SARAWAK HANDBOOK OF ONCOLOGY

BY THE DEPARTMENT OF RADIOTHERAPY, ONCOLOGY AND PALLIATIVE CARE
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Team work makes the dream work!

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CHAPTER 8
CANCER AND MENTAL HEALTH

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8.1 INTRODUCTION

Remember the first time you broke bad news to your patient? Just hearing you say the word "cancer" can have a profound emotional effect on patients and their family. Being diagnosed with cancer means a new journey ahead in which one needs to deal with physical health, mental health and many other social concerns. Similar to other chronic illnesses, managing the psychosocial aspect of cancer should be seen as equally important as the physical component. This chapter will give you a general overview of the psychological aspects from the diagnosis of cancer to palliative care.

8.2 BREAKING BAD NEWS

This is a complex and important task. Your readiness is one of the most important prerequisites to make the session an informative, yet emotionally tolerable one. Hence, equip yourself with adequate knowledge about the diagnosis, treatment options and be aware about your limitations and methods to overcome it during the session. You also have to tune-in to "listening mode" to facilitate the session as a ''dismissive" clinician can be very harmful.

SPIKES strategy1 is an easy-to-use protocol to deliver bad news to patients with cancer.

S – Setting	• Ensure privacy and conducive environment • Involve significant others (Do not assume ALL family members are the significant ones, always ask the patient who they want to involve) • Sit down – maintain the same eye level if possible • Listen attentively and be calm • Make yourself available by minimizing interruption such as phone calls.
P – Perception of condition/ severity	• "Before you tell, ask" principle • Try to explore what the patient knows about the medical condition or what he/ she expects • Comprehend according to the patient's level. • Accept denial at this stage and do not confront
I – Invitation	• Get permission from patient to tell or not to tell the diagnosis and treatment plan • Accept the patient's right not to know • Offer to answer questions later if he/she wishes

K – Knowledge	• Provide medical facts on the diagnosis and treatment. • Be aware of the education level, socio-cultural background and current mental state • Provide accurate facts about treatment options, costs, prognosis, etc • Organise information in small chunks and check understanding of the patient
E – Empathy	• Be prepared to give an empathetic response • Listen and identify the emotion • Identify the source of the emotion • Demonstrate that you made a connection between the source of emotion and the emotion • Allow time to express patients' feelings and validate it.
S – Strategy and Summary	• Close the interview • Summarise all the information given • Check understanding and allow time to voice concerns or questions • Offer agenda for the next meeting

8.3 GRIEF REACTION

Grief is a person's reaction to the experience of loss. This could be experienced by patients who lose their health as well as their loved ones who fear of losing the patient in their lives. It is important to understand that different cultures have its own set of beliefs and rituals that influence the expression of grief.

According to the Kubler-Ross model, there are five stages of grief. It is important to note that not everyone will go through all the stages or in a definite order. This framework helps us to identify how one may feel and think during the grief process.

Stages of grief	Common emotion and reactions
Denial	Individuals may refuse to accept the diagnosis of cancer. They may minimize or outright deny the situation. It is suggested that loved ones and professionals be forward and honest about losses to not prolong the denial stage. Avoidance, confusion, elation, shock, fear e.g. "This can't be happening, not to me. The test must be wrong"
Anger	When one realizes that the diagnosis is confirmed, they may become angry at themselves or others. They may argue that the situation is unfair and try to blame someone, something or even God. Frustration, irritation, anxiety e.g. "Why is this happening to me? It's not fair!"
Bargaining	The individual may try to change or delay the loss of health. Struggling to find meaning, reaching out to others, telling one's story e.g. "I'll do anything for a few more years."
Depression	The individual came to recognise the loss of health. They may isolate themselves and spend time crying. Overwhelmed, helplessness, hostility, fight e.g. "I'm so sad, what's the point of going on after this?"
Acceptance	The individual had come to terms with the loss of health and accepted the situation Exploring options, new plan in place, moving on e.g. "It may be hard, but It's going to be okay."

