PSYCHIATRIC AND PSYCHOLOGICAL ASPECTS OF CANCER

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Biopsychosocial Model
Each physical illness is a crisis

Medically

it involves physiopathologic-organic processes

For patient

A biopsychosocial situation, identity and existential crisis
Psycho-oncology is an area of specialization which aims to understand and to treat from prevention to bereavement, the functional aspects and psychological, emotional and quality of life issues of cancer.

Psycho-oncology or psychiatric oncology investigates:
1- Psychological effects of cancer on patient, family and the medical staff.
2- The effects of psychological and behavioral factors on cancer risk and prognosis.

It is also a discipline which provides psychological medicine services to cancer patients.
**PSYCHOSOCIAL ONCOLOGY**

*Historical Development*

**In 1950s**...Developments in chemotherapy and the onset of questioning of the “quiet attitude” towards cancer.

**In 1960s**...Fast developments in the diagnosis and treatment of cancer and the psychiatric research on cancer patients gains speed.

**In 1970s**...with the developments in cancer care, patients become more involved in treatment options and decisions and their quality of life expectations is heightened. Liaison psychiatry services grow faster in general hospitals and biopsychosocial perception is adopted.
PSYCHOSOCIAL ONCOLOGY

Historical Development

In 1980s... psychiatric complications of cancer and its treatment strategies are better defined, discussion about medico-legal issues and euthanasia took place.

In 1990s... with the increase of the research on psychiatric and psychosocial research of cancer, development of psychoneuroimmunology, appearance of quality of life concept and social education and with the acceptance of psychooncology as a scientific discipline, biopsychosocial integrative approach is ultimately accepted.
ILLNESS AS A STRESSOR

- Diagnosis
- Pain
- Facing death
- Fear
- Change in family roles
- Decisions about treatment
- Decrease in physical capacity
- Changes in social environment
- Difficult treatments
REACTION TO CANCER DIAGNOSIS

In cancer patients, emotional and behavioral reactions can be appeared.

Bolund defined the process after the cancer diagnosis in 4 steps:

1) Shock
2) Reaction
3) Resistance
4) Adjustment

Elisabeth Kübler Ross defined this process in 5 steps:

1) Denial
2) Anger
3) Negotiation
4) Depression
5) Acceptance
REACTION TO CANCER DIAGNOSIS

**First Stage**
Shock, denial, anger-revolt (“why me?”)
Depressive mood

Generally less than 1 week

**Second Stage**
Anxiety, depressive mood, appetite and sleep disturbances, attention deficit, functional disturbances

Generally 1-2 weeks

**Third Stage: Adjustment**
Accepting the diagnosis validity and the evaluation of treatment options and back to normal activities.

Generally 2 weeks, but it may take months
REACTION TO CANCER DIAGNOSIS

FEARS OF CANCER PATIENTS
  Ú
  Death
  Disability
  Distortion of body image
  Dependency
  Disruption in relationships, role functioning, and financial status
CANCER AND ADJUSTMENT

Adjustment mechanisms are defined as;

- Fighting spirit
- Helplessness and hopelessness
- Distressing excessive preoccupation
- Fatalist acceptance
- Avoidance and Denial
PSYCHOLOGICAL IMPACT

High Risk Profile Patients:

Passive/Helpless/Pessimistic attitude
Rigid approach to new environments
Demanding
Highly anxious patients
Low social support
Time pressures “being behind”
Denial’s Function

- Protects patients from unbearable pain causing psychological distress or suicide
- Since it is a coping mechanism, an intervention such as a direct facing is not recommended
- Total denial may cause treatment rejection and may need intervention
GIVING BAD NEWS

1-Preparing the patient for the interview
2-Investigating patient’s level of knowledge
3-Learning how much the patient wants to know.
4-Sharing the information
5-Coping with the patients emotions
6-Sharing treatment strategy and planning the forthcoming interview.
The way of giving information is as important as the information itself.

The session should be held with the patient in a special setting.

Medical jargon should be avoided.

