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<th>PowerPoint Slides</th>
<th>English Text</th>
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<tbody>
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<td>Psychosocial Impact of Breast Cancer Hoping and Coping Video Transcript</td>
<td>الأثر النفسي الاجتماعي لسرطان الثدي غرس الامل وتجاوز المحن</td>
<td>التعليم المهني في علم الأورام الأثر النفسي الاجتماعي لسرطان الثدي غرس الامل وتجاوز المحن</td>
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<tr>
<td>Professional Oncology Education Psychosocial Impact of Breast Cancer Hoping and Coping Time: 49:03</td>
<td>لاكشمي راي نايك، مساعدة طبية، أخصائي اجتماعية أكلينيكية مختصة مدير مساعدة قسم الخدمة الاجتماعية مركز &quot;إم دي أندرسون&quot; لسرطان التابع لجامعة تكساس</td>
<td>اهلاً، أنا لاكشمي نايك، المديرة المساعدة بقسم الخدمة الاجتماعية في مركز إم دي أندرسون للسرطان. سأتحدث اليوم عن الأثر النفسي الاجتماعي للسرطان وكيفية غرس الامل وتجاوز المحن.</td>
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<td>Lakshmi Rai Naik, MA, LCSW Assistant Director Department of Social Work The University of Texas MD Anderson Cancer Center</td>
<td>Hi, I am Lakshmi Naik, an Assistant Director in the Department of Social Work at MD Anderson Cancer Center. Today, I will be speaking about the psychosocial impact of breast cancer, hoping and coping.</td>
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### Psychosocial Impact of Breast Cancer - Hoping and Coping

#### Objectives

- To understand the psychosocial impact of breast cancer
- To more effectively meet the emotional and relationship needs of patients with breast cancer by integrating psychosocial assessments and interventions as part of the treatment and follow-up process; to gain a better understanding about the possible resources among various professionals and staff; and to increase awareness amongst medical teams of the process for assessment, tools used and how to direct referrals.

The objectives of this presentation are: to first understand the psychosocial impact of breast cancer; to more effectively meet the emotional and relationship needs of patients with breast cancer by integrating psychosocial assessments and interventions as part of the treatment and follow-up process; to gain a better understanding about the possible resources among various professionals and staff; and to increase awareness amongst medical teams of the process for assessment, some of the tools we use, and how to direct referrals.

According to the MD Anderson Strategic Vision, Strategy 1.4 states, “We will continue to enhance the patient experience by providing counseling, compassion, and hope in a supportive environment” by meeting “every patient’s emotional needs that will be assessed and identified, providing referrals to the appropriate psychosocial services throughout the entire spectrum of care at MD Anderson Cancer Center.”

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### Psychosocial Impact of Breast Cancer - Hoping and Coping

#### MD Anderson Cancer Center Goals and Strategies for Future Achievement 2005-2010

- Strategy 1.4: “We will continue to enhance the patient experience by providing counseling, compassion, and hope in a supportive environment”
- Vision: “Every patient’s emotional needs are assessed and identified providing referrals to the appropriate psychosocial service throughout the entire spectrum of care at MD Anderson Cancer Center”

The objectives of this presentation are: to first understand the psychosocial impact of breast cancer; to more effectively meet the emotional and relationship needs of patients with breast cancer by integrating psychosocial assessments and interventions as part of the treatment and follow-up process; to gain a better understanding about the possible resources among various professionals and staff; and to increase awareness amongst medical teams of the process for assessment, tools used and how to direct referrals.

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Dr. Louis Lasagna in 1964 stated, "I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the patient’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick."

And so our goal is to look at the cancer patient in relation with the patient’s environment; treating the whole patient’s physical health, spiritual health, emotional health, psychological functioning in the cultural and social context of his life.
So, what do we mean and how do we define psychosocial health services? The Institute of Medicine of the United States brought out a report in 2008 titled: Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs, where they say, “Psychosocial health services are psychological and social services and interventions that enable patients, their families and healthcare providers to optimize biomedical health care and to manage the psychological/behavioral and social aspects of illness and its consequences so as to promote better health.”

So, what is the challenge and opportunity? Our challenge, basic, is to understand that psychosocial barriers and emotional health of patients and their family members are as crucial as their medical treatment in the cancer journey. And so, one cannot happen without the other.
How do we meet this challenge? We meet this challenge by providing a culture of compassion in which every patient’s emotional concerns related to treatment are acknowledged and supported by everyone in the institution. We have started several initiatives to assist with this: The Psychosocial Council, The Relationship Centered Care Model, The Customer Service Initiative, The Culture of Caring, and The Cancer Survivorship Initiative. To also increase the knowledge about various professional psychosocial resources within the institution; a lot of times there are a lot of services that happen within an institution, but professionals, the physicians, the nurses, the medical teams, are not always aware of these supportive services and how patients can be connected to them. Providing timely referrals to these psychosocial professionals, so an oncologist is looking at a patient, looking at the disease status, looking at the chemotherapy to be started, the patient is in great pain, the patient has a lot of fatigue, has nausea, has vomiting. A lot of these problems may be address right away, but the patient’s other problems, which may include emotional pain, the fear, the anxiety, the panic, the family caregiver issues, the financial, the social, and the cultural context, are not always specifically addressed.
And so, the framework of our care for addressing the psychosocial aspects of a patient’s care are, basically, to identify, to assess: what are the distress points and levels of concerns for these patients? How do we link these patients with services? How do we support them? How do we coordinate this? And how do we follow? Most essential elements, communication, education, and research. And more importantly, we must be able to match these with adequate staffing, immediate response, and effective delivery.

