated than patients and cannot remember or understand the explanation accurately Therefore, physicians should not take it for granted that "…families will be alright when receiving bad news, because they are not patients." When necessary, families should also be supported. It is often helpful for the physician-in-charge to ask a psychiatrist for advice.

3. Psychological distress requiring psychiatric attention

Derogatis et al. [4] conducted interviews with 215 inpatients and outpatients at three leading cancer centers in the eastern United States, and investigated the prevalence of psychological

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problems based on the DSM-III (The DSM-III is a set of comprehensive diagnostic criteria for all mental disorders that was drawn up by the American Psychiatric Association in 1980 and is widely used throughout the world in prevalence surveys, etc. The revised DSM-III-R was published in 1987, the DSM-IV in 1994, and the DSM-IV-TR in 2000). They reported that 32% of the 215 subjects met the diagnostic criteria for adjustment disorders, 6% for depression, and 4% for delirium. These 3 psychological manifestations appear to be characteristic of the psychological distress experienced by cancer patients who require psychiatric attention. Moreover, because all these psychological manifestations reduce patients' quality of life (QOL), their proper diagnosis and treatment is needed.

The incidence of adjustment disorders, depression, or delirium has not been previously assessed in colorectal cancer patients. However, some reports have described the prevalence of psychological distress using various symptom rating scales. These reports are summarized in Table 2 [5-13]. The reports suggest that the prevalence of psychological distress in colorectal cancer patients is 7% - 44%. Zabora et al. [14] assessed the prevalence of psychological distress among a large sample of cancer patients and variations in distress among 14 cancer diagnoses; the overall prevalence of distress in this sample was 35.1% (colorectal cancer: 31.6%), and a greater patient burden was associated with similar rates of distress.

Author, Journal (year) [Reference No.]	Subjects	Outcome variables	Major results
Dunn et al, *Psychooncology* (2012) [5]	1966 colorectal cancer survivors	Psychological distress: Brief Symptom Inventory-18 (BSI-18) at six time points from 5 months to 5 years post-diagnosis	Over the 5-year trajectory, the prevalence of high overall distress ranged between 44% and 32%.
Graa Pereira et al, *Eur J Oncol Nurs* (2012) [6]	114 colorectal cancer patients who received treatments	Anxiety and depression: Hospital Anxiety and Depression Scale (HADS) Traumatic stress: Impact of Events Scale Revised (IES-R) during the period of 12 months after treatment	Patients who received only surgery, as treatment, had lower levels of depression, anxiety and traumatic stress symptoms when compared with patients who received surgery and chemotherapy or surgery plus radiotherapy.
Daudt et al, *Suppor*t Care Cancer (2012) [7]	252 colorectal cancer patients referred to an outpatient clinic	Anxiety and depression: Psychosocial Screen for Cancer (PSSCAN) at the first visit to a clinic	The prevalence of anxiety and depression were determined to be 10% and 7%, respectively.
Hyphantis et al, *J Psychosom Res* (2011) [8]	144 early non-metastatic colorectal cancer patients	Psychological distress: Symptom Distress Checklist (SCL-90-R) at baseline and one year after the initial assessment	Paranoid ideation, psychoticism, interpersonal sensitivity, anxiety and depressive symptoms increased significantly over the one-year period of the study.

