

Cancer and Psychosocial Support

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Summary

According to data of World Cancer Report oncology professionals fail to determine psychosocial needs of the cancer patients, and their families. Health professionals working in oncology services, and outpatient clinics who get close contact with cancer patients should have a certain perspective on this issue. All physicians who will work in this field should use psychosocial support systems in the diagnosis, and treatment process of the cancer patients, and their relatives. This review article aims to raise awareness, and provide guidance in satisfying the need for psychological treatment of cancer patients, oncologists, and psychiatrists who provide healthcare services to cancer patients.

Key words: Psychiatry, oncology, psycho-oncology, support

Introduction

Prevalence of cancer in Turkey

Cancer is an important health problem with increasing prevalence. Based on the estimates of the World Health Organization, a total of 14 million cancer patients are living in the world, and annual number of newly diagnosed cancer cases will be predicted to rise up to 20 million in the year 2020.¹

In Turkey every year 150.000 newly diagnosed cases with cancer have been reported. According to Turkey Cancer Control Research Report published in the year 2007, in our country crude mortality rate was 85.7/100.000, and in women it was 58.7/100.000. Age-standardized mortality rates are markedly higher among men (58.7/100.000 vs 107.8/100.000). Crude, and age-standardized rates for cancer in men are 110.3/100.000, and 137/100.000, and women 82/100.000, and 91/100.000, respectively.³ In Turkey most frequently lung cancer is seen in men, and breast cancer in women.⁴

Psychiatric complaints of cancer patients

Cancer is one of the serious diseases where social, and psychiatric disorders are seen most frequently. Human beings experience conflicts very intensely during their strive for their existence, which may lead to important psychiatric outcomes. Studies investigating cancer-related psychiatric problems in patients have gained importance in recent years. Despite many studies, and researches, failure to prolong life span has stressed the importance of the role of mental properties in the prolongation of lifetime. In addition to biological treatment of cancer, in recent years, the role of treatment of psychiatric problems in the prolongation of lifetime has attracted attention. Although most of the psychiatric disorders in cancer patients are treatable, it has been suggested that healthcare professionals do not pay attention to psychiatric disorders in this patient group, so these disorders can not be sufficiently diagnosed, and treated.⁵

Although interest of psychiatry to cancer is very old, psycho-oncology has become an independent discipline only recently. Quality of life of the patients, the factors effecting frequent concomitancy of various psychological disorders with cancer, their treatment, psychotherapies, families of the cancer patients, health professionals, onset of the disease, and progres-

sion are areas of interest of psycho-oncology.⁶

Cancer is a very important crisis experienced by an individual. Despite biomedical developments cancer is still thought to bear the same meaning as death, pain, and suffering. As a stressor cancer creates a serious crisis in one's life. The fundamental process involves disruption of mental, and physical balance. Therefore while deciding on definitive treatment modalities for the patient, the level of emotional stress should be tried to be controlled.⁸ Deterioration of the physical balance also induces progressive worsening of the psychological balance. Both mental, and physical reactions develop against stress which exerts their reflections on social, and interpersonal level. This process may progress up to the onset of psychiatric disorder.

The individuals who suffer from cancer confront with decrease in their ability to keep their lives under control, increase in dependency on others, and impaired balances in family, business, and social life.⁹ Most frequently seen reactions include mourning, loneliness, adaptation difficulty, depressive signs, anxiety, anger, denial, dependency, guilt, increased in hostile behaviours, reflection, aggressive resistance, and weakness. The factors formulating psychological reactions of the patients can be enumerated as especially uncertainties, and suspicions about the future, difficulties in sensemaking of the disease, the belief that he/she will lose control on one's body, feelings of inadequacy, and failure, the fear of stigmatization as a cancer patient, and struggling continuously to hide one's disease from his/her relatives, and intimates.¹⁰

The reactions displayed by the cancer patients after establishment of diagnosis

In her book "Death and Dying" Elizabeth Kübler Ross interrogated with terminal-stage patients who received diagnosis of fatal disease, and described psychological reactions experienced by these patients after diagnosis in 5 stages. These stages are denial, anger, bargaining, depression, and acceptance¹¹ Frequently, the first stage includes shock, disbelief, and denial. Then anxiety, panicky feelings, and despair are experienced followed by anger, and depression, and ending in acceptance. The crisis consists of processes of shock, reaction, and adjustment. At every stage, the attitude displayed towards the

patient is important. It is also important to allow time, and opportunity for hope instilling approach, listening to the patient, understanding the patient, and expressing oneself. Implementation of support systems, and identification of patient's potential of coping with the feeling of anxiety, and depersonalization are also important issues. During adjustment period the individual reviews, and reevaluates him/herself, and his/her life, runs through his/her desires, and constructs a life plan. The patient comes in terms with the disease, questions his/her life, and shapes his/her future.¹¹

