

PSYCHOLOGICAL PROBLEMS OF PATIENTS WITH CANCER

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SUMMARY

Psycho-oncology is a broad approach to cancer therapy which treats the emotional, social, and spiritual distress which often accompanies cancer patients. The development of psycho-oncology began in the second part of the 20th century reflecting the increased interest in the study of cancer patients' psychological reactions to their illness at all stages of its course, and the analysis of the emotional, spiritual, social, and behavioral factors which influence the risk of developing cancer and long-term aftercare treatment. Today the psycho-oncology has become an accepted part of cancer treatment, with departments of psycho-oncology established in most major cancer centers in Canada, the United States and many Western European countries. A key clinical challenge for the oncologist is differentiating the expected and transient distress associated with cancer from the excessive, disabling distress requiring psychiatric interventions. One third of patients with cancer will experience distress which requires evaluation and treatment, and the most common psychiatric disorders are depression, anxiety disorders and adjustment disorders. Psychiatrists should be involved in the multidisciplinary treatment team who work with the cancer patients. Further research is needed to determine the effectiveness of different psychological and psychopharmacological interventions in psycho-oncology and palliative medicine. Mental health issues should be included in the training of health care professionals in all areas of medicine, psychology and social work to meet the demands of cancer patients.

Key words: *psycho-oncology – cancer – depression – anxiety – adjustment – psychotherapy – psychopharmacology*

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Psychological domain within oncology

Although it is well recognised that the diagnosis of cancer and exhausting treatment are extremely stressful events and emotional burdens for the patient, it is only the last decade or two that the specific characteristics of psychosocial problems secondary to cancer have been studied in more detail (Grassi et al. 2000). For the last 20 years psycho-oncology has rapidly developed and has produced a model that integrates psychological domain into oncology. The main purpose of psycho-oncology is to investigate psychological factors within multidimensional understanding of malignant diseases which implies psychiatric diagnostics, therapeutic, educational and research activities in oncological institutions i.e. oncology team (Gregurek 2006). Psycho-oncology addresses (Holland & Friedlander 2006): 1) Psychological reactions to cancer among patients, members of family and care givers. Quality of relationship between physician and patient significantly affects on patients at each appointments with physician, at all levels of care, at all stages of cancer and during all methods of treatment. 2) Psychological, behavioural, biological and social factors that affect risk occurrence of cancer, its detection, treatment and survival. Numerous psychoneuroimmunological mechanisms have been investigated and their possible relationship with psychological and biological aspects of genesis and course of disease. Especially, the way that cytokines affect "disease behaviour" this might represent the biological basis for symptoms for fatigue, depression, anxiety, weakness and cognitive change among oncology patients (Cleeland et al. 2003). The very beginning of psycho-oncology development was closely

connected to psychoanalytic concepts. Those conceptions made etiological links between the occurrence of cancer and early family dynamic, traumatic events, unconscious sexual conflicts and personality traits. This approach led to development of two very important fields in psycho-oncology: many studies were conducted on psychobiology of stress and occurrence of liaison psychiatry.

With development of medical sciences came increasing understandings about malignant diseases, their etiopathogenesis, clinical features and prognosis. Treatment success does not only influence beginning stage, histology type, degree of malignancy and treatment but also psychological factors. Numerous researchers and clinicians have analyzed connection between cancer and specific personality traits. All psychosomatic theories on oncology patients can be classified in two groups (Boranić 1979): permissive and causal. Permissive theories are more moderate and presume that psychogenic factors do not directly lead to cancer but that other factors enable malignant alterations to come out. Of all causal theories those indicating that unconscious conflicts express through somatic should be specifically mentioned. They refer to expressing libido energy. Due to uncontrollable cell growth expression "schizophrenia on somatic level" is used. Some theories say that with unrestrained overgrowth of new tissue symbolically lead to creating a lost object because of real or imaginary object loss on somatic level. The theoretical explanations of malignant disease occurrence have important role in stress theories. Studies suggest that psychological stress is directly linked with immune response respectively with poorer recovery of DNA that gets damaged and usually

results with malignant alteration and cell apoptosis. Under the influence of stress comes to weakening of defence mechanisms in organism (primarily endocrine and immune system) wherein it is not only important the intensity of stress but also a capability of person to deal with it. Many researchers have come to conclusion that common difficulties for oncology patients are emotion expression, inability to express openly, aggression and suppressing depressive mood. Actually those people are well adjusted to others but alienated from themselves. Psychological factors which might affect the occurrence of oncology diseases are stress life events, social relationships and social support, personality traits, coping with disease, negative emotional reactions, psychiatric disorders and suppressing feelings (Gregurek 2008).

