Some Psychological Aspects of Dealing with Cancer

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Cancer has a potentially profound affect upon the emotional and physical life of the patient and his or her family. For most people the word "cancer" has a fearsome connotation.

This discussion explores the areas of self-image, body-image, and personal relationships that are often altered in cancer patients, as well as the emotional and cognitive states which can result from malignancy and its treatment. We will also review some techniques for helping the patient. It is important to remember that the psychological responses to any illness are individual and largely determined by the patient's past experience, psychological strengths, weaknesses and social supports, and by the patient's values, including religious beliefs.

Psychological Aspects

Altered Self-Image

Most healthy people live with a comforting sense of invulnerability; this feeling is violently interrupted by the diagnosis of cancer. Patients feel numb, shocked, and many even disbelieve the accuracy of the diagnosis. In extreme situations this denial can be so strong that the patient even refuses complete evaluation and treatment.

Usually, as the shock fades and the awareness of illness increases, the patient must alter his or her self-image to include the unpleasant concepts of being sick and of being a patient; this frequently results in a loss of self-esteem as illness is often equated with inferiority, dependency, and helplessness.

In addition to feelings of helplessness the cancer patient may even wonder if he or she is responsible for causing the illness. "If I had given up smoking 10 years ago, maybe this wouldn't be happening to me!" Further, the belief that God punishes sinners with illness may motivate the patient to wonder if the cancer is a punishment for past sins, known or unknown. It is common to hear patients angrily protest, "What have I done to deserve this?" These angry and guilty feelings often contribute to depression and hopelessness.

Job performance is another very important aspect of self-image for most people. The cancer may be so debilitating that many weeks are lost from the job or homemaking, and these functions may have to be severely curtailed or discontinued. This frequently leads to a feeling of uselessness and a marked loss of self-esteem.

Altered Body Image

Just as people have images of themselves as personalities, they also have important mental pictures of their bodies synthesized from proprioceptive experience, self-observation, concepts of one's personal appearance, the input of others, and from social norms. Any illness, especially one that mutilates the body, can alter the body-image, and to a greater degree if the damage is external. Thus, mastectomy seems to alter body-image more than hysterectomy

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Changes in body-image are associated with changes in self-image.[1] For example, the hysterectomy patient may feel that her sexuality is diminished, while the patient with a colostomy may generate his or her inability to control defecation into a feeling of being generally out of control.

Each body part has individual meaning for each person; it is therefore important for the physician to explore the meaning of the damaged body part for each patient. Mental agility may be highly prized by one person and valued to a much lower degree by someone who is very concerned with physical attractiveness.

Relationships

Cancer patients often have significant problems with relationships. Friends and relatives may withdraw from the patient because they are unsure how to handle the subject of the patient's illness. The patients themselves may withdraw from relationships because they feel weak, worthless, depressed, and finished. Postoperative head and neck cancer patients often report that people stare at them and then move away. The mastectomy patient may have difficulty finding a comfortable sexual partner. Since appearance and health are important factors determining acceptability in our culture, patients who feel ugly and sick may fear that others will withdraw acceptance and love.

Emotional and Cognitive States

In addition to problems with self- and body-image and relationships, certain abnormal mental changes often accompany serious malignancy. One study of hospitalized cancer patients revealed that more than one half showed moderate to high levels of depression, and 30% had elevated anxiety scores. Almost one quarter of these patients had overall emotional symptom patterns virtually similar to those of patients admitted to an emergency psychiatric service.[2]

Depression vs Mourning. Although pathological depression is a common finding associated with cancer, it is often difficult to differentiate it from both the normal process of mourning and from the direct physical effects of the malignancy. Many of the signs and symptoms of depression are also characteristic of mourning and physical illness. Insomnia, anorexia, loss of weight, loss of interest in usual activities and sexuality are hallmarks of pathological depression but may also result directly from a painful malignancy. Diurnal variation in mood is a useful differentiating characteristic, as people with physical illness usually feel better when they are rested in the morning and worse as the day goes on. The reverse is true of clinical depression. Further, depressed patients often have a personal and family history of serious depression. Self-depreciation and guilt are more characteristic of clinical depression than normal mourning.

Anxiety. Anxiety in the cancer patient can result from realistic fears of pain, surgery, mutilation, or the side effects of chemotherapy. It can also be secondary to fears of helplessness, dependency or death and can add further debility to the patient's already troubled course since insomnia, nausea, and irritability are frequent accompaniments.

Organic Problems. Dementia is "a deterioration of previously acquired intellectual abilities of sufficient severity to interfere with job functioning, memory, abstract thinking, judgment, personality, and impulse control."[3] Many cancer patients suffer from this loss of intellectual capacity and others even become agitated and out of touch with reality as a function of overwhelming stress, sensory isolation, or organic factors. Pain, fever, electrolyte and endocrine changes as well as treatments and medication can cause delirium, anxiety, and depression. Sedatives, psychotropic medication, and steroids can produce mental changes. Those patients who are quietly disoriented may be ignored and therefore undiagnosed. Their loosened contact with reality may be very frightening to them and it certainly decreases their ability to cope daily or to comply with treatment.