This process framework must be so well synchronized to bring out the most effective outcomes. This efficacy of balance between need and response; between service and delivery; expectation and experience, is what will define the quality of our care to our cancer patients.

And, on that note, if the framework of our care for addressing the psychosocial aspects of a patient’s care are, basically, to identify, to assess: what are the distress points and levels of concerns for these patients? How do we link these patients with services? How do we support them? How do we coordinate this? And how do we follow? Most essential elements, communication, education, and research. And more importantly, we must be able to match these with adequate staffing, immediate response, and effective delivery.

This process framework must be so well synchronized to bring out the most effective outcomes. This efficacy of balance between need and response; between service and delivery; expectation and experience, is what will define the quality of our care to our cancer patients.
The continuum of care is very long with cancer patients and their treatment. From the point a patient is diagnosed to the patient’s treatments, or when a patient goes into remission, comes back with remission sometimes, the disease gets progressive or if the patient is in the end stages of disease. At each stage, the psychosocial aspect of the patient’s care must be a part of their medical care for us to have the most effective outcomes.

We need to walk the talk and we know that each and every stage has fear, anxiety, anger. There are financial issues. There are social issues. There are relationship issues. There are caregiver fatigue issues, caregiver burden issues. There is physical pain. There is emotional pain. And not one stage is immune to this fear and anxiety. At each point, we have different levels of distress.

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<td>Start Treatment</td>
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<td>Treatment Ongoing</td>
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<td>Follow-up Treatment</td>
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<td>Recurrence</td>
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<td>Progressive</td>
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<td>Advanced Disease</td>
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- New patient diagnosed
- Treatment
- Remission
- Recurrence
- Progressive
- Advanced disease

Psychosocial care of cancer patients should be an integral part of their medical care and available at all stages of their diagnosis, treatment and survivorship and must occur in a seamless continuous manner.

If a patient goes into remission, comes back with remission sometimes, the disease gets progressive or if the patient is in the end stages of diagnosis, treatment and survivorship and must occur in a seamless continuous manner.
Because we know that barriers lead to frequent crises. There is panic in the system. There is panic in the patient’s family. There is panic with the patient’s psyche. There is lower compliance. The patient does not want to go for treatment because he is afraid of going through an MRI procedure. He says, “I would rather die than go through an MRI”. There are treatment dealings because there has not been sufficient communication. Or the patient has not understood, or the patient does not have the means to get to that test or treatment. This leads to poorer outcomes, increased staff time, higher costs to the system. The patients are less able to use resources and there is poorer quality of life.

So, why are we so interested in looking at the psychosocial impact of cancer on breast cancer patients? Because we know that barriers lead to frequent crises. There is panic in the system. There is panic in the patient’s family. There is panic with the patient’s psyche. There is lower compliance. The patient does not want to go for treatment because he is afraid of going through an MRI procedure. He says, “I would rather die than go through an MRI”. There are treatment dealings because there has not been sufficient communication. Or the patient has not understood, or the patient does not have the means to get to that test or treatment. This leads to poorer outcomes, increased staff time, higher costs to the system. The patients are less able to use resources and there is poorer quality of life.

And so, for us, it is so important to know that cancer patients with different levels of emotional distress will show symptoms and behavior problems that impact their quality of life and their psychosocial function. They eat less, they sleep less, they are noncompliant and they are less vigilant about their disease systems.

• To be non-compliant with cancer therapy, more likely to have cancer treatments delayed or reduced
• To eat and sleep less and have poor self-care
• To be less vigilant about disease symptoms and less able to use proactively those resources that might bring health improvements

Cancer patients with serious depression are more likely:
• To have cancer treatments delayed or reduced
• To eat and sleep less and have poor self-care
• To be less vigilant about disease symptoms and less able to use proactively those resources that might bring health improvements
Patients with compromised immune systems due to depression have been shown to have higher incidence rates of cancer. And this we know from a study by Jimmie Holland and Rowland in 1989. U.S. National Cancer Institute estimates that 25% of cancer patients experience major depression. Now this is a pretty common statistic and we do know that depression and anxiety are highly under-diagnosed in cancer patients.

In a study by Spiegle et al., on 86 patients with metastatic breast cancer who were randomized to receive either routine oncology care, by itself, or routine oncology care with attendance to support groups on a weekly basis for 12 months. The survival time of randomization was significantly higher in the intervention group by almost 100%. That is phenomenal. A number of studies also draw attention to the high levels of distress beyond the period of initial diagnosis.
Goldberg et al. found high levels of anxiety and depression in approximately 25% of breast cancer patients at 12 months following initial diagnosis. And we know that this can extend up to 2 years or even more depending on the traumatic stress disorder that this diagnosis and treatment has imposed on the cancer patients. Again, pain and depression impact each other closely and management of one without the other will not be most effective.

As of 2008, there are about 2.5 million women in the United States who have survived breast cancer. And 1 in 8, about 13%, have breast cancer in the United States. About 40,000 women in the United States were expected to die in 2009 from breast cancer, although the death rates have decreased considerably since 1990. These decreases are thought to be the result of treatment advances, earlier detection through screening and increased awareness.

And we know that, again, at least 25% of patients feel these symptoms even 12 months after initial diagnosis. And we know that this can extend up to 2 or more after diagnosis. Levels of depression and anxiety can also be higher in those patients with advanced disease, with pain being an important contributory factor.