Psychological reactions and adjustment to diagnosis and treatment

When doctor is enclosing information on cancer patient because of existential threat has to use series of adaptive defences to withhold psychological stability. The very first encounter with a diagnosis of malignant disease arouses more intense emotional reactions than with any other disease. This leads to creating defence mechanisms with which doctors should be familiar and should acknowledge in therapeutic process (Tope et al. 1993). Usual accompanying psychological symptoms are fear of body image changes, disabilities, addictions and death. Patients' first reaction is fear of death or fear of separation from others and himself, and psychiatric disorders, communication with family etc. That can lead to developing panic attacks or other disorders. Person confronted with death goes through many different phases and states such as phase of denial, phase of anger, phase of bargaining, phase of depression and finally acceptance. The usual defence mechanisms among oncology patients are regression, denial, projection and suppression. Success of defences does not only depend on ego-strengths forming during development of patients' personality but also on actual object relationships like family relationships and relations with physician (Gregurek 2006). Good communication skills are extremely important for suitable care of oncology patients (Hagerty et al. 2005). Different ways of communicating patients' diagnosis can produce different emotional reactions. For example, absence of empathy can make the moment of finding out the diagnosis the great trauma and get carved in patients' memory for the rest of their life.

Psychological consequences of cancer diagnostics and treatment can be very significant. On the physical level, cancer can cause great changes in body image and in the way patients perceive their body. Oncology patients have various psychological problems such as emotional lability, changes in future perspectives, feelings of solitude, abandonment, marginalisation, stigmatisation, interpersonal problems, an all these

problems can occur during different disease stages and during treatment with variety of psychological consequences (Braš 2008).

The role of liaison psychiatrist on oncology departments consists of two components: helping patient from the diagnosis till the end of treatment and collaborating with medical team (Bloch & Kissane 2000). Assingment of medical staff is to identify negative emotions and overcoming it and openly showing it among colleagues and consequently reducing feelings of guilt and discussion on uniting all the actions that insure patients' better psychological and somatic state (Fawzy et al. 2003).

Most common psychiatric disorders among oncology patients

Recent researches and clinical practice indicate that about third to half of oncology patients have different psychiatric/psychological comorbidity disorders. There are many predispose factors for psychiatric disorders among oncology patients such as nature of disease, reduced fertility, different organic factors, prior stress and psychiatric disorders, communication with family etc (Braš 2008).

Psychiatric/psychological problems that can usually be seen among oncology patients are primarily depressive disorder, adjustment disorder, posttraumatic stress disorder and others are anxiety disorders, sexuality dysfunctions (low sex drive, erectile dysfunction, anorgasmia, experience of unattractiveness), delirium and other cognitive disorders provided that the psychiatrist meets with number of other problems (suicidal thoughts, results of lack of family and social support, personality disorders which causes problems in state of extreme stress, question of ability to make decisions, mourning, quality of life, spiritual and religious questions, etc.) (Kadan-Lottick et al. 2005).

Anxiety associated with cancer amplifies feelings of pain, interferes with sleep habits, causes nausea and vomiting, and negatively affects on patients quality of life (Stark & House 2000). Unless it is treated serious anxiety can affect the length of patients' life. Anxiety symptoms are common at the initial stage of cancer diagnosis, during treatment decisions, as well as with concerns about return of the disease or disease progression but rate of fully developed anxiety disorders is not significantly higher from the one in general population. Contrary to all assumptions patients with advanced cancer have less fear of death but greater from uncontrollable pain, state of loneliness and dependence on others. The experience of life threatening disease, as cancer, can lead to development of PTSD. Some of the risk factors for PTSD occurrence after cancer include past experience of stress life events, history of psychological disorders, high level of distress prior to cancer diagnosis, coping through avoidance, poor social support and worse physical functioning (Braš 2009).

