EAPM 2018
6TH ANNUAL SCIENTIFIC CONFERENCE OF THE EUROPEAN ASSOCIATION OF PSYCHOSOMATIC MEDICINE · EAPM ·
INNOVATIVE AND INTEGRATED APPROACHES TO PROMOTE MENTAL AND PHYSICAL HEALTH
Verona (Italy), 27-30 June 2018

PROGRAM OF THE
Pre-conference on Psycho-Oncology on the theme:
CHALLENGES AND OPPORTUNITIES IN PSYCHO-ONCOLOGY:
SCREENING, ASSESSMENT AND TREATMENT IN CLINICAL CARE

joint with the:
Canadian Academy of Psycho-Somatic Medicine, International Psycho-Oncology Society (IPOS)
World Psychiatric Association (WPA) - Section on Psycho-Oncology and Palliative Care

To attend the Preconference, please ensure to have your place by registering before June 22! For more details see www.eapmverona2018

WEDNESDAY 27 JUNE
9.00 - 15.00
Room T1 – CARMEN – Ground Floor - Polo Zanotto
Viale dell'Università 4 - Verona

8.00-8.45 Registration

8.45-9.00 Introduction – Wolfgang Soellner (Nuremberg, GE) & Luigi Grassi (Ferrara, Italy)

SESSION 1

Chairs: ***Michela Rimondini & Luisa Nadalini (Verona, Italy)***
9:00 - 9:45 Screening for distress: benefits and challenges

Luigi Grassi *(see CV in www.eapmverona2018)*
M.D., Institute of Psychiatry, Department of Biomedical and Specialty Surgical Sciences, University of Ferrara, Ferrara, Italy

AIMS: To analyze the information for the role of screening for distress in oncology in terms of benefits and problems not yet solved.
METHODS: Analysis of the most recent literature concerning the policy of screening for distress in different parts of the world and the advantages to implement.
RESULTS: A series of data exist in several countries on the validation and application of psychological tools for screening for distress, including the National Comprehensive Cancer Network (NCCN) guidelines and recommendations for screening from other international agencies (e.g. Canadian Association of Psychosocial Oncology, . The experience in European countries is also extremely promising. Some problems result not to be solved, such as education of health care professionals, development of algorithms defining the steps involved in screening and assessment, implementation of psychosocial oncology services available. Data on the role of screening as a facilitator of communication are also missing.
CONCLUSIONS: Screening for distress has become a major and mandatory step for optimal clinical care of cancer patients throughout the world. However, a series of problems need to be addressed to implement the policy in cancer care settings and to show its efficacy in terms of facilitation of communication, eliciting problems and concerns, identifying patients at risk for or showing psychological/psychiatric disorders

CONGRESS PRESIDENT EAPM 2018
Mirella Ruggeri
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9:45 - 10:30 **Psychosocial variables and cancer mortality**

Alan Bates *(see CV in www.eapmverona2018)*

MD, PhD, FRCPC, Provincial Practice Leader for Psychiatry at BC Cancer and
President-Elect of the BC Psychiatric Association, University of British Columbia Vancouver, Canada

AIMS: A number of studies have demonstrated associations between cancer mortality and psychosocial variables. We aimed to examine these associations in a large sample of patients attending a major cancer centre.
METHODS: All patients who attended BC Cancer from April 2011-2016 and completed the PSSCAN-R and the Canadian Problem Checklist within 6 months of cancer diagnosis were included. We asked if patients lived alone, had help with IADLs, had regular contact with others, had lost a life partner recently, and had emotional support. We also identified patients with moderate to severe anxiety and/or depression, with analysis to-date being limited to patients 65 and older. Overall survival was estimated using the Kaplan-Meier method with log rank comparison and multivariate analysis conducted using the Cox regression method.
RESULTS: The study included 48,954 patients; median age 66, 55% female, 17% metastatic disease. All measures of social isolation were associated with shorter median survival; living alone: 37months vs. 57 months, p<0.001; no help with IADLs: 49m vs. 52m, p=0.019; no regular contact with others: 39m vs. 49m, p<0.001; recent loss of spouse: 34m vs. 55m, p<0.001; no emotional support: 44m vs. 52m, p<0.001. Multivariate analysis including baseline disease characteristics demonstrated that older age, male sex, metastatic disease, living alone, recent loss of spouse and no emotional support were significant negative prognostic factors. In the subsample of 26, 323 patients 65 and older, median survival was reduced in patients with significant anxiety (34 m vs 43 m, p<0.001) and depression (31m vs 43m, p<0.001). Multivariate analysis including age, sex, metastatic status, anxiety, and depression showed all variables contributing as predictors (increasing age HR 1.05, male HR 1.11, M1 vs M0 HR 3.62, anxiety HR 1.30, depression HR 1.50).
CONCLUSIONS: This large dataset replicates findings of social isolation, depression, and anxiety being significant risk factors for mortality in cancer patients. Further research aimed at developing effective interventions is needed.