Denial: When the patients hear about the diagnosis, they react as "no, not me" Almost all patients deny their being a cancer patient when they hear the diagnosis, or occasionally thereafter. This stage buffers the shocking, unexpected news, and then the patient recovers him/herself, and with time the patient activates radical defence mechanisms less frequently.¹¹

Anger: As the first stage has been weaned, and become nonfunctional, feelings of anger, and resentment replace the stage of denial. "Why me, and not him/her".¹¹ It is very challenging to fight against anger, and overcome this stage. The basic issue is that very few people empathize with the patient, and try to understand the source of anger. Since relatives of the patient, and healthcare professionals perceive this expression of anger as directed against them, they also display an angry mood which in turn reinforces patient's anger.¹¹

Bargaining: During this stage the patient is in collaboration, and strives to comply with the treatment.¹¹

Depression: Within a short time, strong feeling of being lost replaces indifference, and anger. This type of depression is called reactive depression. When vital issues are resolved, rapid recovery of the patient can be seen. Do not tell the patient not to express his/her grief. If the patient is let to mourn, then he/she will accept the reality of death more easily.

Acceptance: This stage should not be considered as a pleasant period of time. One may say that during this stage the patient is devoid of feelings. At this stage, instead of the patient, the family needs help, understanding, and support. Besides the patient may display coping attitudes as horror,

humour or mercy.¹²

Instead of constructing hope-instilling sentences far from reality for cancer patients, it is very important to formulate sentences as "Within my knowledge, I did everything I could. Still I will continue to try my best to make you comfortable" is a very important approach. Therefore the patient will maintain his/her hope, and see the physician as a friend who will attend him/her till the end of his/her life. The patient will cherish the hope that the physician will not abandon him/her when his/her disease becomes incurable..¹¹

Psychiatric disorders in cancer patients

In 47 % of inpatients at least one psychiatric disease is seen.¹³ Psychiatric disorders which might onset in cancer patients include adjustment, anxiety, acute stress, posttraumatic stress, and depressive disorders. Besides anxiety disorder related to general medical state of the patient can be observed.⁶

In anxiety disorder related to general health state of the patient, symptoms of anxiety are secondary to physiologic outcome of the disease. Certain carcinoid, and endocrine tumors may be exemplified.⁸ Anxiety accompanied by acute pain can be best treated with analgesic drugs. If anxiety is accompanied by respiratory stress, it can be treated with oxygen, opiates, and careful use of low doses of sedatives.¹⁴

Bronchodilators which are frequently used in patients with lung cancer, steroids, and antiemetics as metoclopramide may cause anxiety. In this case, benzodiazepines or low doses of antipsychotic drugs can be used for the treatment of anxiety.¹⁴

Fatigue is one of the frequently observed complaints in cancer patients. Incidence rates of fatigue have been detected as 8 % in prostate cancer before radiotherapy, 4 % in breast cancer before chemotherapy, and 91 % after surgery, and chemotherapy¹⁵ The correlation between Cancer-related Fatigue Assessment Scale developed by Piper et al. with a scale ranging between 0, and 10 points or its verbal scoring which evaluates mild, moderate, and severe degrees of fatigue and physical functioning subscale of SF-36 quality of life scale has been reported.¹⁶ For the relief of fatigue, support groups,

psychotherapy, relaxation therapy, coping strategy programs, and massage therapy are used. In anemic patients receiving chemotherapy, the beneficial effects of epoetin alpha on hematological parameters, and fatigue have been reported.^{17,18} In patients with established diagnosis of cancer, one should be on the alert about neurological complications. Delirium is the most important among neurological complications. Besides metastatic brain tumors, leptomeningeal diseases, complex partial seizures, fluid-electrolyte imbalance, paraneoplastic syndromes can induce mental state disorders as delirium.¹⁹

Psychosocial measurement methods in cancer patients

As reported in various studies for the last 35 years, psychosocial measurement tools have been started to be regularly used in order to detect psychological, and social problems of the cancer patients.^{20,21} A general psycho-oncologic measurement tool developed in Germany (PO-Bado), and two basic measurement tools so as to assess psychological problems emerging secondary to cancer disease have been developed.²²