Author, Journal (year) [Reference No.]	Subjects	Outcome variables	Major results
Patel et al, *J Affect Disord* (2011) [9]	99 colorectal cancer patients	Clinical interview: Composite International Diagnostic Interview (CIDI) Psychological distress: Distress Thermometer (DT) Anxiety and depression: Hospital Anxiety and Depression Scale (HADS) within 9 weeks of receiving diagnosis	Seventeen patients (17%) were diagnosed with a current mood or anxiety disorder, 11 (11%) met criteria for a depressive disorder and 7 (7%) with a primary anxiety disorder, and one patient had a secondary diagnosis of generalized anxiety disorder.
Medeiros et al, *J Gastrointest Cancer* (2010) [10]	37 colorectal cancer patients	Anxiety and depression: Questionnaires of Depression and Anxiety After surgical resection; at the beginning and at the end of the treatment in the chemotherapy group (CHG) and at the first and after 6 months of follow-up in the control group (CG)	Mild or moderate depression was diagnosed in 31.6% of the CHG patients in the first evaluation and in 38.6% at the second one. There was a higher number of patients with moderate state or trait anxiety in the CHG when compared to the CG in both evaluations.
Alacacioglu et al, *Support Care Cancer* (2012) [11]	110 colorectal cancer patients undergoing chemotherapy	Depression: Beck Depression Inventory (BDI) Anxiety: State-Trait Anxiety Inventory (STAI) during chemotherapy	The mean Beck depression scores were 11.2±9.0 (range 0–44) and the mean STAI scores were 41.9±8.8 (range 22–71). 23.6% were determined as depressive.
Lynch et al, *Cancer* (2008) [12]	1822 colorectal cancer patients	Psychological distress: Brief Symptom Inventory-18 (BSI-18) at baseline (after diagnosis), approximately 6 (Time 1) and 12 months (Time 2) postdiagnosis	The prevalence of global psychological distress was low: 8.3% and 6.7% at 6 and 12 months postdiagnosis, respectively. Of the143 participants who met caseness for distress at Time 1, 38% remained highly distressed at Time 2.
Pugliese et al, *Health Qual Life Outcomes* (2006) [13]	98 advanced colorectal cancer patients during chemotherapy	Descriptive diagnosis: DSM III-R criteria before initiating treatment	According to the clinical interview, 20 (20%) met criteria for adjustment disorders, 3 (3%) for phobia, and 3 (3%) for generalized anxiety disorder.

Table 2. A summary of psychological distress in colorectal cancer patients

Below, the special features of each of these psychological manifestations are summarized.

1. Adjustment disorders

Adjustment disorders are the most common psychological manifestation exhibited by cancer patients, but few studies or reports have examined adjustment disorders alone. Problems with the diagnostic criteria for adjustment disorders themselves are likely to be one of the reasons for the lack of studies on this topic. The diagnostic criteria in the DSM-IV-TR state that adjustment disorders are "reactions such as anxiety and depression or behavior disorders that occur in association with psychosocial stress." The diagnosis of adjustment disorders is made when the degree of the reaction is stronger than expected or when symptoms interfere with social functions from everyday life to social activities, and such disorders are said to be a continuous condition, without any strict division from normal reactions. Thus, the criteria are vague, and the term "adjustment disorders" is used as a "wastebasket diagnosis" when there is a mood disorder but other diagnoses, including depression, do not apply. Nevertheless, the term has the advantage of being able to include a variety of psychological manifestations that would be difficult to accept as specific mental disorders.

Inadequate pain control can be listed as a primary cause of adjustment disorders. According to a study by Derogatis et al. [1], a higher percentage of cancer patients who met the diagnostic criteria for adjustment disorders had severe pain, compared with cancer patients who did not meet the criteria. Anxiety, depression, and agitation are known to readily develop when pain of unknown cause persists [15]. Clearly, understanding patients' pain, which is a typical symptom that requires symptomatic relief, and adequately controlling such pain seems to be also useful for relieving psychological distress. Moreover, feelings of difficulty breathing [16] or malaise [17], which (similar to pain) often occur in colorectal cancer patients, can have an impact on patient QOL and can be difficult to treat, and their presence appears to be a cause of anxiety or depression.

These adjustment disorders should be evaluated and properly managed, but few patients are actually diagnosed correctly and treated properly [18]. One reason for this situation appears to be that healthcare providers often miss psychological manifestations. Although the issue of physicians and nurses who are not specialists in psychiatric care overlooking mild depression and anxiety symptoms occurring during the course of cancer is, to some extent, unavoidable, there seems to be a need for education regarding the diagnosis and treatment of adjustment disorders, which are the most common psychological manifestations of cancer patients.

