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PROPOSER UNE THÉRAPIE PSYCHOLOGIQUE AUX PATIENTS ATTEINTS DU CANCER UNE ÉTUDE INITIALE DE LA PROPOSITION DE L'APT AUX PATIENTS ATTEINTS DE LYMPHOME, À L'HÔPITAL ONCOLOGIQUE D'HÔ CHI MINH VILLE

APPLYING ADJUVANT PSYCHOLOGICAL THERAPY (APT) FOR CANCER PATIENTS: INITIAL STUDY AND APPLICATION OF APT FOR LYMPHOMA CANCER PATIENTS IN TREATMENT AT HO CHI MINH CITY ONCOLOGY HOSPITAL IN VIETNAM

Thi Uyen-Phuong TRAN

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Lecturer, Department of Medical Ethics and Behavioral Sciences - Psychology
Pham Ngoc Thach University of Medicine (PNTU)
Add: 86/2 Thanh Thai Street, Ward 12, District 10, HCMC, VIETNAM
uyenphuong.tran87@gmail.com

Abstract :

Objective: The goal of this study was to evaluate the efficacy of Adjuvant Psychological Therapy (APT) for lymphoma cancer patients at Ho Chi Minh City Oncology Hospital in Vietnam.

Method and Procedures: Aside from a qualitative analysis method for each clinical case, the Hospital Anxiety and Depression Scale (HADS) was used to evaluate the effect of psychological support on each cancer patient. Levels of anxiety and depression were compared before and after 5 weekly APT therapy sessions, which all had a cognitive-behavioral focus. The 4 participants were all female, ranging from 40 to 65 years old.

Results: Initially, all 4 patients presented anxiety and depression symptoms. They also experienced fear of feeling pain and not having pain management skills, fear of death, insomnia or difficulty falling asleep, and all required psychological support throughout their treatment process. After 5 weekly therapy sessions, both qualitative and quantitative results showed positive changes for all 4 patients: a reduction in anxiety and depression symptoms, an increase in the amount of sleep and better pain management. However, therapy generally needed to be extended for 2 to 4 months more.

Conclusion: Cancer patients who participated in this study had anxiety and depression symptoms that required psychological support. It was shown that 5 weekly APT therapy sessions could significantly reduce these symptoms, supporting the idea that APT could be beneficial to patients if incorporated into their treatment plan.

Keywords : cancer, lymphoma cancer, adjuvant psychological therapy, psychology of cancer patients

RESUME

Objectif : l'objectif de cette étude était d'évaluer l'efficacité de la thérapie psychologique adjuvante (APT) aux patients porteurs de lymphome à l'Hôpital Oncologique de Ho Chi Minh Vietnam.

Matériel et méthodes : parallèlement à une analyse qualitative de chaque étude de cas, la Hospital Anxiety and Depression Scale (HADS) a été utilisée pour évaluer l'effet du soutien psychologique, chez 4 patients, femmes, âgées de 40 à 65 ans. Le niveau d'anxiété a été mesuré avant la mise en place de l'APT et après 5 semaines d'un traitement psychologique de type cognitivo-comportemental.

Résultats : A l'inclusion, les 4 patients présentaient une symptomatologie anxio-dépressive, accompagnée d'une peur de la douleur et de l'incapacité à y faire face. Ils décrivaient également une peur de la mort, insomnie ou des difficultés d'endormissement et réclamaient un support psychologique. Après 5 semaines de thérapie à raison, d'une session par semaine, les résultats quantitatifs et qualitatifs ont montré des changements positifs pour les 4 patients allant dans le sens d'une diminution des symptômes anxio-dépressifs, une amélioration du sommeil et une meilleure gestion de la douleur. Toutefois, la thérapie a nécessité d'être prolongée pendant encore 2 à 4 mois.

Conclusion : Les patients atteints de cancer ayant participé à cette étude et ayant reçu un soutien psychologique ont montré, 5 semaines après la participation à des sessions d'APT une réduction symptomatique significative soutenant l'idée selon laquelle, la thérapie psychologique est bénéfique aux patients et pourrait être incluse dans leur protocole de soins.

Mots clefs : cancer, lymphome, thérapie psychologique adjuvante, psychologie du cancer.

INTRODUCTION

Cancer is a critical health issue as it is the most important cause of death in many countries around the world, including Australia, Canada, Italy, Japan, the Netherlands, New Zealand, United Kingdom and the United States (WHO, 1996). It requires complex and expensive treatments over an extended period of time, and causes severe psychological effects in patients. According to statistics, one in every four people will have cancer and it is the third cause of death worldwide after heart attacks and accidents.