10:30 - 10:50 Coffee Break

SESSION 2

Chairs: ***Claudio Bassi (Verona, Italy) & Franziska Geiser (Bonn, GE)***
10:50 - 11:35

The assessment of demoralization and its consequences in cancer

Anja Mehnert *(see CV in www.eapmverona2018)*

PhD, Professor and Chair of the Department of Medical Psychology and
Medical Sociology at the University Medical Center, University of Leipzig, Germany

AIMS: Demoralisation and existential distress are important factors affecting psychological well-being and quality of life in cancer patients. Demoralization refers to a state in which there is a perceived inability to cope, that is associated with a sense of disheartenment and a loss of hope and meaning. Demoralisation may arise from the impact of multiple existential challenges raised by cancer diagnosis and treatment, which include fear of death and dying and the threat to fundamental human needs for autonomy, self-worth and relatedness to others. This contribution provides an overview about the concept of demoralization and the co-occurrence of other mental states such as depression, its assessment and itsconsequences such as suicidal ideation.
METHODS: We analysed a subsample of a representative multicenter epidemiologic study on the prevalence of comorbid mental disorders involving cancer patients in Germany. We assessed demoralization with the Demoralization Scale (DS); the 4-week mental disorders, and suicidal ideation with the standardized Composite International Diagnostic Interview– Oncology (CIDI-O); and depressive symptoms with the Patient Health Questionnaire-9 (PHQ-9).
RESULTS: In total, 430 cancer patients with mixed tumor entities completed the CIDI-O and were analysed in this study. We found clinically relevant levels of demoralization in 21% of the patients. Demoralization co-occurred with a mood/anxiety

disorder in 7%; 14% were demoralized in absence of any mood/anxiety disorder. Demoralization and adjustment disorders co-occurred in 2%. Demoralization, but not depression, was associated with a significantly
increased risk for suicidal ideation after controlling for mental disorders (RR, 2.0; 95% CI, 1.1-3.5)
CONCLUSIONS: The results of this study indicate that demoralization is a relevant and distinct dimension of distress in patients with cancer. Clinically relevant demoralization frequently occurs independently of a diagnosis of a mood, anxiety, or adjustment disorder inpatients with cancer and demoralization has a unique contribution to suicidal ideation.

11:35 - 12:20

Integrated depression care for cancer patients: a collaborative care model

Michael Sharpe[1] & Jane Walker[2] ***(see CV in www.eapmverona2018)***
[1]Professor of Psychological Medicine at the University of Oxford, Oxford (UK)
[2]Senior Clinical Researcher at the University of Oxford, Oxford (UK)

AIMS: To describe the development, evaluation and implementation of an integrated collaborative care model for depression in cancer patients.
METHODS: Two linked services were developed to systematically identify and treat major depression in cancer outpatients. (1) The Symptom Monitoring Service, a 2 stage symptom monitoring and depression screening service, was implemented in three cancer centres in Scotland, UK, and screened more than 20,000 patients for depression. (2) 'Depression Care for People with Cancer' (DCPC) is a systematic, integrated, treatment programme based on the collaborative care model. It includes both pharmacological and psychological treatments and is delivered by a team of cancer nurses and consultation-liaison psychiatrists. We conducted three clinical trials to evaluate its effectiveness and cost-effectiveness. A project in the Oxford Cancer Centre is currently evaluating the process of implementing these services in routine care.
RESULTS: In the SMaRT (symptom management research trials) Oncology 1,2 and 3 trials we found that DCPC is highly effective and also cost-effective. Implementation in the clinical setting is achievable and welcomed by both patients and healthcare professionals but it is also challenging to train staff to work in new ways and to integrate psychological care into a traditional 'physical' healthcare environment.
CONCLUSIONS: Systematic identification and treatment of depression in cancer clinics is effective and costeffective. Implementing this integrated approach in cancer centres brings great benefits but also offers practical challenges.