Psychotropic drugs, such as anxiolytic agents, hypnotics, and, depending on the circumstances, antidepressants, are often used for treatment, but it is important to make an effort to identify the cause of the adjustment disorders described above by sufficiently listening to what the patient has to say, and then eliminating the cause. To accomplish this task, supportive psychiatric care in which caregivers encourage patients to express how they are really feeling at the present time (especially feelings of fear and anxiety), that supports and empathizes with the patients, and that does not provide unrealistic information but provides assurance within the realm of reality is said to be effective. In other words, supportive psychiatric care can become a valid treatment only when the patients feel that their present suffering is understood by the healthcare provider.

2. Depression

Table 3 shows the diagnostic criteria for depression based on the DSM-IV-TR. A diagnosis of depression is made when either a depressed mood or a loss of interest or pleasure or both occurs, and a total of 5 or more other symptoms are present for at least 2 weeks. However, because some of the physical symptoms included among the listed symptoms of depression, such as sleep disturbance, anorexia and weight loss, a decreased ability to concentrate, and malaise, are common symptoms, especially in palliative care settings, these symptoms are often not regarded as unusual even when present, and there is a strong tendency for depression to be underestimated among cancer patients. Why is the accurate evaluation and treatment of depression important? To answer this question, a specific case is presented below.

1. Depressed mood most of the day.
2. Diminished interest or pleasure in all or most activities.
3. Significant unintentional weight loss or gain.
4. Insomnia or sleeping too much.
5. Agitation or psychomotor retardation noticed by others.
6. Fatigue or loss of energy.
7. Feelings of worthlessness or excessive guilt.
8. Diminished ability to think or concentrate, or indecisiveness.
9. Recurrent thoughts of death.
Depressed mood and/or loss of interest or pleasure in life activities for at least 2 weeks and at least five of the above symptoms that cause clinically significant impairment in social, work, or other important areas of functioning almost every day.

Table 3. Diagnostic criteria of depression

[Case]

The patient was a 65-year-old man who was being followed up for advanced colorectal cancer and had entered the terminal stage. Predominantly palliative care was being performed, and symptom control was fairly good. However, he gradually began to experience insomnia, and this symptom persisted. A short while later he was heard to say, "There's no point in living anymore. I want to die," and he exhibited minimal facial expressions. A hypnotic was prescribed, but the treatment was ineffective. Because the condition described above persisted, he was referred to a psychiatrist. Based on an examination, the psychiatrist concluded that the cause was depression, and when the patient was treated with a low dose of an antidepressant, he no longer made the above complaints, and his facial expression became peaceful.

It is not rare for cancer patients, particularly terminal patients, to speak of suicidal ideation (a feeling that they want to die or that there is no point in living), similar to the case described above, and more than half of such patients are reportedly in a depressed state [19]. However, since depression can be alleviated suicidal ideation can be stopped with proper treatment,

whenever a patient desires an early death, it is essential to always keep depression in mind and to evaluate the patient's decision-making ability.

A younger age, a past history of mood disorder, a history of alcohol dependence, low social support, a poor physical condition, and inadequate pain control have been implicated as risk factors for depression in cancer patients [20].

In addition, caution is also necessary with regard to the fact that depression is sometimes induced as a side effect of drugs that are used to treat physical illnesses [21]. Associations with depression have also been pointed out for some β-adrenergic antagonists and benzodiazepines as well as some anticancer drugs, including vincristine and asparaginase. Steroids are widely used to treat brain edema caused by brain metastasis and for malaise and nausea, but they are known to be possible causes of depression.

A variety of questionnaires and rating scales have become available as ways to conveniently screen for depression, and these tools have a high utility value as indicators of the presence of depression in cancer patients. However, prior to the use of these tools, healthcare providers must first take an interest in their patients' psychological distress and discuss the matter with their patients. When Chochinov et al. [22] used a 13-item short version of the depression screening scale and inquired about only a depressed mood in a study of 197 terminal-stage cancer patients, they reported that asking, "How are you feeling? Aren't you feeling depressed?" was the most useful way of screening for depression. When healthcare providers are standing in front of a patient, after inquiring "How are you?" the healthcare provider can easily ask an additional question, "How are you feeling?" without imposing any great burden on everyday clinical practice, and this additional question seems to be a convenient and effective way of not overlooking depression that healthcare providers can implement immediately.