According to the Vietnam Cancer Society, more than 150,000 people are currently suffering from cancer in Vietnam and 82,000 people die from it each year. Approximately 13,000 people are diagnosed at Ho Chi Minh City Oncology Hospital (HOH) alone, including those transferred from other provinces, every year 5,500 of those patients live in Ho Chi Minh City (Nguyen Ba Duc, 2009; Pham Xuan Dung, 2014).

Cancer is a disease that has a severe psychological impact not only on patients, but also on their relatives. Often they are riddled with despair, pessimistic, depressed and want to stop treatment and give up. During the treatment process, psychological support from medical staff and family is essential to give hope to those facing the disease and to foster compliance to the treatment protocol (Morrey et al., 1999). This support can also help reduce emotional stress, enhance communication between patients, relatives and doctors, limit the consequences of treatment and improve quality of life for patients. However, psychology, and especially psychotherapy, are fields that have yet to be thoroughly explored in Vietnam. Currently, the main focus is developing educational psychology and social psychology, while medical psychology fields have not been paid proper attention. Indeed, no formal training programs exist and research is almost non-existent.

Dr. Eric L. Krakauer, the program director of international palliative care at Harvard who was advising the research team at the time, suggested that CBT be used. CBT constitutes appropriate psychological support for cancer patients as it can help them be more positive and better comply with treatment (Beck, 1988; Dattilio & Padesky 1990; Savard et al 2006; Moorey et al., 2009). After training in cognitive-behavioral therapy conducted by Dr. Armin Kulr in Germany, Adjuvant Psychological Therapy, or APT, was also considered. APT is a form of CBT that helps cancer patients deal with anger, fear, sadness, anxiety, depression, and pain management (Turk & Fernander, 1991; Crichton & Moorey 2002; Morrey et al., 2012). It is suitable for cancer patients because it usually spans 6 to 12 therapy sessions, over a maximum of 3 months. As in classic CBT, psychological evolution of patients is easily evaluated, making this an interesting research tool. Some techniques have even been shown to bring immediate results, sometimes within the first session, such as therapeutic relaxation, mindfulness, and breathing exercises (Kabat - Zinn, 1999; Speca 1999 Segal et al, 2002; Lengacher et al., 2009; Barley, 2011).

1. Literature Review

Lymphoma

Lymphoma is a form of cancer affecting cells in the immune system, called lymphocytes or leukocytes, which have an important role in helping the body fight against diseases. These cells are stored in lymph nodes found throughout the body, especially in the neck, armpits, groin, heart, major blood vessels around the stomach, spleen, tonsils and thymus. Lymphoma is a type of cancer that develops from lymphocytes in those areas. No specific cause has been found but lymphoma can be closely associated with immunodeficiency diseases caused by congenital immune system abnormalities or due to the AIDS virus.

There are two types of lymphoma cancer: Non-Hodgkin's lymphoma (NHL) and Hodgkin's lymphoma. Patients in this study were all diagnosed with the former.

NHL is one of the ten most common cancers in Vietnam and many other countries around the world, ranked 5th in prevalence and 6th in mortality. It occurs most commonly between 45 and 55 years old and is rare in children. Also, men tend to be more vulnerable to this disease than women. Like most forms of cancer, treatment includes chemotherapy, radiotherapy and surgical treatment.

Adjuvant Psychological Therapy (APT)

In medical terms, adjuvant therapy, also known as supportive care, is the additional treatment suggested for patients with a high risk of recurring cancer. The goal is to add support to initial treatment to better its results (Moorey & Greer, 1989; Cunningham, 2000).

Adjuvant Psychological Therapy (APT) is a new therapy based on Cognitive-Behavioral Therapy, which was designed specifically for cancer patients. APT was developed as a reworking of Beck's Cognitive Therapy (1976) and based on clinical experiences and therapeutic research with a group of cancer patients in King's College Hospital and Royal Marsden Hospital in London (Greer, 1995). It is a short-term therapy with an average of six problem-focused therapy sessions designed to be integrated into a medical environment. Its focus is the improvement of quality of life through the reduction of emotional stress and a boost of the fighting spirit. APT emphasizes on building positive attitudes to help people cooperate during treatment and be well prepared when faced with varying physical symptoms (Moorey and Greer, 2012).

Framework of APT

The APT therapeutic program is usually comprised of six to twelve weekly sessions, but frequency can increase if the patient's level of distress requires more treatment. The varying length of treatment usually depends upon the stage and form of cancer. The average duration of a therapy session is 60 minutes. The first session can last up to 90 minutes as it is designed for data collection.

Session structure

Like all CBT-based therapies, sessions are well structured and the therapist must follow this sequence.

First, the therapist and the patient establish which symptoms (usually one or two) will be specifically targeted in the session. Then, the previous session is reviewed and the patient recalls what he remembers and what the objectives were for that session. This feedback helps the therapist adapt each session to the patient's needs and helps him see what the patient took away from it. Then, homework is reviewed and the person must share what was difficult and what needs to be changed.