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Pain and depression impact each other closely and management of one without the other will not be most effective.
And again, when we talk about awareness, we want to say awareness amongst the patients, the families, the medical staff, the physicians, the nurses, the social workers, the case managers, the business center people, patient advocates. All of these people being able to work as equal partners in the single goal of providing the most optimum quality of life for our patients. The intensity and duration of a patient’s emotional discomfort or pain can be sometimes more crippling than the disease itself. I have had patients who have felt this pain, emotional pain that does not allow them to think clearly; does not allow them to want to even go through this treatment anymore even though we have a highly optimistic view of a cure of treatment for their disease. And patients will sometimes say, “Forget it! I do not want to go through this.” And that comes from a sense of deep emotional pain, which has crippled them and we need to do something about it as soon as possible. Patients and families have multiple stressors at different stages of their disease. The intensity can change dramatically at different points in the journey depending on what triggers this patient’s state of mind, and fear or anxiety. There are patients that are terrified by MRI images, patients that are terrified by just seeing the prick of a needle or looking at bandages or smells even. So, emotional comfort is a vital, vital piece of the treatment and significantly enhances a patient’s overall care and also the family’s overall care.
So, while we are hoping and coping, what are we doing? What is the paradigm for helping patients hope and cope while they are on this journey? Their emotional comfort, the communication to the patient

...
Coping with

- Pain, swelling, body changes
- Feeling overwhelmed
- Anxious
- Fearful
- Relationships
- Life changes
- Getting back to “normal”

How do people really cope?

[ ] just can’t take this constant stress anymore not knowing what is going to happen.
[ ] I am going to shoot that doctor. He told me I was going to die!
[ ] I am going to beat this. I am NOT going to die.

So the coordination outside of the institution is different than the coordination within the institution. Has the physician called the PA? Has the physician called the social worker? Has the PA talked with the pharmacist? Has the nurse spoken with the nutritionist? This is coordination of care where everybody is looking at every aspect of the patient’s care. The pain, the feeling overwhelmed, anxiety, fear, life changes and getting back to normal. How do people really cope? “I just cannot take this constant stress anymore not knowing what is going to happen”. There is this constant sense of dread, so how do I stop this dread for my patient? “I am going to shoot that doctor, he told me I was going to die”. Now what brings about a response like this? When a physician has with all good intentions provided the patient with the most correct information as a scientist, and still faces a response that can be as violent and aggressive as this. The reason is that we did not quite understand or gauge the patient’s emotional state at that point. And to be able to break that piece of news, or present that piece of news in a different manner, is the skill we need to pick up. “I am going to beat this; I am not going to die”. So, we have a lot of patients who want to fight, who want to beat it, who are hopeful that they are going to live forever.
How do we manage this expectation? How do we take them along on the continuum from the best to the worst, and from the worst to the best? Patients have questions all the time. “How do I tell my daughter I am sick?” “Where can I talk to other cancer patients about treatment?” “Are the changes in my sex drive normal?” Now how many patients would talk to you about this on a daily basis unless you really ask them? And sometimes, even if you ask them, they are not going to tell you. So, what kind of skills do we need to get an understanding for some of these issues and are these issues important? Absolutely, because that impacts the patient’s quality of life. “What if I cannot afford these expenses?” “What things should I tell my family?”

“Am I supposed to feel sad all the time?” “Why do my husband and I fight so much?” “Our relationships have changed and some things have gotten worse.” What if someone is abusing? “What does hospice mean?” “I do not have anything like hospice in my country or in the city where I live.” “Is that another hospital?” “Is that another service?” “What if I lose my job?”

How can I manage this? “How do I make sure I will not be kept alive by a machine?” “Am I supposed to feel sad all the time?” “Why do my husband and I fight so much?” “Our relationships have changed and some things have gotten worse.” What if someone is abusing? “What does hospice mean?” “I do not have anything like hospice in my country or in the city where I live.” “Is that another hospital?” “Is that another service?” “What if I lose my job?”

How can I tell my family? “I do not want my wife going crazy and jumping off the roof because I have this diagnosis because that is not going to help.” “How can I manage this?” “How do I make sure I will not be kept alive by a machine?” “Am I supposed to feel sad all the time?” “Why do my husband and I fight so much?” “Our relationships have changed and some things have gotten worse.” What if someone is abusing? “What does hospice mean?” “I do not have anything like hospice in my country or in the city where I live.” “Is that another hospital?” “Is that another service?” “What if I lose my job?”

How do I tell my daughter I am sick?
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What if I can’t afford the expenses?
What things should I tell my family?
“What are my alternatives to manage this disease” and “what am I hoping all the time?” The patient is saying, “I hope to feel better” because most patients come with a hope that they will be cured. And again it is up to the professional to be able to navigate through this and manage that expectation in a very tactful manner, where we are looking at cancer as a more chronic illness, where there is no cure, so to speak, for diseases like diabetes, And so cancer, in much the same way, may be a long-term phenomenon with no actual cure, but maybe remission, maybe stabilization of disease. And maybe we can say that this disease will never come back for the next 10 to 15 to 20 years or over the lifetime. But again, it is about managing expectations where patients are able to move along the continuum of care with much more comfort. To focus on the possibilities of what can happen in a positive direction. Lead a healthier, more meaningful life, even in the face of a terminal nature of any type of disease, if it is terminal. Strengthen body and mind. Take charge. Help the patient if the patient wants to take charge, be in control. And so, always being told do this, do not do that, eat this, must have this, can wear a patient down and make him feel like he has lost control. Build connections with survivors, counselors. Set new goals. Adjust to a new normal.
Another very important aspect which we sometimes tend to forget is that we are more focused on the disease itself and curing that disease, but the patient feels as if sometimes even more by the patient's family and caregivers. The shock of the disease and the physical change that is happening to the patient, feels equally or sometimes even more by the patient, is felt equally or sometimes even more by the patient's family and caregivers. This cancer has given me a new perspective on life. This cancer has given me a new perspective on life. **Some patients will say that whereas some patients will say, I am going to try and live a normal life even though so much has changed. I am going to try and live a normal life even though so much has changed.** And so we have got to be able to gauge, where is this patient in that journey of coping and hoping?
patients have gone undiagnosed, with cancer or some other serious illnesses, because they did not want to impose further stress on the spouse. The fear of losing a partner and, “What am I going to do next, I cannot live without my spouse or without my partner.” “What kind of resources are there and how will I cope with this whole thing.” Says a survivor, “The support of my family has truly helped me to better cope with the challenges I have faced after my cancer diagnosis.”