As a general rule, depression is treated with drug therapy, primarily with antidepressants, and although it takes 1-2 weeks for them to take effect, these drugs are very effective in many cases. In the past, thirst and constipation were frequent side effects, but antidepressants with fewer side effects have been recently developed, and it seems possible to utilize them effectively. Nevertheless, the fact that some antidepressants inhibit the metabolism of anticancer drugs and affect their blood concentrations needs to be kept in mind when using them concomitantly. However, as stated above, the most important point is to evaluate accurately whether the patient is in a depressed state.

3. Delirium

Delirium is an organic mental disorder that is often seen during the early stage of cancer therapy or from an advanced to terminal stage, and it is a "consciousness" disorder that is accompanied by cognitive disorders such as psychomotor excitation manifesting as a mild clouding of consciousness, delusions, and hallucinations. Because cognition is impaired, a wide variety of accompanying psychological symptoms may develop. Classical cases of delirium are characterized by an abrupt onset of symptoms and diurnal fluctuations in symptoms (especially symptoms becoming worse during the night), as well as difficulty in focusing and maintaining attention. Sometimes, psychiatric departments are frequently

consulted, and the nature of the requests is a failure to cooperate with treatment, negativity, and suspicion of dementia. The prevalence of delirium increases as the patients' physical conditions deteriorate and they reach a stage [23], and an overall prevalence of 4%-27% has been reported for all stages.

Several hypotheses, including impaired neurotransmitter metabolism in the brain and an impaired sleep-wakefulness mechanism, have been proposed with regard to the pathogenetic mechanism of delirium, but nothing definite is known. The causes of delirium in cancer patients consist of direct causes, such as cancer metastasis to the brain, and indirect causes caused by electrolyte abnormalities (caution is particularly necessary in regard to hypercalcemia secondary to bone metastasis), the side effects of drugs (drug-induced delirium is relatively common and is seen with narcotic analgesics, such as morphine, and drugs that have an anticholinergic action) or irradiation, and in association with multi-organ failure, infection, changes in nutritional status, etc., the incidences of which increase as a terminal stage is reached;, however, indirect causes are by far more common. Drug-induced delirium is relatively frequent and is seen with narcotic analgesics, such as morphine, and drugs that have an anticholinergic action.

An examination of the causes of delirium according to disease stage showed that single factors based on treatment (surgery, chemotherapy, etc.) are more common during stages when the patients' conditions are relatively good and that multiple factors tend to be involved in the terminal stage. Bruera et al. [23] conducted a study of the causes of delirium in terminal-stage cancer patients using peripheral blood biochemistry tests, CT examinations of the brain, and arterial blood gas analyses and reported that the cause was unknown in 56% of the cases. The factors identified were, listed in order starting with the most frequent,: drugs, sepsis, brain metastasis, hepatic or renal failure, hypercalcemia, and hyponatremia. They reported that the results showed that two thirds of the patients with a cognitive disorder died later without recovering and that the other third recovered before they died. A variety of factors in the etiology of delirium have often accumulated in terminal patients, making it difficult to identify a cause and to treat the condition.

The basic approach to treatment is to determine the cause of the delirium, and then to eliminate the cause. However, it is important to distinguish between whether recovery in response to treatment is possible or would be difficult and to decide upon an appropriate care goal (Table 4). A variety of factors in the etiology of delirium have often accumulated in terminal patients, and the identification of a cause and subsequent treatment are often difficult. When intense excitement is present or when the delirium interferes with everyday living as a result of hallucinations, delusions, etc., symptomatic drug therapy, including treatment with antipsychotic drugs, is often performed. In principle, drug therapy is the same as for the usual treatment of delirium: (1) benzodiazepine monotherapy is not used, (2) antiparkinsonian drugs are not used in combination, and (3) multiple drug combinations are not used. Table 5 contains points that should be kept in mind with regard to adverse events when using psychotropic drugs to treat cancer patients. Moreover, modifications of the patient's environment, family support, and the support and education of the staff of the hospital unit are also needed, in addition to the above.

