

# Psychological Status of Cancer Patients

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**Abstract:** ***Aim:** To review the psychological problems of cancer patients. **Objective:** The objective of the review is to understand and analyse the psychological problems of patients affected by cancer. **Background:** The diagnosis of cancer and cancer treatment can cause distress, emotional turmoil and different psychosocial disorders. Taking into consideration different psychological reactions of cancer patients can be helpful for organizing adequate psycho-educational and psychosocial support, and psychotherapy for cancer patients and their families. **Reasons:** By analysing the psychological problems of cancer patients we can provide them with psychological therapies which may help them in various ways, ranging from reducing the side effects of cancer treatments to improving patients' immune function and longevity.*

**Keywords:** psycho-oncology, depression, psychotherapy

## 1. Introduction

Psychological stress describes what people feel when they are under mental, physical, or emotional pressure. Although it is normal to experience some psychological stress from time to time, people who experience high levels of psychological stress or who experience it repeatedly over a long period of time may develop health problems (mental and/or physical).

Stress can be caused both by daily responsibilities and routine events, as well as by more unusual events, such as a trauma or illness in oneself or a close family member. When people feel that they are unable to manage or control changes caused by cancer or normal life activities, they are in distress. Distress has become increasingly recognized as a factor that can reduce the quality of life of cancer patients. There is even some evidence that extreme distress is associated with poorer clinical outcomes. Clinical guidelines are available to help doctors and nurses assess levels of distress and help patients manage it.

Cancer accounts for nearly 3 lakh deaths annually in India, exceeded by heart disease. Major Depressive Disorder accounts for 4.4 percent of the overall global disease status, and the Disability Adjusted Life Years (DALYs) for depression in the near future will be greater than cancer<sup>1,2</sup>. A strong body of evidence demonstrates the coexistence of depression and cancer, reported prevalence rates of depression for solid tumours ranging from 20 to 50%. These results generally include all the depressive disorders not just the Major Depressive Disorder. Grassi. et. Al<sup>3</sup> found that out of 201 recently diagnosed cancer patients, 15% met the criteria for a Major Depressive Disorder, the same reported by Coyne et al<sup>4</sup> among breast cancer patients. There is reason to agree that many patients affected by subclinical depression go undetected. More research is required to establish the prevalence of depressive disorders in the forthcoming years after the diagnosis using standardized diagnostic criteria.

## 2. Psychological Distress

Psychological distress is common among cancer patients due to the effects that the disease has on the patient, the patient's

family and the inherent difficulty in coping with a life threatening illness. Some studies over the years have been reported a high incidence of psychological distress in this patient population<sup>5,6</sup>. The initial diagnostic phase can be very stressful and can cause a great deal of psychological turmoil, including feelings of depression, anxiety, anger, fatigue and denial. Some patients have pre-existing psychological distress and this group find the cancer diagnosis much harder to deal with. Other difficult issues arise from the fact that cancer is potentially a terminal disease that often requires invasive treatment and has a high rate of recurrence. Psychosocial needs require attention due to their direct and indirect effects on health and quality of life. It is possible to screen for psychological morbidity relatively easily using the HAD (Hospital Anxiety and Depression) scale. In addition, single item domain measures would appear to be effective<sup>7</sup>.

## 3. Common Psychiatric Disorder Faced By Cancer Patient

Recent researches and clinical practice indicate that about third to half of oncology patients have different psychiatric/psychological co-morbidity disorders. There are many predisposing 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<sup>8</sup>.

Psychiatric/psychological problems that can usually be seen among cancer patients are primarily depressive disorder, adjustment disorder, post traumatic stress disorder and others are anxiety disorders, sexuality dysfunctions, 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<sup>9</sup>.

Several studies clearly demonstrate that psychosocial distress occurs in one-third to one-half of all cancer patients. There are some groups of cancer patients that are especially vulnerable to psychosocial distress. Particularly patients with history of chronic depression, patients with breast and

genital cancer, patients using specific coping strategy (hopelessness/helplessness), patients without social support, children and elderly patients should be recognized at earlier stages of cancer diagnosis and treatment. Although severity of emotional distress is more closely related to a patient's pre-existing vulnerability than to the characteristics of the cancer, it is more likely to occur at the following stages of patient's experience with cancer.

#### 4. Pharmacotherapy and Psychotherapy

Certain measures can be taken by the physician to overcome the depression and anxiety the cancer patient has been going through. This can be achieved by both pharmacological therapy and psychological therapy. However, prescribing antidepressants to cancer patients requires specific knowledge, experience and caution. One must take into account: the anti cholinergic side effects of tri cyclic antidepressants, the pro-emetic effect of Selective Serotonin re-uptake inhibitors (SSRIs) and their potential effects on the pharmacokinetics of other drugs, and the specific syndromes occurring in combination with chemotherapy. Medication should be tailored to each cancer patient based on the different characteristics of the various drugs.

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, 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.

#### 5. Fear of Recurrence

Recurrence following head and neck cancer tends to occur within the first two years following treatment. This is a particularly stressful time for patient and carers. One study reported that at three months post-treatment, over 80% of patients expressed concern over the possibility of recurrence and that this level reduced to 72% at seven months<sup>10,11</sup>. Fears of recurrent disease remain for some time following initial

treatment and are not necessarily related to the stage of disease or radicality of treatment. There is an association with psychological morbidity, especially anxiety. Therefore, an attempt should be made to identify patients who have a notable fear of recurrence and they should be offered appropriate support.

#### 6. 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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