General Health Questionnaire (GSA): It is a scale completed by the patient, and used especially in the first-line health care services to screen patients with psychiatric diseases. In our country validation, and reliability studies of the questionnaire were performed in 2 different researches. The original questionnaire has 60 items. In some studies using short forms containing 30, 28, 20 and 12 questions improved results similar to those obtained with original forms were achieved. Because of the time constraints most frequently the form with 12 questions was used.²³

Hospital Anxiety, and Depression Scale (HADS) completed by the patient consists of a total of 14 items which inquire depression (n=7), and anxiety (n=7) symptoms. The aim of the scale is not to make a diagnosis, but it targets to screen patients with somatic diseases as for the presence of anxiety, and depression. In a short time with the intention to determine risk group. HAD scale was developed by Zigmond, and Snaith (1983), and its validation, and reliability studies were performed.²⁴ In our country, its validation, and reliability studies were performed. Their cut-off values were determined as 10, and 7 points for anxiety, and depression subscales, respectively.²⁵

Although the above-mentioned tests have been used in many hospitals, presently lack of any standard psycho-oncological measurement tool has let psychiatrists dealing with consultation-liaison psychiatry in a difficult situation

Therapeutic approaches in psycho-oncology

Families of the cancer patients, and physicians most of the time experience difficulties in telling the patients the diagnosis, describing the characteristic features of the disease, and the treatment. Most of the time physicians felt uneasy about the reaction of the patients concerning diagnosis of cancer which threatens their most precious existence, ie. their lives, and harbours the probability of getting lost. Priority should be given to whether the patient grasped the disease process clearly. If the patient is not sufficiently knowledgeable about the disease, the attendant physician should be requested to inform his/her patient adequately. In every human being confronting a fatal condition, universal mourning reactions can be observed. During this process, the patient should be allowed to live his/her grief, they should not be treated as if they are not sick. In case this stage turns into a psychiatric disorder, psychiatrists can involve in the condition. One can benefit from pharmacotherapy, and psychotherapeutic methods can be also used. Chemotherapy-related vomitings, and long-term isolations can lead to conditions as hospital anxiety, and claustrophobia. In such cases, benzodiazepines can be used.²⁶ Depressive disorders can be seen in 5-8 % of cancer patients¹³ In recent studies this incidence has been demonstrated to rise up to 58 percent.²⁷ Selection of antidepressants should be performed based on the type of depressive symptoms, and side effect profile. Generally firstly selective serotonin reuptake inhibitors are preferred. In conditions of insomnia, and anorexia, one can benefit from side effects of antidepressants. Psychotic symptoms can manifest dependent on the effects of both cancer drugs, and premorbid psychological conditions of the patients. In such cases, appropriate antipsychotic drugs should be selected based on both effective, and multiorgan functions of the patient. Apart from this, methods aimed to decrease somatic, and psychological complaints should be used including cognitive, and behavioural therapy, relaxation exercises, and hypnosis. Development, and improvement of disease-coping skills should be used in times of crisis. Together with these methods, combination of the met-

hods of group, and , couple therapy can facilitate reaching the goal.^{28,29} Treatment method to be performed should be individualized. In a meta-analysis performed on breast cancer patients, short-term intensive psychotherapy has been shown to be more effective than long-term psychotherapy.³⁰ Exercises have been shown to improve sleep disorders, and fatigue considerably in cancer patients.³¹

Various psychiatric disorders can be seen in relatives who care for their cancer patients. This condition is not related only to their assuming responsibilities, and mourning over their bereavement. The highest rates of depression have been revealed among relatives who provide health services to the rapidly dying patients after establishment of their diagnosis.³²

Conclusion

Apart from chemotherapy, radiotherapy, and surgery which are applied, and emphasized by the physicians who undertake cancer treatment, mental, and social aspects of cancer should not be overlooked. Within the frame of present health care system, psychosocial support systems have not drawn adequate attention. In the World Health Report published in the year 2008, it has been stated that psychosocial components of oncologic care should be integrated into each national cancer care program, and psycho-oncological services should be offered in every cancer treatment service.³³ Psychosocial approach leads the way among issues which should be emphasized within the frame of health policy. The society should be informed about cancer. Informative, and educational studies related to its psychologic effects should be performed. Psychological support units should be opened for the cancer patients, and their relatives. In the treatment of cancer patients synchronous studies should be conducted with psychiatrists. Active services of consultation liaison psychiatry units in university hospitals should be actively enabled. Psychologic, and social check-up of oncology patients is a recently developed field. Since a standardized psycho-oncologic measurement tool is not available in our country, and in the world, as the most important stage of this process studies should be performed, and a standard measurement tool should be developed, and implemented.



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