Defense Mechanisms. All people have unconscious mental mechanisms which are used to protect the ego from excessive emotional stress. Denial is one of the defense mechanisms frequently used by cancer patients. In denial unpleasant information is forgotten, a process which can be helpful or detrimental. The patient who continues chemotherapy but denies his or her unfavorable prognosis may be using this defense mechanism constructively to avoid anxiety. On the other hand, the patient whose denial prevents her from seeking prompt evaluation of a breast mass is hurting herself.

Polivy et al conducted a pertinent experi-

ment exploring defense mechanisms in a large group of women with breast masses.[4] The study began in the pre-diagnosis phase and the study sample was later divided into one group who had benign lesions at biopsy and another group who had mastectomy for malignancy. The body image, self-image, and general mental well-being of all patients were studied before and after surgery and on 6 to 12 month follow-up. Before biopsy both groups strengthened themselves and mobilized their resources to deal with the stress. They maintained adequate body- and self-images and did not show significant anxiety or depression. Immediately post-biopsy the nonmalignant group, feeling safe, was able to express their emotions of feeling scared, assaulted, and helpless. The mastectomy patients did not express these feelings. They were busy maintaining their defenses by using denial to deal with the operative stress. They were being strong and brave and telling their doctors and their husbands and themselves that things were going well. Six to 12 months after surgery the nonmalignant group was back to normal and the cancer group, having survived the acute postoperative phase, was now showing evidence of marked decrease in self- and body-image with significant evidence of depression and anxiety. This study is clinically useful because it alerts us to be aware that the patient may be hiding emotional symptoms in the early postoperative phase when we are forming our opinion about her health and prognosis. Up to a year following mastectomy, many patients will have significant depression with insomnia, anorexia, suicidal ideas, and this is true even if the patients have an excellent long-term prognosis. About 15% will seek professional help for mastectomy-related problems and many who had normal and satisfying pre-mastectomy sexual relations will have significant sexual difficulties for many months post-surgery.[5]

Therapeutic Management

A "temperogluteal" approach is usually required to competently evaluate the patient, to understand his or her feelings, and to facilitate the resolution of the problems. This approach means sitting down and spending time with the patient. A serious discussion of feelings is highly unlikely if you are standing by the bedside writing in the chart or if you are in your office answering the phone or being interrupted by your nurse. The presence of a box of kleenex is an important nonverbal message to the patient that you are a doctor who can handle the expression of feeling. Even in privacy and with an interested doctor, the patient may give an inaccurate social response, "I'm fine," when greeted. If you sit down and say, "How are you *really* doing?", there is a good chance the patient will talk honestly with you. Once the patient knows you are really interested in his or her feelings, then it is appropriate to find out exactly what the person is feeling about the condition, about the diseased body part and about the future. It is also important to find out what the patient knows about cancer as beliefs about treatment and prognosis may be inaccurate. In order to understand each patient's emotional response to the cancer and the person's strengths and weaknesses, the physician should ask personal questions to explore the patient's character, to determine how stress has been handled in the past, and what the personal meaning of the damaged organ or illness is to the individual. It is equally important to respect a patient's need for privacy and not to insist on exploration of these issues if the patient is unwilling or unready.

Understanding the patient's personality type can be extremely important in helping you to individualize your approach. A very dependent patient will usually be comforted by a fairly parental approach: "I'm going to help you get through this; things are under control." If you are dealing with a person who is more obsessive-compulsive, for example, someone who is hard driving, meticulous, and likes to control his or her anxiety by having facts and information, an approach that offers facts and a sharing of control with the patient will be welcomed whereas the parental approach may make this patient very anxious. There are many other personality types and guidelines for medical management.[6]

In the advanced stages of malignancy many patients fear abandonment, a fear often greater than the fear of death. Repeated medically unnecessary calls for attention and requests for pain medication can be the patients' communication of their fear of loneliness and their attempt to obtain reassurance that they will be attended.

We may forget to evaluate how various

family members are feeling about the illness and the future. Their attitudes and support can be critical. They may need help in coping with the illness and in dealing with their feelings about it. Mobilization of self-help organizations can also be effective by demonstrating that others with similar histories have returned to relatively normal and effective lives.

A stance of *realistic hopefulness* is most important in helping the patient. This concept embodies two necessary components of empathetic medical care; to be honest while retaining hope. No matter how grim the situation, no matter how grave the prognosis, a thoughtful physician can always offer something realistically hopeful. The ability to say, "we are going to stick with you, you are not going to be alone, we are going to keep your pain under control," is extremely helpful and comforting to the patient.

Most of the psychological problems of the cancer patient can be effectively managed by the primary care physician. Supportive psychotherapy is often sufficient; however, psychiatric evaluation, psychopharmacology, behavior therapy, or even electroconvulsive therapy may be indicated. Consultation with a psychiatrist skilled in the emotional problems of the medically ill is indicated if the emotional diagnosis is unclear, if there are questions about treatments, or if the primary physician is having difficulty managing the symptoms. It is important to properly prepare the patient for psychiatric consultation by emphasizing that many people have difficulty coping with illness and that the psychiatrist will offer the patient and physician advice about the emotional aspects of the illness and about the effects of treatments and medicines on mental functioning. Naturally, psychiatric consultation is best accepted when the psychiatrist is a regular member of a multidisciplinary team routinely working with cancer patients and their families.

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