It is unpredictable. It is a roller coaster. There is no point in time where a physician can truly say, “Hey, you are going to live forever,” or, “You are going to live for 20 years,” because none of us is a God. However, we all do know that there are ups and downs in every phase of life, and with cancer, it is even more unpredictable. And all we can do is strengthen these patients along their roller coaster journey and make sure we are able to pick them up when they fall off the coaster.
### Psychosocial Impact of Breast Cancer - Hoping and Coping

**A Comprehensive Approach**

- Psychosocial assessments
- Psychosocial counseling and cognitive behavioral interventions
- Transition planning
- Education and referral
- Advocacy
- Program development, monitoring and follow-up

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“*I’ve been touched by the smallest gestures, a squeeze of the hand, a gentle touch, or a reassuring word. In some ways, these quiet acts of humanity have felt more healing than the high-dose radiation and chemotherapy that hold the hope of a cure.*” Kenneth Schwartz said this.

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So, at the end of the day, what we want to look at, is a comprehensive approach institution-wide, wherever this institution may be, wherever cancer care is being provided, to make sure that we have a comprehensive approach towards cancer care, in that, other than the medical assessments and the treatments, that we are on a parallel front, dealing with the psychosocial aspect of a patient’s care. Which means psychosocial assessments, counseling and cognitive behavioral interventions, transition planning, education and referral, advocacy, program development, monitoring and follow-up.
Psychosocial Impact of Breast Cancer - Hoping and Coping

Tools for Psychosocial Assessment

Identification of barriers and stressors, which impact patient and family coping and/or compliance with treatment must be done in a systematic manner.

- Screening should be routinely established
- Depression in the terminally ill should be treated as vigorously as for those patients with a better prognosis
- All staff should have basic skills to determine if there is any suicidal risk so patients may be managed

So what are some of the tools for psychosocial assessment? At MD Anderson, we have several ways to identify barriers and stressors that impact a patient at family coping or compliance. We may have a patient who is highly compliant, but there may be a family member who has a mood disorder or a family member who is completely stressed out, burnt out and fatigued, and may not be willing to comply with the treatment plan or even be supportive of the patient or the medical team.

A lot of our discharges get held up because patient’s family members do not think that it is the right time for discharge or are not ready for the patient to be taken home, because they are afraid of how to care for the patient. Screening should be routinely established. Depression in the terminally ill should be treated as vigorously as for those patients with a better prognosis. So we are looking at screening at all levels, from the point of diagnosis to the end of treatment, at the point of progressive disease and advanced disease. And all staff must have the basic skills to determine if there is any suicidal risk so patients may be managed and be able to refer these patients very quickly to the department of professionals within the institutions that handle these issues.
The National Cancer Comprehensive Network of the United States came up with a very, very valuable assessment tool for patient distress. This simple tool looks at four dimensions of patient care. Those dimensions are the practical concerns, the family concerns, emotional concerns, and the physical concerns encompassing the entire patient, which then gives us an idea for the patient’s distress level on a scale of 1-10. And, if the patient tells me that he is feeling suicidal, or he is feeling sad, or he is concerned about his sexual functioning on a scale of 1-10, his distress level is 6. Then that tells me something about where I need to start with this patient and where I need to go with this patient.

So again, psychosocial assessment varies by provider, the type of screening tools they use, emotional states of patients at different points of assessment, and the reporting structure.
### Psychosocial Impact of Breast Cancer - Hoping and Coping

#### Patients at Increased Risk for Distress

- History of psychiatric disorder/substance abuse
- History of depression/suicide
- Cognitive impairment
- Communication barriers
- Severe comorbid illnesses
- Family/caregiver conflicts
- Inadequate social support

### Patients at Increased Risk for Distress (continued)

- Living alone
- Financial problems
- Limited access to medical care
- Young or dependent children
- Spiritual/religious concerns
- Social problems

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**History of psychiatric illness, history of depression, suicide, cognitive impairment, communication barriers, severe comorbid illnesses, like diabetes or hypertension or bipolar disorder or AIDS, all of these will put the patient at increased risk for distress and more so the inadequate social support of a patient’s circumstances can impact the patient’s distress level very highly.**

Again, patients living alone, how many times and how often have we had patients being dropped at our doorstep who have no family, no friends, nobody wants them back home, or they are so tired taking care of the patient that they think it is the hospital’s duty to take care of this patient. Patients with financial problems, limited access to medical care, they are living in remote locations and areas and want to be closer to the hospital, they have young and dependent children, spiritual religious concerns as well as social problems. And how do we help these patients? These are the patients at increased risk for distress, but which are these patients? Who are these patients and how can you tell?
### Psychosocial Impact of Breast Cancer - Hoping and Coping