After this review, the patient describes the difficulties that need to be worked on and, collaboratively, therapeutic techniques are chosen to help the patient. Based on this content, homework tasks are designed.

The therapist then summarizes the aim of this session, the techniques implemented and the homework assignments that were decided upon.

The first sessions

The first therapy session, considered to be an important step in the treatment process, often lasts up to 90 minutes as the therapist is trying to collect as much information as possible. First, he needs to explore the patient's anxiety and depression levels, financial situation, relationships and prognosis. Specific emotions and thoughts also need to be assessed. This data can be collected through semi-directed interviews or tests, questionnaires, and checklists (such as CCC or HADS).

After obtaining this general information, the focus will be assessing current issues that are a priority for therapy, and how they will be treated sequentially by APT. Typical issues often include: general problems related to cancer (fear of death, fear of recurrence, fear of side effects of treatment); specific problems related to each type of cancer (the loss of femininity in breast cancer, stress about sex life after cervical cancer or vaginal cancer, etc.); emotional reactions (depression, anxiety, anger, envy, fear, guilt,…); interpersonal problems, physical problems (nausea and vomiting, pain, fatigue,…) and socio-economic issues (responsibilities and obligations, joblessness, financial difficulties). Each session will then be designed according to these targeted symptoms.

The first sessions also allow the therapist to explain how APT works and its essential characteristics. It is best described as a method allowing a change in the perception process, in which patients will learn the relationship between thoughts, emotions, behavior and physical responses. For example, patients will learn the impact of automatic thoughts, which often create negative emotional states. These emotions then trigger maladaptive behaviors, which in turn create more mental anguish.

During the treatment process, the therapist must always make sure that the patient understands the reason why each technique is implemented, and how to put it into action. For example, when a cognitive technique is introduced, the therapist can present a diagram to demonstrate the interaction between the thoughts, emotions and behaviors of the patient. The therapist can also explain concepts related to core belief systems. A core belief is created by our own experiences, and we often act and think in ways that will confirm this belief, thus rejecting things that do not. Those core beliefs constitute our views about ourselves, our relationships, our world and our outlook on the future. Not all core beliefs cause psychological issues, only those which are maladaptive and destructive (Le Thi Minh Tam, 2013). As treatment progresses, the therapist will help patients to become more aware of their core beliefs and how they affect their current situation, and modify them with specific techniques if needed.

The different phases of the therapeutic process

During the initial sessions (usually no more than three), the principal objective is to create a good therapeutic alliance and trustful relationship with the patient. This will help the patient express emotions with more ease and will facilitate the therapeutic process
In addition, the patient's general goals are discussed and the program's basic techniques are introduced. Patients understand that symptoms will be reduced by developing new coping strategies and that urgent issues will be treated first.

During the following sessions, the patient's history, current life and problems are discussed. When did these problems arise? How have they been processed? During this period, the therapist often takes time to assess the patient. After determining target symptoms and ranking them from most to least important, the therapist can select an appropriate strategy or combine alternative strategies to resolve these problems. Patients are asked to record their dysfunctional thoughts to serve as examples for cognitive methods during sessions. New methods are learned during this period, and help the patient and relatives cope with negative thoughts and improve quality of life.

The last one to three sessions are used to talk about the future after therapy has ended. Possible cancer relapse and death are often common topics, as the therapist must prepare the patient to be able to cope with such possibilities. The patient is also encouraged to plan for his short and long term projects (over a 3 to 12 month span). Core beliefs are also identified and the therapist helps implement changes in the patient's lifestyle to promote better self-care (working less, preserving sleep, etc.)

Homework assignments

After every session, the therapist assigns homework based on what was discussed that day. The goal of these assignments is to help patients transfer these new skills to everyday life. Each task

is chosen in collaboration with the patient, and tweaked if considered too difficult. For example, the therapist can ask the patient to write down automatic thoughts corresponding to a specific situation, and the emotions and behaviors that ensue. For anxiety symptoms, relaxation is often suggested, and depressed patients are often asked to plan interesting or pleasurable activities.

The therapeutic relationship

As in all cognitive-behavioral therapies, the therapeutic relationship is not as asymmetrical as in other forms of therapy. APT emphasizes on the patient's cooperation and active participation in every session. Therapists share the theories which APT is based on, and explain every aspect of the therapeutic process to the patient, thus clarifying what they do not understand or dislike. Patients can also question the usefulness of each therapeutic step, as the therapist's transparency and explanations will help them adhere to the therapy.
The end of therapy will also be discussed collaboratively.

Goals of APT's therapeutic: a problem-based method

The aim of APT is to show patients the relationship that exists between emotions, thoughts and behaviors, thus helping them modify them through cognitive and behavioral techniques. The goal of therapy is symptom relief, most notably the decrease of emotional distress.