	Possible to recover	Difficult to recover
Typical cause	Electrolyte imbalance	Organ failure
Goal of care	Drug	Brain metastasis
Drug therapy	Anemia	Relief of delirium symptoms
Content of care	Inflammatory reaction	Antipsychotic drug,
	Recovery from delirium	Benzodiazepine is used in combination, as
	Antipsychotic drug,	appropriate.
	Benzodiazepine is used at a minimum.	Relief of restlessness or agitation
	Recovery from delirium	Maintenance of sleep
	Correction of daily living rhythms	Care of families
	Care of families	

Table 4. Delirium causes for which recovery in response to treatment is possible or difficult

	Points to be paid attention to
Extrapyramidal symptom	Antiemetic with dopamine receptor antagonistic action (e.g., metoclopramide) is
Anticholinergic effect	often administered antecedently.
Hepatic dysfunction	Adverse effects of morphine (dry mouth, constipation, dysuria, sleepiness) are
Malignant syndrome	aggravated.
	In case of under administration of anticancer agents or liver metastasis.
	In case of the poor general conditions.

Table 5. Points regarding adverse events during the use of psychotropic drugs to treat cancer patients

4. Communication skills

Nothing is more important to the process of conveying bad news and obtaining informed consent than that healthcare providers strive for good communication with the patient and the patient's family. Good communication is said to have a favorable impact on physical and mental health, such as helping patients to cope with their disease, improving compliance, and bringing about the control of blood pressure and blood glucose levels, as well as pain control, and as a result of achieving a strong trusting relationship with their healthcare provider, patients are willing to engage actively in their treatment, increasing its therapeutic effect. [24]. Moreover, forging good relationships with patients also reportedly decreases the risk of burn out by healthcare providers [25]. However, in reality, training in communication skills and support skills is seldom provided, and as a result, many healthcare providers are thought to experience stress because they have not acquired adequate skills.

Against this background, a training program designed to improve communication skills was conducted in the United Kingdom with 178 highly experienced oncologists as the subjects [26]. When the physicians were the subjects of the evaluation, the results reportedly showed that the physicians were able to gain self-confidence with regard to communication, and had

become able to engage in patient-centered communication, including directing their attention to patients' psychosocial aspects. This study was the first of its kind, and it was followed by the start of a succession of studies regarding the effectiveness of communication skills training (CST). The effects of CST interventions for health care professionals have been compiled and analyzed in several systematic reviews across recent decades [27-30]. These reviews have consistently concluded that CST leads to better communication behaviors among clinicians [28, 30]. A recent meta-analysis of 13 studies reported a moderate effect size of 0.54 (Cohen's d) for the impact of CST on the communication behaviors of oncology clinicians [30]. However, on the other hand, Kissane et al. [31] pointed out in the most recent review article that outcomes impacting patient satisfaction, improved adaptation, and enhanced quality of life are still lacking, and that patient benefits, such as increased treatment adherence and enhanced adaption, need to be demonstrated from CST.

Thus, evaluations of training in communication skills have not yet led to any definite conclusions, but an education system and a curriculum designed to improve communication skills is definitely needed in the near future. Bad news must often be conveyed, particularly in cancer care settings, and the acquisition of such skills by healthcare providers seems to be absolutely essential.

5. Conclusion

Based on the characteristics of colorectal cancer patients, the forms of psychological distress that are said to often be encountered in cancer care settings and to require evaluation and management from the standpoint of a psychiatrist have been summarized. The necessary communication skills, which are one of the skill sets that must be acquired to engage in cancer care, have also been described. However, the people who are closely involved with such psychosocial aspects and need such skills to deal with patients in actual clinical settings are typically the attending physicians, who are oncologists, and allied healthcare professionals, rather than psychiatrists. Thus, it is paramount that all healthcare providers involved in the care of cancer patients become proficient in communication skills so that they may interact with patients and their families and so that they may always aim to provide medical care with patients' psychological aspects in mind.

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