Psycho-oncology

a report by
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Introduction

The diagnosis of cancer is an extreme stressor. The stress of the diagnosis is caused by the patient's perceptions of the disease and its manifestations, and by the stigma commonly attached to cancer. For most individuals, the primary concern is of suffering a painful death. In addition, patients with cancer fear becoming disabled and dependent, disfigurement or alteration of appearance and changed body function, and losing the company of those close to them. Although such fears are similar in all patients, the level of psychologic distress and ability to adjust is highly variable. This variability is accounted for by three factors:

- medical factors (site, stage, treatment, clinical course of the cancer, and the presence of pain);
- psychologic factors of prior adjustment, coping ability, emotional maturity, the disruption of life goals, and ability to modify plans; and
- social factors such as the availability of emotional support offered by family, friends, and co-workers.[1]

Emotional distress is a normal response to the catastrophic event that a cancer diagnosis represents. By understanding the factors outlined above, however, the clinician can better predict and manage the distress that exceeds what is arbitrarily defined as 'normal'. Distress that is highly disabling (i.e. compromises the usual function of the patient) is of greater intensity or duration than the 'normal' responses to the illness and requires evaluation, diagnosis, and management.

Depression

There is a commonplace assumption that all patients with cancer are depressed. This thought minimizes the degree of suffering that can be associated with comorbid depression and its impact on a person's quality of life, and promotes the underdiagnosis of depression and, in turn, its undertreatment. Health professionals may underestimate the morbidity caused by depression, because they tend to believe they would feel depressed if roles were reversed. Depressive states exist on a continuum from normal sadness that accompanies life-limiting disease to major affective disorders. It is important that physicians differentiate between these levels of distress. Using screening tools and raising awareness about depression is an important step. Several studies[2,3] have suggested that physicians and nurses do not recognize levels of depressive symptoms and that failure to do this is worse when patients have more severe depressive symptoms.[4,5]

Diagnosing depression in physically healthy patients depends heavily on the presence of somatic symptoms such as decreased appetite, loss of energy, insomnia, loss of sexual drive, and psychomotor retardation. These neurovegetative symptoms of depression are very compelling when present in the absence of physical illness but are somewhat less reliable for diagnosing depression in patients with advanced disease. Loss of appetite due to chemotherapy, fatigue due to cancer, and lack of sleep due to unrelieved pain are examples of the problems in differentiating somatic symptoms due to depression or other medical causes. Physical symptoms must be carefully evaluated to clarify their etiology and target them for intervention. However, due to the correlation between higher levels of symptom distress and the other, more reliable, cognitive or ideational symptoms they should not be discounted and indeed may be a useful tool for beginning discussion with the patient. Assessing these symptoms can be a way to open a dialogue with the patient who might otherwise resist discussions of emotional issues. Moreover, antidepressants can be chosen so as to target the physical symptoms that are most distressing to the patient.[5]

Persistently depressed mood can be an appropriate response for a patient with a life-threatening disease, so the diagnosis of depression in advanced cancer patients relies more on the other psychologic or 'cognitive symptoms'. Anhedonia is a useful, if not the most reliable, depressive symptom to monitor.[6] Cancer patients who are not depressed, while periodically sad, maintain the capacity for experiencing pleasure, and there is nothing inherent to the disease or treatment process that robs them of the ability to feel pleasure. Such patients react positively to opportunities to engage in the activities that they enjoy, even though the range of activities available to them may be diminished. Indeed, some patients with far advanced disease

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experience exhilaration in things such as intimacies with family or friends knowing that the experiences are among the last they might have. The knowledge that death is near can increase the poignancy and emotion in such contacts.[7] Feelings of hopelessness, worthlessness, excessive guilt, loss of self-esteem, and wishes to die are also among the most diagnostically reliable symptoms of depression in cancer patients.

The interpretation of even these more reliable symptoms can be difficult. For example, feelings of hopelessness in dying patients who have no hope for recovery can be normal. While many cancer patients never have a hope of a cure, they are able to maintain hope that life can be extended, symptoms can be controlled, and/or quality of life can be maintained. Hopelessness that is pervasive and accompanied by a sense of despair or despondency is more likely to represent a symptom of a depressive disorder. Similarly, patients often state that they feel they are burdening their families unfairly, causing them great pain and inconvenience. These beliefs can be addressed through counseling the patient and helping them to reframe the care they need as something their family needs to provide as part of the mourning process.[7] The patient can come to see that allowing him or herself to be cared for is important for their family's sake. Thus, such beliefs are less likely to represent symptoms of depression than if the patient suffers with guilty recrimination or worthlessness. Suicidal ideation, even in mild and passive forms, is very likely associated with significant degrees of depression in patients with advanced disease. Several groups, recognizing these difficulties in applying traditional Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnoses of depression in these settings, have tried to define a group of more relevant variables responsive to a range of interventions. These variables include loss of meaning, hopelessness, loss of dignity, boredom, and demoralization.[8–11]