One may take some time to strive through grief at their own pace. However, when it is severe enough that it impairs someone's normal daily function such as social isolation, refusing food and being persistently depressed, or having suicidal thoughts, referral to mental health service is warranted.

8.4 COMMON PSYCHIATRIC COMORBIDITY AMONG PATIENTS LIVING WITH CANCER

There are some psychological impacts related to cancer. These could be due to the: -

a. Response to the illness
b. Response to the complications of the illness
c. Response to side effects of treatment (radiotherapy, chemotherapy, immunotherapy and surgery)
d. Response to psychosocial concerns e.g. poor coping mechanisms, lack of social support, financial concerns, family/ children, caregiver burden, etc
e. Underlying psychiatric illness and coping mechanism

We should be aware that emotional distress can also affect natural killer cell function, which is essential in cancer cell control[2]. Also, depression can lead to dysregulation of the Hypothalamic-Pituitary Axis (HPA), causing the rise of cortisol level and the inflammatory response that affects cancer defense processes[2]. Therefore, we should treat psychiatric disorders promptly in people living with cancer.

Common psychiatric comorbidities in patients with cancer include[3]

a. Adjustment disorder
b. Delirium
c. Depression
d. Anxiety
e. Posttraumatic stress disorder

8.5 ASSESSMENT

Patients living with cancer may have physical symptoms that mimic anxiety and depression. The clinicians need to interpret the symptoms carefully to not over diagnose or under diagnose possible psychiatric conditions. For instance, psychiatric symptoms like depression may be caused by chronic anaemia and anxiety may be triggered by palpitations due to cardiac pathology.

Before diagnosing a psychiatric disorder, it is always important to do the basic blood and radiological investigations to identify treatable causes. The tests may include:

a. FBC (Anaemia and infection)
b. BUSE (Electrolyte imbalance)
c. LFT (Hepatic encephalopathy)
d. ECG (Any ischaemic changes)
e. CT/MRI brain (Brain metastasis)

**This is not an exhaustive list. The clinician may need to do more tests depending on the case.*

Psychological tools that are useful to screen for common psychiatric conditions in patients living with cancer and caregiver burden.

1. Delirium – Confusion Assessment Method (CAM)
2. Anxiety and depression – Hospital Anxiety and depression Scale (HADS)
3. Caregiver burden - Burden Scale for Family Caregivers (BSFC-s)

Clinical confusion	**Recommended tool**	**Time**	**Advantage**
Hypoactive Delirium may mimic Depression	*Confusion Assessment Method*	< 2 minutes Clinician-rated	Diagnose delirium Sensitivity 94 -100% Specificity 91-95%
Tiredness and losing appetite may be due to cancer but also a possible manifestation of Depression	*Hospital Anxiety & Depression Scale*	<10 minutes Patient-rated	Suggest the presence of Depression & Anxiety. It focuses on psychological symptoms rather than physical symptoms.

It is not uncommon to observe new onset of psychiatric symptoms after initiation of chemotherapy agents. Knowing some chemotherapy-related side effects to the nervous system can assist physicians in coming up with differential diagnosis as well as delivering correct information to family members.

Neuropsychiatric side effects of common chemotherapeutic agents[2]