Comprehensibility, being emphatic and making eye contact is important.

Using open and simple expressions is important.

Information should be given slowly.

Giving support is important.

Including the patient into the decision making process is important.

Second interview should be arranged.

The patient should be given enough time to process the news and formulate his questions.

Questions should be answered honestly by maintaining hope.
PSYCHIATRIC DISORDERS IN CANCER PATIENTS

Adjustment Disorders
Anxiety Disorders
Depressive Syndromes
Organic Brain Syndromes
  (delirium, dementia, neuropsychiatric side effects of chemotherapeutical agents)
Personality Disorders
Pain Disorder
  Loss of appetite, nausea and vomiting
Sleep disorder
Sexual dysfunction
DISTRIBUTION OF PSYCHIATRIC DISORDERS IN CANCER

Normal responses to cancer, Day to day crisis, stress

Adjustment disorders with depressed/anxious symptoms

Depression
Delirium
Anxiety Disorders
Personality Disorders
Major Mental Illness
About 21% of cancer patients have adjustment disorders.

Emotional or behavioral symptoms as an evidence of maladaptive reactions to stressor.

Adjustment to the diagnosis of cancer, its course, and treatment.

Malfunctioning in one or more psychosocial areas such as work, interpersonal relationships, activities of daily living is the characteristic of adjustment disorders.

Symptoms are not very specific and usually resolve within 6 months.
PSYCHOLOGICAL ADJUSTMENT TO CANCER

*Psychological Adjustment is influenced by:*

1) **Medical factors:**
   - site of tumor
   - stage and course of disease
     - prognostic factors
     - symptoms
     - pain

2) **Factors related to patient:**
   - personality
   - coping mechanisms
   - life events

3) **Socio-cultural factors:**
   - attitudes and beliefs
   - available social support
%9-20 in general population in Turkey
More in women
The prevalence of depression in cancer patients is reported to be in between %20-50
CANCER AND DEPRESSION

The factors that increase depression risk in cancer patients are:

- Depressive disorder or alcoholism history
- Late stage of cancer
- Insufficient social support
- Uncontrolled pain
- Some drugs used during treatment
ASSESSING DEPRESSION IN CANCER PATIENTS

Paying attention to somatic symptoms which could be caused by cancer (or treatment) is important:

- Poor appetite or anorexia
- Sleep problems, insomnia
- Poor concentration
- Loss of physical energy
DIAGNOSIS OF DEPRESSION IN CANCER PATIENTS

β Intensive and continuous depressed mood

β Diminished interest or pleasure in activities
(also in the area of interpersonal relations)

β Feelings of worthlessness or excessive guilt
(considering the illness as a punishment for his / her faults)

β Recurrent thoughts of death or suicidal ideation
(not fear of death)

β Psychomotor retardation or agitation
DIAGNOSIS OF DEPRESSION IN CANCER PATIENTS

β If the patient does not participate to the treatment, does not feel good and/or has a low functioning although his physical situation does well

β If somatic symptoms are intensive, continuous and not proportional to physical illness, but elated to depressive mood
WHY DEPRESSION IS MORE FREQUENT?

BIOLOGICAL MECHANISMS

- Primary or metastatic involvement of brain, existence of BOS tumor cells, related to mania or depression
- Chemotherapeutic agents; vinkristine, vinblastine, corticosteroids, interferon, interleukine-2, asparaginase, procarbazine, tamoxifen
- Cortisol, IL-6 and changes in natural killer cell activity
- Chronic stress and depression, activation of hypotalamic-hypophysial-adrenal axe; release of mediators that supress normal immune responses; especially in virus induced cancers, it may affect the appearence and development of the illness
PSYCHOSOCIAL FACTORS
Stress, social relations, support, coping, personality, anxiety, depression

ENDOCRINE ACTIVATION
HPA axe, autonomous activation, Other hormones.

CIRCADIAN RHYTHMES
Sleep, activity, endocrine, Metabolic and immune rhythms

IMMUNE DEFENSES
CTL, T cells, B cells, NK and LAK cells, macrophages.

