

Highlights from the Canadian Association of Nurses in Oncology/1'Association canadienne des infirmières en oncologie (CANO/ACIO) Annual Conference Held October 25-28, Montreal, Canada  
**PRESENTED HERE** ▼

## Tending to Patients' Psychosocial Needs an Important Part of Oncology Nursing

**MONTREAL**—Oncology nurses should learn techniques to address their patients' emotional needs—even if it means overcoming their own resistance to engaging patients on this level, according to presenters at the Canadian Association of Nurses in Oncology/1' Association Canadienne des infirmières en oncologie's (CANO/ACIO) 2009 Annual Conference.

Mary Jane Esplen, PhD, RN, noted that patients usually do not require specialized care from mental health professionals, but may have significant difficulties trying to adjust to the treatments and their side effects. Since other healthcare professionals have

little time to discuss various psychosocial issues, patients often look to nurses to assist them with this—even though many do not feel they have the time, confidence, or skill to do so.

"I always tell nurses, 'I know you don't have a lot of time. But it's all of your care—how you walk into a patient's room, your stance, and manner, and whether you directly address patients' expectations and fears surrounding their treatment, and provide some emotional and psychological support that matters,'" explained Dr Esplen.

She has created the de Souza Institute to help fill in this gap in Ontario. The organization provides a range of services, from education on psychosocial aspects of nursing and funding for graduate studies and graduate courses, to support in achieving certification in oncology and palliative or hospice care.

Another presenter, Linda Watson, RN, MN, also stressed the importance of letting patients talk about what they're going through while receiving cancer treatment. Ms Watson has been con-

ducting research on the positive effects of engaging patients in this way, and the negative consequences of not doing so.

"A lot of the time we don't know why we're reacting the way we do," noted Ms Watson, professional practice leader, department of nursing, Tom Baker Cancer Centre, Calgary. "We need to listen and learn from these situations, and ask ourselves, 'What's going on in me that makes me feel like running away and not listening to these people?'"

She admitted that when she was caring for patients, the hardest and most emotionally draining individuals to take care of were those who were her age and, children at home.

"I was terrified that I would end up in their place and not see my kids grow up, not be able to walk them down the aisle," recalled Ms Watson. "But when I moved past that, and saw that I could become a really wise person because of what I was being exposed to, and because of learning to listen and talk to the patients about their personal struggles—that's when I decided to stay in oncology."

### Listening Draws Out Telling

Ms Watson recommended reading an article by Arthur Frank, PhD, a sociology professor at the University of Calgary, "Just listening: Narrative and deep illness" (*Fam Syst Health*, 1998;16[3]:1-19). In the article, Dr Frank describes the 3 main types of stories very ill patients tell.

In the "restitution" story, a person gets sick, is treated, and is restored to health. This is the most comforting story for patients and healthcare providers, according to Dr Frank.

Another is the "chaos" story. In it, the disability increases, the pain never remits, the physicians cannot understand what's wrong with the patient, and the patient's medical problems translate into an array of personal problems.

"These [stories] are the most difficult stories to listen to, because they remind us that the ice we are all skating on is terribly fragile," said Ms Watson. "But patients who tell chaos stories need [to be listened to] in a deep way, first and foremost, as this is in itself therapeutic."



The third type of story is the "quest" story, in which the patient does not romanticize illness but speaks of it as a quest—as a way of offering insight into a new dimension of the human experience, explained Ms Watson.

Research Dr Esplen is conducting is complementary to Ms Watson's, as it addresses the ways patients can learn to validate their own feelings and hence restore their sense of worth and purpose. For example, Dr Esplen is leading a randomized, controlled trial into whether guided imagery or standard care is more helpful for women dealing with body-image issues that often follow breast removal as a result of cancer treatment.

In this trial, women who have completed breast-cancer treatment are randomized for 8 weeks to receive either standard care or a once-weekly, 90-minute session of group support and guided-imagery exercises. Dr Esplen used this approach successfully in an earlier 6-week trial on bulimia (*Psychol Med*, 1998;28[6]:1347-1357). In the guided imagery used in the breast-cancer trial, participating patients learn to imagine how they will look and feel once they have achieved equanimity with respect to having breasts that have been altered in

size or shape or removed altogether. They also learn to focus on other aspects of their identity.

"Women's self image is not being talked about by nurses; they feel they don't have time, and also they can be uncomfortable broaching the topic," said Dr Esplen. "The patients' partners also are uncomfortable discussing it because they're just glad the women are alive... And the women themselves feel they might come across as being vain, so they don't bring it up."

More than 100 women have enrolled in the trial to date. Already a picture is emerging of how difficult this issue is for these patients.

"One of the women said, 'I even carry a picture of what I used to look like in my purse. I've got long blonde hair... I'm having a hard time saying goodbye to that person,'" Dr Esplen recounted.

In summing up her own thoughts, Ms Watson once again emphasized how important it is for nurses to try to listen to, and learn from, what patients are trying to tell them.

"Imagine that when we enter into conversation a space opens up between the nurse and the patient. We can step into that open space and suggest from our professional knowledge what's best in the situation, and hopefully make a difference for the patient," Ms Watson the told meeting attendees. "But if the nurse is not open to listening to, or talking with, the patient, has she fulfilled her duty as a moral agent? She's delivered the treatments, but has she done what's right for the patient?" ONN

—Rosemary Fyvi, MSc

To learn more about psychosocial aspects of cancer treatment, visit the American Psychosocial Oncology Society ([www.apos-society.org](http://www.apos-society.org)).

This group's annual conference will be held February 18-21, 2010, in New Orleans.



Mary Jane Esplen,  
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Linda Watson, RN, MN