#### Periods of Increased Vulnerability

- Finding a suspicious symptom
- During workup
- Finding out the diagnosis
- Awaiting treatment
- Change in treatment modality
- End of treatment
- Discharge from hospital following treatment

Again, when a patient finds a suspicious symptom after treatment and feels that, “Oh, gosh, my disease is coming back, I am not going to through this again and I am not going back.” Or patients during work-up get into panic bouts where they feel, “Well you know I am feeling really sick, my hair is falling off and I think probably this is not a good sign. I might as well go home instead of spending so much money on this treatment and save up all my bucks for my family.” Finding out about the diagnosis: this is a pivotal moment in the life of any cancer patient is finding out about the diagnosis. Almost feels like a death warrant to many. Then awaiting treatment, anxiety of awaiting treatment, [you know] “What kind of treatment? How long will this treatment go on?” “What kind of side effects are going to happen?” “How can I cope with this?” Change in treatment modalities, okay, so we finished Herceptin, now we are going to do Taxol and then we are going to go and do radiation, or we are going to do surgery. “When is this treatment ever going to end and what does the end of treatment mean? “Is that the end of chemotherapy and the start of radiation or the beginning of immunotherapy?” “What does treatment itself mean?” “What is the difference between acute treatment and palliative treatment?” Discharge from hospital following treatment? Patients do not understand the differences between transition -- between transition points, being in the hospital, being discharged from the hospital, going to a nursing home or to a hospice.
### Psychosocial Impact of Breast Cancer - Hoping and Coping

**Periods of Increased Vulnerability (continued)**

- Stresses of survivorship
- Medical follow-up and surveillance
- Treatment failure
- Recurrence/progression
- Advanced cancer
- End of life

### Psychosocial Impact of Breast Cancer - Hoping and Coping

**Patient Needs Assessment or ePNA**

A patient needs assessment screen to review the various dimensions of a patient’s care i.e. psychosocial, nutrition, spirituality, etc.

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Periods of increased vulnerability, again, could include stresses of survivorship for patients who survived their cancer, who have now been treated, their disease is in remission, but they still need to go back to a normal life. They still need to pick up the pieces where they left off. They need to have medical follow-up and surveillance. They need to understand that, if there is recurrence or progression, they need to come back, and who do they need to come back to? Again, how are they going to deal with advanced cancer issues, end of life issues?

At MD Anderson, we have what is called a Patient Needs Assessment, which, a patient—when the patient comes into the hospital or as an outpatient, the patient fills out a self-assessment about their own needs that are on a form, which are sectioned, or categorized into different sections. And so, when a patient decides that he is feeling a stress level from 1 to 10, of 6 or 5 or 4, he will indicate that on this form. When he does that, that referral is kicked out to social work to assess for psychosocial distress. If a patient says that they are not eating well, they need some nutrition consult, then the section on nutrition is checked off and the referral is kicked off to nutrition. If the patient has problems with mobility and needs physical therapy, or the patient has problems with bowel management, all of these sections deal with these problems separately and referrals are kicked out to the different disciplines to assess the patients further and meet their needs quickly.
So there are different psychosocial needs and different strategies for each psychosocial need. Whether it is the understanding of the illness, treatments and services. And this is not just for patients, but also for the patients and their families. Coping with emotions, managing illness, how to manage this illness both at the hospital and at home. There are a lot of behavioral changes in patients. Some of them become quite obsessive sometimes. The families become overanxious sometimes. And that can have a very dynamic effect on both sides, including the providers. We do have patients sometimes who will not listen to any advice or instruction because they are not emotionally comfortable. And how do I get this patient there?

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<tr>
<td>Understanding of illness, treatment, and services</td>
<td>Strategies to improve patient-provider communication</td>
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<td>Coping with emotions surrounding illness and treatment</td>
<td>Peer support groups, counseling/psychotherapy, pharmacological management of symptoms</td>
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<td>Managing illness and health</td>
<td>Comprehensive self-management/self-care programs</td>
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<tr>
<td>Behavioral change to minimize disease impact</td>
<td>Behavioral/health promotion interventions such as smoking cessation help, patient education</td>
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<tr>
<td>Managing disruptions in work, school and family life</td>
<td>Family and caregiver education, assistance with activities of daily living (ADLs)</td>
</tr>
<tr>
<td>Financial assistance</td>
<td>Financial planning, insurance counseling, eligibility assessment for social security disability income</td>
</tr>
</tbody>
</table>

So, patients with breast cancer again have the same problems. We are constantly dealing with crisis intervention: a patient who is in a panic bout, has major issues adjusting to the diagnosis, cannot cope with the idea of maybe a surgery, radiation treatment, the side effects of fatigue, body image, grief and loss, the fear of death and dying. And so we try to provide services with counseling, the transitions of care, and patient protection or patient safety.