Tumor progression

(Semphton, 2003)
RISKS FACTORS IN MEDICALLY INDUCED DEPRESSION

- Unrelieved pain
- Other chronic illness/disability, terminal stage
- Treatment side effects
- Metabolic (anemia, hypercalcemia)
- Nutritional (deficiency of vitamin B12 or folat)
- Endocrine (hyper-hypotiroidism, adrenal insufficiency)
- Neurologic (paraneoplastic syndromes)
- Site of the cancer (pancreas, small cell lung, liver, head and neck, leukemia)
Sadness and anxiety alone with the feeling of loss accompanying the cancer diagnosis are normal reactions.

Grief process may be diminished in days and weeks by the support of the treatment team, family and the spouse.

Anhedonia, treatment rejection or hopelessness and suicidal ideation which may cause social isolation should be given attention.

“Blues” sorrow is a normal reaction.

Depressive syndrome is never “normal”, the need for its treatment is certain.
EFFECTS OF DEPRESSION IN CANCER PATIENTS

- Deterioration of the quality of life
- Higher levels of pain
- Burden for the family
- Longer hospital stay
- Reduced adherence to treatment
- Less efficacy of chemotherapy
- Shorter survival expectancy
- Risk of suicide
SUICIDE RISK IN CANCER

- In cancer patients, the risk of suicide is 1.5 times higher than normal population
- Especially in terminal phases, suicidal ideation is about %8
- Desire for a faster death in cancer patients with an advanced and terminal stage disease is about %17
- The desire for death is usually associated with poor physical conditions, depressive state, hopelessness, low social support
FACTORS AFFECTING SUICIDE RISK

Psychological factors

- A history of depression or suicide attempt in patient or in the family
- Alcoholism and/or substance abuse
- Depression
- Helplessness, hopelessness, burnout
- Loss or grief in near past
- Social isolation

Medical factors

- Uncontrolled pain
- Delirium with disturbed impulse control
- Advanced disease
Antidepressants

- TCA are potentially problematic because of anticholinergic and anti-alpha-adrenergic effects
- Can be useful in patients with co-morbid neuropathic pain syndromes
- Attention should be given to patients with a tendency for delirium and using opioids
- MAOI should be avoided because of drug-drug and drug-food interactions
Antidepressants

- SSRI, SNRI, mirtazapine, bupropion - most frequently because of their safety and generally favorable side effect profiles
- Venlafaxine, duloxetine and milnasipran are useful in pain syndromes, indicated in neuropathic pain
- SSRI and venlafaxine are useful for hot flashes and night sweating
- Be careful for the drug interactions with SSRI
Fast effect
Especially for those with a limited survival time
May correct cognitive problems (increase attention and concentration)
Increase energy
Increase the effects of analgesics and decrease opiate induced sedation
Metilphenidate is especially effective for terminal patients in 48 hours
ANXIETY

THREATS
- Disappearing
- Separation
- Loss of control
- Conflicts

Defense Mechanisms

Coping Skills:
- Effort for being informed
- Sharing
- Taking action
- Denial
- Dependency
- Regression
- Projection

Symptoms of Anxiety
- Discomfort
- Anxious waiting
- Physiological complaints
- Sleep disorder

Free Anxiety
- Panic Disorder
- Psychotic Anxiety
CANCER AND ANXIETY DISORDERS

- Anxiety is quite often precipitated by cancer
- It is a subjective phenomenon difficult to assess
- It is about twice as common in cancer patients as in controls
- Often coexistent with depression
- Its principal component is negative affect
CANCER AND ANXIETY DISORDERS

Main symptoms of anxiety disorders:

- Insomnia
- Excessive sensitivity
- Concentration deficits
- Impatience
- Panic attacks
- Dyspnea, heart palpitations, sweating
- Mouth dryness, vertigo
- Gastrointestinal symptoms
CANCER AND ANXIETY DISORDERS