There is strong evidence of cancer-depression association, with depression prevalence from 20 to 50 % at substantial tumours. There are many scientific studies that tried to explain possible connections between psychological factors, especially depression, and development and progression of cancer (Spiegel et al. 2003) but often with very different results and very contradictory conclusions. Some studies show that depressive symptoms are linked with higher prevalence of cancer and higher mortality risks. Depression is also connected with worse pain control, poorer compliance and less desire for long-time therapy. Some depressive symptoms can be normal reaction, psychiatric disorder or physical consequence of cancer and treatment. Since cancer can cause anorexia, weight loss, fatigue and other vegetative symptoms, diagnosis of clinical depression is associated more with psychological symptoms such as social withdrawal, anhedonia, dysphoric mood, feelings of worthlessness or guilt, low self-esteem and suicidal thoughts. It is important to emphasise that in the assessment of depressive symptoms there is a risk of non-recognition (estimating depressive symptoms as normal reactions) or over-diagnosis (estimating normal reactions or symptoms connected to cancer as a part of depression) (Bailey et al. 2005). Cancer patients much more frequently have passive suicidal thoughts than real suicidality, although it can be present among uncooperative patients or among those who refuse treatment. The effects of depression on mortality are not definitively confirmed although depression is linked to rapid progression of disease (Prieto et al. 2005). Possible reasons are neuroimmunological changes, reduced compliance with treatment, behavioural changes and effects of depression on social, labour and family functioning.

Psychotherapy and pharmacotherapy

Psychotherapeutic approach in treating oncology patients contains work with patients, from the diagnosis till the end of treatment as well as work with medical team. It is important for psychiatrists – psychotherapist who provide therapeutic services on oncology department to be familiar with psychoanalytic theory and concepts of psycho-sexual development. Psychoanalytic knowledge greatly contributes to understanding of unique personality in the structure of the patient, specific models of stress response, unique defence mechanisms, memory as a result of unique experiences, fantasy, fiction, desire, dreams, thoughts and feelings (Neuburger 2000). Elements necessary for formulating psychotherapeutic approach in work with oncology patients are based on defining personality structure of patients, current problems (reason for psychiatric interventions), patient situations (“life stories”), including experience and meaning of actual disease, identifying life events and crisis that could affect current situation, defences for reducing disease related stress, hospitalization, operative or conservative treatments and

behavioural patterns used in the past as possible predictors of reactions to present situations (Gregurek 2006). The aim of psychotherapeutic interventions during treatment of oncology patients is reducing and removing difficulties and bringing psychic stability. The purpose of treatment is not in personality change because they are primarily treated for other difficulties but by the end of treatment some personality changes might occur as a consequence of long term hospitalization and psychotherapeutic interventions. Psychotherapeutic approach for oncology patients includes following activities: informative-educative meetings with patients (individual and group); individual psychotherapeutic interventions; group psychotherapy; consultations of liaison psychiatrists with oncologists; supporting families.

Disease of one family member can emotionally affect every other family member and family as whole. In the situation of serious disease of one of their member reacts every family reacts with fear and reinforces the interdependence of family. After initial diagnosis cooperation between families members should be established on different subjects like dietary regime, medication or possible disabilities or death of patient. Families have difficulties to accept their members' pain and that is the reason why therapeutic interventions are very important for families. They make it possible for patients to reconnect with their families again, to re-identify their parents, partners and children needs and to learn again how to live together with giving and accepting.

Clinical practice indicate on the need and usefulness of antidepressants in oncology for treating anxiety disorders, adjustment disorders and depressive disorders as well as for states and medications that can cause or imitate anxiety or depression. For depression treatment only few antidepressants have been tested in oncology (mianserin, fluoxetine) Depression and anxiety can be connected to cytokine or immune system and there are evidences that for example antidepressants can prevent or reduce depressive symptoms after therapy interferon alpha. It has been recently reported that interaction between CYP2D6-polymorphism and applied antidepressant can be connected with changed tamoxifen activity. Antidepressant with poor inhibition of CYP2D6 should be prescribed to avoid those situations. Those antidepressants that interfere with other medicine (carbamazepine) should be prescribed with great caution. Antidepressants reduce the symptoms of chemotherapy, like insomnia, decreased appetite, acts as analgesics and treats depressive disorder. They also affect on level of prostaglandin which are responsible for regulation of every component of cell microanatomy and physiology (Lieb 2007). Ideal anticancer medication should inhibit production of prostaglandin in a way to stop pathogenesis and recent researches show that antidepressants have those characteristics. Antidepressants have autonomous analgesic effect, enhance narcotic effect and improve sleep, appetite and energy.

Their immunostimulative and antimicrobial effect can help in treating infections incurred after chemotherapy or radiation (Braš 2009).

Conclusion

Significant number of patients with cancer will experience distress which requires psychiatric evaluation and treatment. The most common psychiatric disorders in cancer patients are depression, anxiety disorders and adjustment disorders. Psychiatrists should be involved in the multidisciplinary treatment team who work with the cancer patients. Further research is needed to determine the effectiveness of different psychological and psychopharmacological interventions in psycho-oncology and palliative medicine.

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