

This issue:

Resilience and Hope in Cancer Survivorship

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Guest Editor



Hope is more than a word. *Resilience* is not just a state of mind. These are lessons that have been taught to us on a daily basis by our patients, whom courageously battle against cancer with dignity and perseverance. At the George Washington University (GWU) Survivorship Center, we have worked since 2009, in an interdisciplinary fashion, to treat an ever-growing number of cancer survivors through all phases of the cancer care continuum.

This is the third issue of *Psychiatric Annals* that I have had the great honor of guest editing. Each issue has sought to address the role that psychiatry can play in the treatment of cancer survivors at various phases along the cancer care continuum. The first issue, “Cancer and Depression,”¹ focused on distress and depression and helping clinicians understand the main challenges and treatment strategies available in the acute phase of cancer treatment. The second issue, “Psychosocial Interventions in Palliative Care,”² was focused on the palliative phase of cancer care and applying different novel approaches to help a patient find meaning and purpose when facing end-of-life decisions. In this third issue, we have

chosen to focus on “Hope and Cancer Survivorship.” The field of cancer, and cancer survivorship in particular, has progressed significantly since the first two issues were published in 2011, and 2012, respectively. Given this, a very brief overview of the current cancer survivorship landscape is warranted.

In 2012, The American Association for Cancer Research reported that as of January 2012, there were approximately 13.7 million cancer survivors in the United States, a number that was expected to rise by 31% to 18 million by 2022.³ With this increased number of cancer survivors, patients, clinicians, and key policy organizations have continued to focus and build on the idea of cancer survivorship. In years past, cancer was considered a terminal illness but with recent treatment advances, cancer is now in many cases treatable and can be conceptualized as a chronic disease that the patient will need to manage over his or her lifetime. This “new normal” involves its own unique set of adjustments, and in 2006 the landmark Institute of Medicine (IOM) study “Lost in Transition”⁴ defined the four essential elements of survivorship care:

- Prevention and detection of new

cancers and recurrent cancers.

- Surveillance for cancer spread recurrence of a secondary cancer.
- Interventions for consequences of cancer, including late effects as well as long-term effects.
- Coordination between specialists and primary care providers.

Since this IOM publication, research has grown tremendously in the area of cancer survivorship. A critical study performed by the American Cancer Society (ACS)⁵ found that the top five concerns of cancer survivors were in the psychosocial realm:

- Fearful that illness will return.
- Fatigue and loss of strength.
- Concerns about relapsing.
- Fears about the future.
- Sleep difficulties.

This study, along with a second IOM report, “Cancer Care for the Whole Patient: Meeting the Psychosocial Needs,”⁶ highlighted the importance of providing survivors with access to high-quality psychosocial care. Recent survivorship guidelines published by the National Comprehensive Cancer Network, the American Society of Clinical Oncology, and the ACS have placed an ever-growing emphasis on treating the late, and long-term, physical side effects of cancer in conjunction with

the various psychosocial concerns the patient will face.

The cases and articles in this issue are meant to represent the lessons we have learned from our patients, as well as illustrate solutions to some of the real challenges patients, and clinicians, are likely to encounter in this phase of care. In the first article, James L. Griffith, MD, leads us through a discussion of hope in cancer treatment. He beautifully illustrates how hope can be defined as a practice and not simply as an abstract state. With this definition in mind, Dr. Griffith then elaborates on ways clinicians can assess hope in their patients and construct brief psychotherapeutic interventions to help patient mobilize hope.

In the second article, Sanaa Bhatti, MD, and Allen R. Dyer, MD, PhD, illustrate the challenges clinicians can face when they first work with a cancer survivor. Bhatti and Dyer's case illustrates how a psychodynamic approach can be blended with psychopharmacology in a manner that allows the patient to address a number of challenges related to the survivorship phase of cancer.

In the third article, Veronica Sloatsky, MD, discusses in detail the decision process in regard to genetic testing in breast cancer. She also explores the psychological impact of dealing with the uncertainty of testing and how a clinician can best offer guidance and support.

Cognitive difficulties that arise after chemotherapy ("chemobrain") are a common chronic side effect of cancer treatment. Yu Dong, MD, PhD, Catherine Crone, MD, and Thomas Wise, MD, guide us through a discussion in which they describe the various factors related to the development of chemobrain and how a clinician can best manage this condition through a combination of pharmacological interventions and day-to-day coping strategies.

I would like to thank all of my colleagues whom have contributed articles and published with me with me over the past 3 years. In particular, I would like to acknowledge Dr. James L. Griffith and Julie Noblick. Dr. Griffith's knowledge, expertise, and humanistic approach have directly shaped the themes by which we practice in the GWU Survivorship Cen-

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