Hormone	
Corticosteroid	Mild to severe insomnia, hyperactivity, anxiety, depression, psychosis with prominent manic features
Tamoxifen	Sleep disorder, irritability
Biologicals	
Cytokines	Encephalopathy
Interferon-alpha	Depression, suicidality, mania, psychosis Delirium, akathisia Seizures
Interleukin-2	Dysphoria, delirium, psychosis Seizures
Chemotherapy agents	
L-Asparaginase	Somnolence, lethargy, delirium, depression
Chlorambucil	Hallucinations, lethargy, seizures, stupor, coma
Capecitabine	Multifocal leukoencephalopathy Cerebellar ataxia Reversible neuromuscular syndrome: trismus, slurred speech, confusion, ocular abnormalities
Cisplatin	Encephalopathy (rare), sensory neuropathy
Cytarabine	Delirium, seizures Leukoencephalopathy
5-Fluorouracil	Fatigue, rare seizure or confusion, cerebellar syndrome
Gemcitabine	Fatigue
Methotrexate	Intrathecal regimens: possible leukoencephalopathy (acute and delayed forms) High dose: possible transient delirium
Thalidomide	Fatigue, reversible dementia
Vincristine, vinblastine,	Depression, fatigue, encephalopathy
Multikinase inhibitors	
Sorafenib, Bevacizumab	Posterior leukoencephalopathy syndrome

8.6 TREATMENT OF CANCER RELATED PSYCHIATRIC CONDITIONS

The treatment generally adopts a bio-psycho-social model.
For biological treatment:

a. Symptomatic control such as pain management, sleep disturbance, nutrition needs, etc
b. Psychiatric conditions (may refer to psychiatrist for further management)

Psychosocial management includes:

a. Provide adequate education on the diagnosis and treatment options
b. Supportive counselling
c. Psychotherapy
d. Relaxation exercise
e. Identify their social needs such as finance, home modification, link the patients to social service etc.

8.7 MENTAL HEALTH ASPECT OF PALLIATIVE CARE

Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual.[4]

Facing terminal illness brings different meanings to different people. It is heavily influenced by life history, spiritual and culture background as well as one's own perception. The aim of psychological work at this stage would be to strengthen the sense of identity and continuity by reflecting important aspects of the patient's life.

Some scholars suggested life review, music therapy, creative art-based therapy or dignity therapy. It sounds rather sophisticated and the evidence is scarce. For the purpose of this book, we will be focusing on "preparing to leave" and "preparing to be left" in assisting the emotional journey of palliative care.

Preparing to leave

Interpersonal and family dynamics can influence disease management outcome. It can provide calming effects of secure or disruptive effects of family discord and criticism [5] depending on the intensity of the issues. Going through with patients about their unresolved yet important matters in their life would give some emotional ease. For instance, identify people in their life whom they wanted to seek forgiveness or even to express long-withhold matters. Discussing unfinished business and ways to come to term or facilitate the completion, would also give a powerful impact to psychological health.

Preparing to be left

This preparation is for the family members or the loved ones. Expressing pleasant emotion to the patient may help them to feel a sense of identity and satisfaction in life. In return, it helps the family members to ease their grief and provide a chance to communicate effectively to the patient. Similarly, facilitating expression of unpleasant emotion also may provide some relief on both sides.

In conclusion, to achieve good palliative care, a comprehensive psychosocial care is imperative.

It is common to see delirium amongst patients receiving palliative care. Apart from medical treatment, holistic palliative care management also include non-pharmacological approaches to provide best comfort care for the patients.

Non-pharmacological management of delirium for palliative care patients [6]

Delirium management strategies	Details
Optimize sleep–wake pattern	Daytime: increase exposure to daylight. Shades/curtains open Night-time: reduce light and noise Familiar sleepwear
Patient orientation	Re-orientate person: explain where they are, who they are, who you are and your role Complete orientation whiteboard, visible clock Avoid frequent room changes
Communication	Use eye glasses, hearing aids, and dentures where needed
Encourage mobility	Mobilize as patient's performance status allows Sit out of bed for meals if possible Avoid using physical restraints Minimize use of immobilizing urinary catheters
Monitor hydration and nutrition	Encourage patient to drink, if able to swallow safely Assist patient at mealtimes
Monitor bladder and bowel function	Assess for urinary retention, constipation, and faecal impaction. Avoid unnecessary catheterization
Provide support and education	Reassure patient with calming voice Use delirium information leaflet