At the beginning, in cancer patients anxiety attacks are frequently seen during diagnosis and crisis stages. Anxiety provoking situations in these patients are:

- Diagnosis stage
- Waiting for examination results
- Before a new treatment
- Change of treatment
- Appearance of symptom
- Appearance of relapse
- Experiencing changes being reminiscent of the illness
TREATMENT

- Benzodiazepines
- SSRI
- Other antidepressants such as: Venlafaxine, mirtazapine, trazadone
- Beta-blockers
- Antihistaminics
- Neuroleptics
- Buspiron
- Combination Strategies
The incidence of delirium in cancer patients is about 15-20%; as a pretty high percentage. In terminal patients this percentage is around 85.

**Direct causes**
- Primary tumor
- Local invasion
- Metastatic invasion hematogenically or lymphatically

**Indirect Causes**
- Metabolic problems
- Effects of treatment
- Infections
- Vascular complications
- Nutritional deficits
Delirium is a fast and suddenly developing brain insufficiency.

Delirium in cancer patients is a frequently seen psychiatric situation which necessitates emergency intervention and treatment.

It has high potential of causing death or dementia development. Therefore, its early detection and its fast and efficient treatment is very important.
Symptoms experienced in these patients are as follows:

- Confusion
- Orientation deficits
- Psychomotor agitation or retardation
- Inability to pay attention (distractibility)
- Sleep-wake cycle disruption
- Diurnal variation
- Autonomic dysfunction
- Illusions and hallucinations
- Delusions
The main aim is the treatment of the underlying disorder

- Preventing self or environmentally injuring behaviors
- Close observance
- Arranging environmental conditions
- Antipsychotics
- Benzodiazepines
CANCER AND FAMILY

* The illness causes a crisis not only for the patient but also for his/her family.
* Besides the cancer patient, generally families also need psychological treatment and support.
* In the families where the relationships are balanced, emotions are easily expressed, conflicts are rare and cooperation is high, thus the patient adaptation is increased.
* In case of unclear family roles, over controlling and strict family contexts, the adaptation of the patient becomes more difficult.
* Denial of the possible conflicts makes the solution of these conflicts even more difficult.
Staff working with cancer patients are under stress in every stage of the illness, especially during terminal stage.

Difficulties experienced by the staff are related to:

- The patient’s situation
- Relations with patient and patient’s family
- Care context
- Treatment conditions
- Their own roles and expectancies
After the death of the patient many experts experience:
- Feelings of guilt
- Headache
- Sleep disturbances
- Various psycho-physiological function deficits

The team of consultation-liaison psychiatry by providing psychiatric and psychosocial care help medical staff in solving these difficulties
PSYCHOTHERAPY IN CANCER

- Cognitive behavioral therapy
- Psychodynamic therapies (supportive-expressive)
- Crisis intervention and short term psychotherapies
- Behavioral techniques
- Short term dynamic psychotherapy
- Group psychotherapy
- Psychosocial care and the arrangement of therapeutic context
PSYCHOLOGICAL TREATMENT

The main goals:

- to reduce psychological anxiety and pain
- to establish adaptation
- to increase the quality of life
- to help in the expression of emotions
- to increase the life energy and coping
- to help in coping with the illness’ multidimensional crisis in a healthy way
- to correct existing misperceptions
- to correct “all or nothing” style behaviors and thoughts
- to enhance social support and communication
Considering the patient as a whole while treating the patient

Psychological withdrawal precipitates bodily exhaustion

The healthy adjustment of a patient to the new situation is related to his/her psychological health

Life should be reconstructed relevant to the new physical and psychological condition and relationships maintained normally
The perception of the treatment team towards the patients and the illness influences patient’s self perception

Avoidance of stigmatic attitude towards cancer is important

A positive fighting spirit should be created

Our aim is to conduct a marathon together with the patient, family and multidisciplinary treatment team without being exhausted
From illness to life…

As a team, with the belief and pride that science, trust and affection are the prime values for health and happiness
THANK YOU