12:20 - 13:10 Lunch Break

SESSION 3

Chairs: ***Marta Novak (Budapest, HU) & Lidia del Piccolo (Verona, Italy)***

13:10 - 13:55

Communication Skills Training in Cancer Care; a Pathway to improve Patient Support

Darius Razavi ***(see CV in www.eapmverona2018)***
M.D., Ph.D., Psychiatrist, Professor of Psychosomatic and Psycho-oncology at the Institut Jules Bordet and "Université Libre de Bruxelles" (Belgium)

Communication skills are now recognized as one of the core clinical skills. Communication is also related to patients' psychological adjustment. Communication is particularly stressful for physicians as they have to break bad news, inform patients about highly complex treatment procedures, and ask for informed consent. Physicians moreover have reported that this stress lasts beyond the interaction. It should be recalled that physicians often have to communicate with depressed and anxious patients and their relatives and to deal with uncertainties and fear of death and dying. Physicians need to tailor information to every patient's

needs in order to promote recall of information, to facilitate decision-making and to improve satisfaction. Contrary to common social conversation, professional communication are not learnt spontaneously in the course of a clinical career. Health care professionals thus face very diverse and highly complex communication tasks for which they should be trained. In the last two decades, communication skills training programs designed for health care professionals working in cancer care have been the focus of several research endeavors of our group. The efficacy of these communication skills training programs has been tested in studies using a controlled design. All our studies included a microanalysis of patient-physician interactions in simulated and actual consultations. This presentation will review knowledges about communication skills trainings and will focus on challenges for the future in this area.

13:55 - 14:35

Psychological Care in Advanced Disease: The Global Revolution

Gary Rodin *(see CV in www.eapmverona2018)*

MD, Professor of Psychiatry at the University of Toronto, Canada; University of Toronto/ University Health Network Chair in Psychosocial Oncology and Palliative Care and Head of the Department of Supportive Care at Princess Margaret Cancer Centre in Toronto, Canada.

AIMS: The revolution of palliative care has drawn attention to the importance of relieving physical and psychological suffering in patients with advanced disease. However, approaches to relieve psychological distress and to improve psychological well-being in this population are still much less systematized than those to relieve of pain and other physical symptoms. A global knowledge translation project is required for psychological care to become a standard of care for this population.
METHODS: A number of psychological interventions have been shown to be effective to relieve depression and other symptoms in patients with advanced cancer, but none have become a standard of care. managing cancer and living meaningfully (calm) is a brief, supportive-expressive therapy tailored for patients with advanced disease and integrated with cancer care and early palliative care. calm has been evaluated in large randomized controlled trials in canada and in europe.
RESULTS: Calm has been shown to relieve depression and death-related distress and to support death preparation in patients with advanced disease. a global project involving twenty countries has been launched to establish hubs and networks of calm training and treatment delivery for this population.
CONCLUSIONS: Robust evidence is now available to demonstrate the benefit of psychological interventions for patients with advanced disease. however, a global network is needed for such interventions to become part of routine care. the global calm project is a unique knowledge translation initiative for psychological care for patients with advanced disease to be delivered as part of routine cancer care and early palliative care.

14:35 - 15:00 **Discussant:**

Franziska Geiser *(see CV in www.eapmverona2018)*

Head of Department Clinic and Polyclinic for Psychosomatic Medicine and Psychotherapy, University of Bonn, Germany)

PRACTICAL INFORMATION: All participants to the Preconference will receive a Certificate signed by the EAPM, the Canadian Academy of Psycho-Somatic Medicine, the International Psycho-Oncology Society (IPOS), the World Psychiatric Association (WPA) - Section on Psycho-Oncology and Palliative Care. The EAPM Preconference, the Congress and the Masterclasses have been assigned **14 CME Credits.**

HOW TO REGISTER: see www.eapmverona2018 for more info

CATEGORY:	**LATE REGISTRATION After April 15th, 2018:**
Members of EAPM	€ 145
Non Members of EAPM	€ 185
Members of National Organisation associated with EAPM (see CHECK LIST and SIMP MEMBERS)	€ 165
Member of ACLP	€ 145

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