The following are the six main goals of APT:

- Decreasing the level of depression and anxiety
- Boosting the fighting spirit by enhancing positive thoughts
- Reinforcing sense of control and helping patients follow the treatment process
- Developing effective strategies for issues related to cancer
- Improving the quality of relationships between patients and their relatives, which will improve the awareness of the value and meaning of life.
- Encouraging patients to release anger and negative feelings in a safe environment.

Targeted symptoms

When suffering from diseases, patients are in the state of restricted activity, unbalancing in all psychological, social and physical respects (Vexenkin, 1980) [20; 17]. Arrcodring to Dr C.D. Sherman, Jr. about the psychosocial aspects of cancer in Manual of Clinical Oncology-Fifth edition by International Union Against Cancer (1990): "All of the diseases, cancer is the one that has the most formidable psychological impact. It spells not only death – the disnity of us all – and a progressive painful approach to it, but also multilation, either natural or posttherapeutic" [31; 16]. Patient reactions vary depending upon levels of study, ethnicity, socio-economical context, religious beliefs and the patient-physician relationship. (Phạm Thị Oanh, 1998).

Generally speaking, anxiety and depression are important targets of APT, but to be able to modify these symptoms, coping mechanisms, automatic thoughts and other various cognitive symptoms need to be explored:

- Adjustment: for cancer patients the capacity to adjust to their illness and develop their stress management skills is an important aspect of their mental health. In the early stages of cancer, many patients are angry, sad or fearful because of this life-threatening disease.

These reactions are normal. Over time, each patient needs to individually adjust to his circumstances. Those who have a low capacity for adjustment have a tendency to be rigid, have negative thoughts on treatment and feel a complete loss of control. Five basic adjustment styles have been described in research:

- Fighting spirit: patients believe that they can control their sickness and their lives.
- Denial: patients may avoid, refuse, or even forget necessary treatment, believing that they are in fact healthier than they are (Institute of Medicine, 2008)

- Fatalism: Patients do not believe that they can control their sickness but think that others can.
- Helplessness/Hopelessness: Patients believe that nothing could change the status of their health. These negative thoughts about themselves, their lives and their future usually lead to symptoms of depression.
- Anxious preoccupation: Patients are uncertain about their efforts to control their sickness.

- Basic assumptions: cancer patients' basic assumptions about their lives change once they get their diagnosis as their prior perspective on life is shaken up. The diagnosis can generate a drastic loss of faith in the world and in what life has to offer (Janoff Bulman et al., 1999).

- Cognitive distortion: Depressing thoughts are maintained by cognitive distortion, as patients minimize positive information and exaggerate the negative aspects of their illness. They often consider that their efforts have never borne results and that the future is bleak, whatever they may do. Patients often fall into the "black or white" mindset, and have a tendency to look for and adhere to rigid and negative thoughts.

- Cognitive and affective avoidance: at some point, all patients will experience what it is like to be overwrought with worry, and will try to avoid thoughts and emotions related to cancer. They can intentionally avoid negative emotion, thus numbing all other emotions, in the hopes of decreasing their anxiety and depression. This is often the only strategy they find to experience relief during lengthy periods of treatment. Avoidance can help patients function for a time but eventually, they will need support to release these negative thoughts and emotional states they have been suppressing.

- Negative Automatic Thoughts: Negative automatic thoughts are the main reason for depression in patients, and appear in the patients' mind without them even noticing (Le Thi Minh Tam, 2013). Based on APT's theory, inappropriate adjustment styles trigger more pessimistic thoughts that are usually exaggerated. Thus, they fall into the «traps of negative thoughts» which will prevent them from finding effective solutions for their sickness. When people are healthy, they usually have a positive outlook on life, their relationships and the world. After being diagnosed with cancer, their core beliefs are shattered. Their self-image and self-esteem are altered by a flood of continuous negative, rigid thoughts.

- Threat to survival and threat to the self: When facing a cancer diagnosis, patients usually experience an alteration of self-image and the traumatic possibility of death. They believe death to be unavoidable, that painful sensations will inevitably increase, and that the body will be devastated regardless the stage of the disease (Pham, 1998). In the first stage of the disease, patients can sometimes wish to die even though they still love to be alive, because they cannot manage the threat of imminent death (Vũ Đức, 2009). These two threats can coexist.

Therapeutic techniques

Emotional Expression

It is important for the therapist to help patients express their emotions before introducing therapeutic techniques. According to Dr. Elizabeth Kubler-Ross (1969), the mindset of cancer patients, whatever stage of cancer they may be in, are rather like those of patients near death. They can go through five different stages: shock and denial, anger, bargaining, sadness and depression, and finally acceptance. She believed that not all cancer patients would necessarily go through the five stages sequentially as above. There are those who will be stuck at a certain stage, while others go through the stages in a less linear fashion.