لا تفوتني أي الحاجة الاجتماعية المختلفة، وذلك أيضاً استراتيجيات مختلفة لكل احتياجات نفسية اجتماعية مختلفة، وذلك أيضاً استراتيجيات مختلفة للتعامل مع العواطف وإدارة المرضى، أي كيفية إدارة المرضى في كل من المستشفى والمنزل. تحدث الكثير من التغييرات السلوكية لدى المرضى. فالمرض يصبح موسعاً في بعض الأحيان، والأمر قد يصبح مركلاً في أحيان أخرى. ويمكن أن يعترض ذلك على كلا الطرفين تشنجاً، بما في ذلك مقدم الخدمات. لقد أظهرنا في بعض الأحيان المرضى للاستعون إلى أي مساعدة أو تعليمات؛ لأنهم لم يستعندوا بالراحة الوجدانية. وكيف لي أن أوصي المريض إلى تلك الراحة؟

حسناً، المرضى بسرطان الذي يعاني من المشاكل نفسها. ونحن نتعامل بصفة مستمرة مع إجراء التشخيص لحالات الأمراض؛ فالمريض تتناجي نهاية هلع، ويبحث عن مساعدة كبيرة في التكيف مع التحدي، ولا يمكنه التعامل مع فكرة إجراء جراحة، أو التجاعيد، أو الأثار الجانبية للجراحة، أو مصروف الجسد، أو الأشياء الصغيرة، أو الخوف من الموت، أو الموت. ومن ثم نحاول تقديم الخدمات على طرق المشورة، وتقليلات الإجهاد، وحماية المريض، أو سلامة المريض.
There are different types of counseling and there are different specialists for the different types of counseling. And so we must be very aware of who is the right professional or staff that can do the most effective piece of counseling for the different issues: adjustment to diagnosis, crisis intervention, communicating with the team, making treatment decisions, helping the family and caregiver to be more supportive, empowering them, discussing end of life issues. And discussing end of life issues, there is the point where the physician says, “Okay, we are at the point where the disease is so advanced, terminal nature of disease, the prognosis is less than a few months,” that is discussing end of life in terms of providing the prognosis. However, there is much more to that. There is more to discussing the end of life in terms of, “Okay, so we are at a point here and let us look at what our goals are from this point onwards. Is this quality of life? Do we want more treatment? What would be the impact of that? Where would you like to be at this point? How would you like to be planned?” The different mental health resources within the institution and outside.

Now, there are also other concrete resources, which are equally important and that address the practical concerns of a patient’s day-to-day treatment journey, and that is: housing, transportation, financial assistance, pharmacy, education, documents. These are not small issues.
A patient came in for cancer treatment, was told what the estimated bill would be, this patient was self-pay. Patient paid up a certain bill as a deposit and then was told that he can go in for a couple of consults. The patient went for consults, went and checked on his bill. The amount that he had deposited was almost now down to half. The patient was shocked and the reason being that the patient had not been adequately informed or provided the information about what happens at each stage. The patient said, “Hey, I have been here only for two consults and one test or two tests and the bill is so much.” Well, all the rates were then provided to the patient and he finally understood where his money had gone, and how quickly the money can go, and what we need to do to make sure that he is still able to continue his treatment. So, now at MD Anderson Cancer Center we have several departments that help with psychosocial support services and each area has its area of expert professionals who work with patients to resolve psychosocial concerns and issues.

The Department of Social Work provides individual and group counseling that identify and counsel high-risk patients and families, provide crisis intervention, and help with adjustment to diagnosis and treatment. They help with transitions of care. So if a patient is going into hospice, just to tell the patient, “Oh you know I am going to get you connected to hospice,” means nothing. But to be able to explain to the patient what hospice can do, how will it help the patient in the long run, what does it actually mean, and making the patient feel completely comfortable about this new transition to care, because, if do not that, the patient is going to come right back through our emergency center and not have the quality of life that they have got otherwise. Protection issues like guardianship, and parental rights are also discussed. If there are any other circumstances that require our help then we will be able to help.}

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Psychosocial Impact of Breast Cancer - Hoping and Coping

The Place of Wellness

- Integrative medicine consultation
- Acupuncture
- Massage
- Individual and group counseling
- Support groups
- Expressive therapies (art, music)
- Movement therapies (yoga, tai chi, pilates)
- Nutrition groups and consultation
- Relaxation techniques
- Complementary

We have The Place of Wellness that helps patients with integrative medicine consultation. They have acupuncture. They have massage. They have individual and group counseling, support groups, expressive therapies like art and music. There is yoga, tai chi, nutrition groups, relaxation exercises and complementary medicine consults that give patients another alternative to the cancer treatments, or complements the cancer treatments that they are undergoing currently.

abuse, domestic violence, exploitation. A lot of cancer patients do have issues with being exploited or abused, not because there are actually abusers in the home, but because the caregivers are completely burdened and overwhelmed and are not able to cope with the situation themselves. Resources for housing, transportation and practical quality of life concerns, custodial and provider services information. This is very, very important because patients, -- this is the first time they have been hit with something like this. They have no idea of where to start, where to go and what to do. And advanced care planning in terms of, "Okay, so this might take another six months to a year, or two years or five years. Let’s look at what we want to do; what are the different things that could happen and how do we want to proceed in a planned manner?"

السك، والانتقادات، والشكاوى العملية المتعلقة بنوعية الحياة، ومعلومات عن الخدمات الوصائية، وخدمات السوق. هذا الأمر مهم للغاية، حيث أنه لم يسبق للمرضى المرور بتجربة مماثلة من قبل. وليس عددهم أدويَّة، من اين يذهبون، وانما يفطنون. والتخطيط المقدم للرعاية على نحو مثل "حسنًا، قد يستغرق الأمر ستة أشهر أخرى، أو عام، أو عامين، أو خمسة. لنر ما الذي يمكننا عمله: ما هي الأمور المختلفة التي يمكن أن تقع، وكيف يمكن التصرف عليها بطريقة منظمة؟"
<table>
<thead>
<tr>
<th>Psychosocial Impact of Breast Cancer - Hoping and Coping</th>
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</thead>
<tbody>
<tr>
<td><strong>Psychiatry</strong></td>
</tr>
<tr>
<td>• Counseling for individuals, caregivers, couples and children</td>
</tr>
<tr>
<td>• Medication management for psychiatric disorders</td>
</tr>
<tr>
<td>• Treatment for sexual dysfunction and substance dependence</td>
</tr>
<tr>
<td>• Physician referral required</td>
</tr>
</tbody>
</table>

Also Psychiatry helps with medication management for psychiatric disorders while providing counseling for individuals, caregivers, couples and children. They also help with the treatment of sexual dysfunction and substance dependence.