Anxiety

Patients with advanced disease may present with a complex mixture of physical and psychological symptoms in the context of their frightening reality. Thus, recognizing anxiety symptoms that require treatment can be challenging. Patients with anxiety complain of tension or restlessness, or they exhibit jitteriness, autonomic hyperactivity, vigilance, insomnia, distractibility, shortness of breath, numbness, apprehension, worry, or rumination. Often the physical or somatic manifestations of anxiety overshadow the psychologic or cognitive ones.[12] These symptoms are a cue to further inquiry about the patient's psychologic state, which is commonly one of fear, worry, or apprehension. In deciding whether to treat anxiety, the patient's subjective level of distress is the primary impetus for the initiation of treatment rather than qualifying for a psychiatric diagnosis. Other considerations include problematic patient behavior such as noncompliance, family and staff reactions to the patient's distress, and the balancing of the risks and benefits of treatment.[13]

Anxiety is a symptom in this population that can have many etiologies. It may be encountered as a component of an adjustment disorder, panic disorder, generalized anxiety disorder, phobia, or agitated depression. Additionally, in patients with advanced disease, symptoms of anxiety are most likely to arise from some medical complication of the illness or treatment such as organic anxiety disorder, delirium, or other organic mental disorders.[12–14] Hypoxia, sepsis, poorly controlled pain, and adverse drug reactions such as akathisia or withdrawal states are specific entities that often present as anxiety. Benzodiazepine withdrawal, for example, can present first as agitation or anxiety, though the diagnosis is often missed in cancer patients with advanced disease, and especially the elderly, where physiologic dependence on these medications is often unrecognized.[15]

Despite the fact that anxiety in patients with advanced disease commonly results from medical complications, equally as often it is psychologic factors related to existential issues that cause anxiety, particularly in patients who are alert and not confused.[12] Patients frequently fear isolation and estrangement from others, and may have a general sense of feeling like an outcast. Also, financial burdens and family role changes are common contributors to stress.

Delirium and Dementia

Delirium has been characterized as an etiologically non-specific, global, cerebral dysfunction, characterized by concurrent disturbances of level of consciousness, attention, thinking, perception, memory, psychomotor behavior, emotion, and the sleep–wake cycle. Disorientation, fluctuation, or waxing and waning of the above symptoms, as well as acute or abrupt onset of such disturbances, are other critical features of delirium. Delirium is also conceptualized as a reversible process, compared with dementia. At times it is difficult to differentiate delirium from dementia since they frequently share such common clinical features as impaired memory, thinking, judgment, and disorientation. Dementia appears in relatively alert individuals with little or no clouding of consciousness. The temporal onset of symptoms in dementia is more insidious or chronically progressive, and the patient's sleep–wake cycle is generally not impaired. The most prominent symptoms of dementia are difficulties in short- and long-term memory, impaired judgment and

abstract thinking, and disturbed higher cortical functions (i.e. aphasia, apraxia, etc.). Occasionally, one will encounter delirium superimposed on an underlying dementia such as in the case of an elderly patient, an AIDS patient, or a patient with a paraneoplastic syndrome.[16]

Delirium is most common in patients with far advanced disease. Between 15% and 20% of hospitalized cancer patients have organic mental disorders.[17] Massie et al.[18] found delirium in more than 75% of terminally ill cancer patients they studied. Delirium can be due either to the direct effects of cancer on the central nervous system (CNS), or to indirect CNS effects of the disease or treatments (medications, electrolyte imbalance, failure of a vital organ or system, infection, vascular complications, and pre-existing cognitive impairment or dementia). Early symptoms of delirium can be misdiagnosed as anxiety, anger, depression, psychosis, or unreasonable or uncooperative attitudes to rehabilitative efforts or other treatments. In any patient showing acute onset of agitation, impaired cognitive function, altered attention span, or a fluctuating level of consciousness, a diagnosis of delirium should be considered.[19]

A common error among medical and nursing staff is to conclude that a new psychologic symptom is functional without completely ruling out all possible organic etiologies. For example, given the large numbers of drugs that patients with advanced disease require and the fragile state of their physiologic functioning, even routinely ordered hypnotics are enough to create an organic mental syndrome. Opioid analgesics such as levorphanol, morphine sulfate, and meperidine, are common causes of confusional states, particularly in the elderly and patients with advanced disease.[20] Except for steroids and biological response modifiers, most patients receiving these agents will not develop prominent CNS effects. The spectrum of mental disturbances related to steroids includes minor mood lability, affective disorders (mania or depression), cognitive impairment (reversible dementia), and delirium (steroid psychosis). The incidence of these disorders ranges from 3% to 57% in non-cancer populations, and they occur most commonly on higher doses. Symptoms usually develop within the first two weeks of treatment, but in fact can occur at any time, on any dose – even during the tapering phase.[21] Prior psychiatric illness or prior disturbance on steroids are poor to fair predictors of susceptibility to, or the nature of, mental disturbances during subsequent steroid treatments. These disorders are often rapidly reversible upon dose reduction or discontinuation.

Conclusion

The most common psychiatric complications in the cancer population are depression, anxiety, and delirium. All are more likely to occur in the cancer patient who has pain, which helps to support the notion that psychologic problems can have a serious impact on physical well-being and outcome. It is important for patient comfort and quality of life to evaluate and manage the psychologic distress of a patient with cancer, especially if pain is a complication. ■

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