Anger, one of the most common emotions related to such a diagnosis, is often the most difficult emotion to express (Watson et al., 1984). APT is designed to create a safe environment where the patient can share the full range of their emotions: "The important task in APT is to encourage patients' expression of negative feelings" (Greer, 1995).

Behavioral Techniques

Behavioral techniques are usually applied in the early stages of the treatment process and are similar to those used in CBT for anxiety or depression. These techniques include assigned homework, relaxation and distraction. Cancer generally causes a loss of the sense of control, making patients slip into passive behavior. By using behavioral techniques, therapists help patients develop new self-control skills despite the challenging circumstances the illness has brought on. This then fosters cooperation and helps patients understand the need for self-help techniques as the treatment progresses.

Cognitive techniques

During each therapeutic session, therapists examine patients' thoughts. During the first few sessions, therapists need to request that patients record these thoughts so that they can be explored one on one. Together, they will evaluate and discuss them. This helps patients become more aware of their automatic thought processes, especially those that trigger negative emotional states. Different techniques can be used to help patients modify or distance themselves from thoughts:

- Reality testing: patients search for evidence for their thoughts. This helps them separate reality from sorrowfulness.
- Search for alternatives: during this exercise, patients are challenged to find alternative thoughts that would have generated different, and more positive, emotions.
- Decatastrophizing: Therapists encourage patients to think of their fears and evaluate whether they are evaluating them in a realistic way.
- Behavioral plan: Cognitive changes lead to behavioral changes. When patients start to question automatic thoughts, it can be a good idea to give them behavioral homework that will further reinforce their new beliefs.

Efficacy of APT

Over the course of the last 25 years, several studies have proven the efficacy of APT. Many research teams from the US, UK and Canada have been exploring different applications of this therapy for cancer patients, in the hopes of confirming Moorey and Greer's initial research.

In 1991, Greer, Moorey and Baruch began studying the effect of APT on cancer patients. After 8 weeks of treatment, there was a significant decrease of patients' initially high levels of anxiety and depression. One year later, Baruch et al. (1992) began a randomized clinical trial on a much larger scale. According to the evaluation, the results showed that APT therapy significantly improved psychological distress, most notably anxiety and depression symptoms, in patients with cancer. The effect of treatment was observed during the eight weeks of treatment and were maintained in some cases after the four month follow-up. There was a significant increase in fighting spirit in the experimental group compared to the control group and patients with high scores of helplessness, anxious preoccupation, and fatalism were significantly relieved of these symptoms.

In 1998, Greer published a case study of a woman suffering from cancer with mild depression and severe anxiety concerning her imminent death. After a few APT sessions, her anxiety symptoms had disappeared and she began to recover a sense of control and to have more peaceful communication with her daughter. Greer believed that APT could also be applied to a hospital setting. In that same year, Bliss et al. (1998) compared classic supportive counselling with APT in a hospital setting with 57 in-patients. After eight weeks, APT demonstrated a significantly greater change compared to normal counseling interventions with issues such as fighting spirit, helplessness, coping with cancer, anxiety, and self-identification with problems. After a four month period, those following the APT program had greater changes in morale, coping skills and anxiety.

Cunningham (2000), who had previously shown the efficacy of psychoeducational programs for the improvement of cancer patients' quality of life, insisted APT be put on the same footing as other therapies proposed in medical settings. He stressed the need for more research for APT to become a common evidence-based medical practice.

Most recently, Morrey and Greer published an Oxford guide for CBT treatment of cancer, in which they specifically detail APT, its applications and its capacity to enhance quality of life (2012).

As of yet, no studies have been developed to prove the effectiveness of CBT in Vietnam, hence the importance of this seminal research.

Indications and contraindications for APT

APT is best suited for cancer patients experiencing adjustment issues, who are suffering from mild depression or anxiety (NICE, 2009) or who are experiencing pain management issues (Turk & Fernander, 1991; Crichton & Moorey, 2002). It has also been proven to help patients in chemotherapy with anticipatory nausea (Watson and Marvell, 1992; Watson, 1993).

In cases where it is combined with pharmaceutical treatment, or where the duration of therapy is prolonged, patients suffering from severe depression or anxiety disorders, personality disorders, addiction or major pre-existing relationship issues may also benefit from APT.

Patients with schizophrenia, bipolar disorder, confusion syndrome, amnesia, or dementia are not suited for this type of therapy (Moorey & Greer, 2012).

METHOD

PARTICIPANTS

The sample consisted of four female patients, aged 40 to 65 years old diagnosed with Non-Hodgkin's Lymphoma. They were all receiving in-patient treatment at the Lymphoma cancer department of HCMC Oncology Hospital, with a life expectancy prognosis of at least six months

for patients with early diagnosis, and at least three months for patients with severe or metastatic cases. Selected patients were those who had at least 11 points on the HADS-A or HADS-D or both. Informed concent was obtained from each of the four patients.