<table>
<thead>
<tr>
<th>Psychosocial Impact of Breast Cancer - Hoping and Coping</th>
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</thead>
<tbody>
<tr>
<td><strong>Chaplaincy</strong></td>
</tr>
<tr>
<td>• Spiritual support to all patients, family members and staff</td>
</tr>
<tr>
<td>• Spiritual support for all faith traditions</td>
</tr>
<tr>
<td>• Visits from a particular religion upon request</td>
</tr>
</tbody>
</table>

Chaplaincy is a wonderful department at MD Anderson that helps with spiritual support to all our patients and family members. And this support is provided for people from all faith traditions.

كما يساعد أيضا قسم الطب النفسي في تنظيم أدوية الاضطرابات النفسية إلى جانب تقديم المشورة للأفراد ومقدمي الرعاية والأزواج والأطفال. كما يساعد أيضا في علاج خلل الأداء الجنسي وإدمان المواد.

ويعتبر قسم الخدمات الكنسية أحد الأقسام المتميزة في إم دي أندرسون حيث يساعد على تقديم الدعم الروحي للمرضى وأسرهم.
**Psychosocial Impact of Breast Cancer - Hoping and Coping**

**Anderson Network**

- Connects patients with patients
- Two hospitality centers
- Patient/caregiver telephone line
- Pediatric caregiver telephone support network
- Annual patient/caregiver conference
- Weekly educational presentations (PiKNC)
- Adult patient camp and day trips (camp carefree and day away)
- Community outreach programs
- Online support: Cancer Survivor Message Board, WarmNet, Ask the Expert

We have what is called The Anderson Network that is a network of patients who have been diagnosed with cancer, treated with cancer, and are part of the MD Anderson family. So this Anderson Network connects one patient to the other. A patient with breast cancer with metastatic disease, Stage 1, might be connected to another patient who has a similar diagnosis, disease has been treated or undergoing treatment, and help the other patient to find some support with emotional, psychological, and cultural issues. There are hospitality centers all around the hospital. There are patient/caregiver telephone lines. They have adult patient camps, community outreach groups and online support groups through The Anderson Network.

**Psychosocial Impact of Breast Cancer - Hoping and Coping**

**Cancer-related Fatigue Clinic**

- Comprehensive evaluation of fatigue
- Patients with or without evidence of cancer
- Physician referral required

We also have a Cancer-related Fatigue Clinic. And we know, we all know that fatigue impacts the quality of life of a patient just like pain, and can, in fact, drive a patient into serious depression. Comprehensive evaluation of fatigue, and again, for patients with or without evidence of cancer, this can be done at our Fatigue Center.
<table>
<thead>
<tr>
<th>Psychosocial Impact of Breast Cancer - Hoping and Coping</th>
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</thead>
<tbody>
<tr>
<td><strong>Child, Adolescent, and Young Adult Psychosocial Outreach Program</strong></td>
</tr>
<tr>
<td>• Child and adolescent life</td>
</tr>
<tr>
<td>• Pediatric psychology and neuropsychology</td>
</tr>
<tr>
<td>• Pediatric education</td>
</tr>
<tr>
<td>• Career and vocational counseling</td>
</tr>
<tr>
<td>• Kim’s Place</td>
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</tbody>
</table>

We also have a Child, Adolescent, and Young Adult Psychosocial Outreach Program for children, adolescents, siblings, parents of children. We have a wonderful place called Kim’s Place where children can go and play games and connect with each other.

<table>
<thead>
<tr>
<th>Psychosocial Impact of Breast Cancer - Hoping and Coping</th>
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</thead>
<tbody>
<tr>
<td><strong>Patient Advocacy</strong></td>
</tr>
<tr>
<td>• Complaints</td>
</tr>
<tr>
<td>• Unresolved issues</td>
</tr>
<tr>
<td>• Questions about MD Anderson</td>
</tr>
<tr>
<td>• Resources and services</td>
</tr>
</tbody>
</table>

Patient Advocacy helps with patient complaints regarding, maybe wait times. Maybe they do not like the way someone has spoken to them, or they are not happy with the billing concerns or issues. Patient advocacy will assist patients and navigate them through the right channels to address their questions and concerns.
We have a wonderful Learning Center that has immense information and updated information on cancer care with every type of cancer, the support, prevention programs, and general health and wellness information.