Patients with a short life expectancy that were too weak to complete the evaluations, or presenting other mental disorders were excluded from the case study.

MEASURES
Qualitative measures

A qualitative method was used to further support and complete the quantitative results. Individual appointments were taken to:

- Collect administrative information about the patient involved (name, sex, age, profession, living situation, personal context…)
- Collect information about the patient's current problems: history of the patient, history of the disease…
- Examine patient's adaptability, their knowledge and thoughts about the disease and their resources (support, caregivers…)

Specifically, a semi-directional personal interview was used to help patients express feelings and feel free to give feedback through open-ended questions based on our research hypotheses. The interview questionnaire included:

- Biographical information and current situation
- How are you coping with cancer?
- What are your thoughts about cancer and death?
- What is your relationship with your family members/care givers like?
- Questions about the details of their concerns
- Questions about the details of their mental adjustment
- Questions about the details of HADS (Hospital Anxiety and Depression Scale-Anxiety).

Quantitative measures

The HADS-A (Hospital Anxiety and Depression Scale-Anxiety) and The HADS-D (Hospital Anxiety and Depression Scale-Depression) were administered during the first and last session of the 5-week therapy program.

HADS is a scale composed of fourteen sections and was originally developed by Zigmond and Snaithin (1983). Seven sections are used to measure anxiety (2, 4, 6, 8, 11, 12, and 14) and seven others to measure levels of depression (1, 3, 5, 7, 9, 10, and 13). This scale allows the therapist to pinpoint the severity of each symptom (scored from 0 to 3 for each item). HADS scores range from 0 to 21 for both anxiety and depression: up to 7, patients are considered to have low levels of anxiety or depression, from 8 to 10 they are considered to be "borderline" cases and cases with a score of more than 11 are considered to have severe symptoms.

HADS is quickly administered, lasting about five minutes, and patients answer based on their feelings over the past week. Before this research, it had previously been used with cancer patients (Moorey et al., 1991). It was translated into Vietnamese by professional interpreters working in the field of clinical psychology for the purpose of this research. This translation is not official and the reliability and validity of this scale have not been established in Vietnam. Therefore, the researcher will keep these limits in mind while discussing the results of this research.

In addition to the HADS scales, the Cancer Concerns Checklist (CCC) was also used (Harrison et al., 1994). CCC is a list of fourteen common concerns and patients with a score of four or more are considered to possibly have signs of anxiety or depression. CCC was used in order to target which concerns were a priority for each patient.

PROCEDURE

The first phase of research, before data collection, was the introduction of the study to the medical team and to the entire medical staff of the department after the outline proposal had been approved by HCMC Oncology Hospital's board directors and ethics committee. The head nurse was designated as the exclusive supervisor and administrative support.

The research was then introduced to the patients who had agreed to participate and an introduction to the research as well as a letter of consent were sent to them.

Once the letter of consent was signed, the HADS was administered and we explained to patients that they would also fill it out at the end of the five therapy sessions. Afterwards, the content of the individual sessions was explained to participants and schedules were decided upon with each person.

Depending upon the situation and the problems that patients encountered, individual interventions were planned. Therapy sessions, lasting 45 to 60 minutes, continued after the last official session of APT if deemed necessary. During each therapeutic session, targeted symptoms were reevaluated and feedback was collected. Homework assignments were given and the end of each hour.

This study was implemented over a five-week period instead of the recommended eight weeks because some difficulties were encountered for the approval of this research at the hospital. However, patients continued to be treated until the end of the psychotherapy process, with goals based on the issues identified throughout the course of therapy, even if these final results could not be integrated into this research paper.

RESULTS

Results show that all four patients had anxiety and depression scores of 14 or higher (considered to be severe as they were <11):

- Patient 1 had the most severe depression symptoms with a HADS-D sub-scale score of 21/21pts. This patient also had the most severe levels of anxiety with a HADS-A sub-scale score of 19/21pts.
- The other three patients had moderate anxiety with HADS-A sub-scale scores of 17/21pts and mild to moderate depression with HADS-D sub-scale scores of 14/21pts.

After five APT sessions:

- Patients 1, 3 and 4 had anxiety scores at borderline level (10, 8, and 10pts respectively) and Patient 2 had no more anxiety.
- Patients 1 and 4 still had significant HADS-D scores (14 and 11 respectively), Patient 2 had a depression score at borderline level (HADS-D=9) and Patient 3 had no more depression (HADS-D=7).

	HADS-A (before APT)	HADS-A (after APT)	HADS-D (before APT)	HADS-D (after APT
Patient 1	19	10	21	14
Patient 2	17	6	14	9
Patient 3	17	8	14	7
Patient 4	17	10	14	11

In general, all four patients benefitted from these five therapy sessions. Their levels of anxiety and depression decreased, albeit at different rates. The qualitative analysis also showed that quality of life was significantly improved, especially concerning sleep and pain management.

CASE STUDY

D.T.T, a 59 year old farmer from the province of Long An, lives with her husband and three sons. Her husband is recovering from meningitis, which prohibits him from working, and the family has had financial difficulties since D.T.T. became the primary breadwinner.

She was diagnosed with breast cancer a year ago, but refused to seek treatment when she heard that the total cost was approximately 100 million Vietnamese Dong. As the family had no money, she worried that her hospitalization would further worsen their financial situation. She decided to take traditional medicine instead. When she was evaluated in April 2014, the disease had become quite severe and she assessed her pain at 10/10. Originally in the breast, her cancer had spread to the back of neck, shoulders, arms and armpits.

She finally decided to go to HCMC Oncology Hospital, where doctors diagnosed her with an advanced metastatic form of breast cancer, with metastases also found in her lymph nodes and liver. She was then transferred from Breast cancer Department to the Lymph nodes Department on 15/07/2014 accepted to be a part of the study on 19/07/2014.

She was quite depressed, and cried easily at the very mention of cancer. She experienced severe body aches, especially in the areas where tumors were growing. When walking around the department, she was unable to find other people with such an advanced stage of cancer, which created a lot of anxiety. Sleep was difficult as her pain was quite severe and her anxious rumination brought on insomnia. When she thought of treatment costs, she felt like a burden to her family and blamed herself for not getting treatment sooner.

She also felt gratitude for her husband because he spent all of his time caring for her. Thinking of her three sons also generated anxiety, as they were all over 30 years old, not yet married, and had no children. Despite being dependent on her financially, her children were quite indifferent, which frustrated D.T.T. and made her wish she had had girls.

The more she focused on her fear of death, the more she was unable to sleep. She sometimes looked forward to injections, hoping that the doses would take her life. When she was evaluated, she had not yet been put on any form of medication or chemotherapy, and was afraid that none would work. This somehow relieved her as she thought that she would leave the hospital sooner and save money.

The patient's problems are defined as follows:

- Anxiety about disease and death
- Lack and loss of sleep
- Regret and self-blame for not being in treatment one year ago
- Worry about the family's financial situation and the future of her children
- Lack of support from the relatives (especially sons)

After having recorded her dysfunctional and automatic thoughts, breathing and relaxation exercises were introduced in the last twenty minutes of each session. After five sessions, the patient had adapted to the hospital environment, no longer cried when thinking about the disease, nor blamed herself for not following treatment earlier and tried to focus only on the present. She was also able to sleep better, felt less pain and was less anxious than previously.

In summary, before APT, the patient had mild depression symptoms and moderate to severe anxiety symptoms. After 5 sessions of therapy, the patient was able to reduce these symptoms. However, she still needed 3 months of therapy after these initial sessions.

DISCUSSION and Limitations

Although results were recorded after only five sessions of treatment, all four patients presented significant changes in their levels of anxiety and depression. Unfortunately, this limited sample cannot allow us to confirm the effectiveness of APT for cancer patients in general in Vietnam. This research is only a pilot study, whose main goal is to introduce the notion that psychotherapy is a necessary component of cancer treatment, for patients as well as their relatives. Indeed, this research was set up in a country where most physicians believe that lymphoma cancer patients do not have psychological difficulties, anxiety or depression.
During the course of this study, it was found that the participants, just like other cancer patients, were worried about their health status and treatment costs, and were overwhelmed with thoughts about death. All of these concerns generated anxiety, depression and insomnia. Coupled with the side effects of medication and pain due to illness, it is clear that patients and their family desperately need psychological support. It could be interesting to specifically analyze the major themes of depression or anxiety and APT's effectiveness for each of them, in a future study. It is also important to train more physicians and psychologists, to facilitate the implementation of such programs and to allow supervision for professionals in Vietnam.

We realized that three out of four patients, who all had the same initial levels of anxiety and depression, benefitted from APT differently as their scores were notthe same at the end of the five sessions. It seems that some factors influenced these results: financial situation, relationship with family members, use of drugs, knowledge of acquired disease, etc. In order to better interpret and control these influences, future research needs to examine the impact of these factors on psychological support results.

Creating the research sample was also quite a task. Fifteen patients were initially chosen, but all seven male patients categorically refused to participate stating that they had absolutely no psychological issues. Their wives and their relatives also agreed that they did not need specific support. Among the remaining eight female patients, three initially agreed but then withdrew due to severe pain and exhaustion and another woman did not complete treatment due to incompatible schedules. The difference in perceived need for psychological support depending upon gender should also be the object of further research.