Our Supportive Care Center assesses and manages physical and emotional symptoms, preventing, minimizing losses of physical functioning, and this is very, very crucial to our patients who have mobility issues.
<table>
<thead>
<tr>
<th>Psychosocial Impact of Breast Cancer - Hoping and Coping</th>
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</thead>
<tbody>
<tr>
<td><strong>Pain Management</strong></td>
</tr>
<tr>
<td>- Comprehensive pain assessment</td>
</tr>
<tr>
<td>- Multidisciplinary pain treatment for inpatients and outpatients</td>
</tr>
<tr>
<td>- Treatment for acute and chronic pain related to cancer</td>
</tr>
<tr>
<td>Pain Management, again, we have a superb Pain Management Service that does comprehensive pain assessment and treats acute and chronic pain related to cancer.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial Impact of Breast Cancer - Hoping and Coping</th>
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</thead>
<tbody>
<tr>
<td><strong>Ethics Consultation Service</strong></td>
</tr>
<tr>
<td>- Patients and caregivers who face difficult decisions related to medical treatment or other aspects of care</td>
</tr>
<tr>
<td>- Ethics consultation advisory only</td>
</tr>
<tr>
<td>- Available 24 hours/7 days a week</td>
</tr>
<tr>
<td>- Strictly confidential</td>
</tr>
<tr>
<td>- Free of charge</td>
</tr>
<tr>
<td>Our Ethics Consult Service is available 24 hours, 7 days a week. This is strictly confidential. And patients and caregivers who face difficult decisions related to medical treatment have the privilege of asking for an ethics consult with their providers to be able to make a reasonable decision.</td>
</tr>
</tbody>
</table>

| معالجة الألم، لدينا مرة أخرى، خدمة عالية لمعالجة الألم تجري تقييم شامل للألم وعلاج الألم الحادة والمزمنة المرتبطة بالسرطان. |

| متعارف خدمة الاستشارات الأخلاقية لدينا على مدى 24 ساعة طوال الأسبوع. وهي بالغة السرية. حيث يمكن للمرضى ومقدمي الرعاية الذين يواجهون قرارات صعبة تتلاقى بالعلاج الطبي التمنع بميزة طلب استشارة أخلاقية مع مقدمي الخدمات للتمكن من اتخاذ قرار معقول. |
### Psychosocial Impact of Breast Cancer - Hoping and Coping

#### Neuropsychology and Chemo Brain

Neuropsychologists provide:
- Assessment of cognitive and neurobehavioral symptoms
- Intervention strategies for cognitive and neurobehavioral changes due to cancer, cancer therapy or co-existing problems (MIND Clinic)

We have Neuropsychology and ChemoBrain Clinics that help with assessment of cognitive and neurobehavioral symptoms, which come up with intervention strategies for these patients with chemobrain.

### Psychosocial Impact of Breast Cancer - Hoping and Coping

#### Cancer Prevention

- Comprehensive and site-specific cancer screening
- Risk assessment and risk reduction
- Smoking cessation and programs
- Genetic testing

Also our Cancer Prevention Center that does cancer screening, risk assessment, has smoking cessation programs and genetic testing.

وهي مركز الوقاية من السرطان اختبارات لتحديد السرطان وتقييمه للمخاطر، ولديه برامج للافلام عن التدخين والاختبارات الوراثية.

كما يوجد لدينا فحصات توعية عصبية وعياً الدماغ الكيميائي للمساعدة في تقديم الأعراض المعرفية والعصبية السلوكية التي تظهر مع استراتيجيات الاجراءات التشخيصية المستخدمة مع المرضى الذين يعانون من الدماغ الكيميائي.
<table>
<thead>
<tr>
<th><strong>Psychosocial Impact of Breast Cancer - Hoping and Coping</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Tobacco Treatment</strong></td>
</tr>
<tr>
<td>• Voluntary program</td>
</tr>
<tr>
<td>• Counseling and tobacco-treatment medication to eligible MD Anderson patients</td>
</tr>
<tr>
<td>• In-person behavioral counseling</td>
</tr>
<tr>
<td>• Over-the-counter nicotine replacement</td>
</tr>
<tr>
<td>• Therapies</td>
</tr>
<tr>
<td>• Tobacco-treatment prescription medication</td>
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</table>

Our tobacco treatment is an extremely effective program that helps with patients who want to stop smoking. And this again, they provide behavioral counseling on an individual basis and also provide over-the-counter nicotine replacement therapy.

<table>
<thead>
<tr>
<th><strong>Psychosocial Impact of Breast Cancer - Hoping and Coping</strong></th>
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</thead>
<tbody>
<tr>
<td><strong>Sleep Clinic</strong></td>
</tr>
<tr>
<td>For patients with the following symptoms:</td>
</tr>
<tr>
<td>• Sleep apnea and snoring</td>
</tr>
<tr>
<td>• Restless leg syndrome</td>
</tr>
<tr>
<td>• Insomnia or excessive daytime sleepiness</td>
</tr>
<tr>
<td>• Behavioral sleep disorder</td>
</tr>
</tbody>
</table>

We have a wonderful Sleep Clinic that helps with the sleep apnea, restless leg syndrome, insomnia and behavioral sleep disorders; a lot of counseling, and management of their sleep cycles.
### Psychosocial Impact of Breast Cancer - Hoping and Coping

**Palliative Care and Rehabilitation**

- Assess and manage chronic cancer-related symptoms
- Help patients attain the best possible quality of life
- Physician referral required

Our Palliative Care and Rehabilitation Center assesses and manages chronic cancer-related symptoms. This could be while they are undergoing active cancer treatment, or when they come to the end of their treatment, when they are at the end stages of their disease. This service helps patients obtain the best possible quality of life by coordinating their symptom management between pain and fatigue, emotional, psychological, physical and spiritual. Again, physician referral is required and this service also helps patients understand the difference between symptom management in acute care treatment, and symptom management at the end of treatment where it is mainly palliative and end of life therapy. So, we come to the end of this presentation with the psychosocial support for patients with breast cancer and I do hope that this presentation was useful to you. Thank you for your time and attention.