Often, the majority of APT studies evaluated the treatment outcomes after eight weekly therapy sessions or an average of six to twelve weekly sessions. However, after having implemented APT

over a course of only five sessions, significant positive changes were found. It is possible that APT has a great effect with fewer sessions in Vietnam because psychotherapy is still new. It would be interesting to further study the impact of the number of sessions on the efficacy of APT for cancer patients.

Furthermore, the qualitative and quantitative results seem compatible concerning levels of anxiety and depression in this study sample. These results support the idea that the HADS scale needs to be standardized in Vietnam, but that the use of the current data as a reference was not problematic. Also, according to Morrey and his colleagues (1991), the HADS scale can be split into two sub-scales measuring anxiety and depression. Thus, these two sub-scales could be used independently the Vietnamese context.

During the studies, it was found that patients' relatives also had anxiety and depression issues and required psychological support. For example, Patient 1's sister had a depression relapse when she discovered that her sister was ill. She suffered from severe insomnia and was admitted to a psychiatric ward. On the morning following her sister's admission to our hospital, she had panic symptoms and uncontrolled behaviours. The second example is Patient 3's husband: following the onset of treatment, he started having depression and insomnia symptoms, and his health also deteriorated.

The issue of the impact of cancer on relatives is quite important in Vietnam because family members generally become primary caregivers, whereas in other countries nurses often come to the home. They have little caregiving skills and knowledge of the disease, and must often leave their jobs to assure this informal role, which often causes more stress.

When discussing symptom relief with patients and their relatives, we noted that spirituality and religion often played an important role. Indeed, two patients were atheist but converted to Buddhism after their diagnosis, as they believed it could only be explained by karma, that is to say a debt in their previous life. In the Vietnamese context where psychologists and social workers are not available in hospitals, is a therapeutic approach that integrates spirituality important for patients? These are ideas for follow-up research which may concern spiritual support for cancer patients and the role of spiritual life during the treatment period.

Psychology in Vietnam: difficulties pertaining to the implementation of research

Many difficulties were encountered during the research process, even though HCMC Oncology Hospital was considered to be a favorable place to set it up, which shows how difficult it is for these types of studies to be implemented in Vietnam.

Firstly, collecting data and meeting patients was problematic at times. We expected it would take no more that two to four weeks to identify the participants but this process lasted three months due to hospital administration. It was necessary to also wait one month to receive final approval of the outline made by the head director of the hospital as well as the the head of the Lymphoma Department. Data collection was set to begin in February 2014, but only began in June 2014.

Next, we were not given full freedom concerning the choice of our participants. It was initially thought to be better to work with breast cancer patients, but the head of the hospital insisted on the Lymphoma Department. We were also only allowed to work with patients who had been treated by the vice-dean of said department. As all male participants refused to participate, this left only women. Initially, it was thought to be better to choose only patients living in Ho Chi Minh City, to be able to continue treatment after the five weekly sessions, but the majority of patients at hand lived elsewhere. Due to the deterioration of three participants' health and an incompatibility of schedules with a fourth patient, only four others were selected for final data analysis.

Finally, there is still no standardized scale for anxiety and depression for cancer patients in Vietnam. Therefore, when conducting this study, it was difficult to choose a reliable scale. We knew that the HADS had been used by many international researchers in their studies about cancer, but it was not yet standardized in Vietnam. As our results were derived from a non-standardized scale, they are less conclusive. To try to compensate this issue, expert interpreters were asked to translate the scale and three clinical psychologists proofread it before it was used.

Conclusion

In conclusion, both quantitative and qualitative analyses show that APT was beneficial for all four patients, at varying levels. This research, which was approved by the board of the EPP and UPNT (Ecole de Psychologues Praticiens and Pham Ngoc Thach Medical University) to ensure its feasibility and scientific nature, shows that levels of anxiety and depression were significantly decreased and quality of life was improved in areas such as sleep and pain management.

As this study was only conducted on a small sample, its results cannot yet be generalized. That being said, they confirm the need for treatment for patients with lymphoma in Vietnam, who suffer from the difficult medical process and thus benefit from psychological support.

Despite these efforts, the dominant culture, social context and economic conditions are not favorable to the implementation of such protocols in Vietnam. Indeed, the role of psychologists is still very new in the Vietnamese hospital environment and conditions are not optimal for therapy sessions due to noise and lack of space for one on one psychological interventions. This research constitutes the first attempt to evaluate the efficacy of APT for cancer patients. The objective was to show that cancer patients being treated at Lymphoma Department of the HCMC Oncology Hospital have a need for psychological support throughout their treatment processes, and that APT could reduce their psychological difficulties. Hopefully, these promising results will help these types of treatments to be more widely applied and will allow Vietnamese psychologists to ensure the critical role they have to play in cancer treatment.

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