Psychooncologic Aspects of Breast Cancer

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Key Words

Breast cancer · Psychooncology · Psychosocial interventions

Summary

Around one third of all patients reveal signs of stress disorder and adaptation difficulties following breast cancer or during the course of the illness, often manifested clinically as fear and depression. Supportive treatment should be made available to all patients in the form of psycho-educative group sessions introducing information and assistance to help overcome the illness. The indication for extensive treatment, e.g. psychotherapy, can be deduced from the somatopsychic disorders presented. Individual or group therapy will be offered to the patient corresponding to her diagnostics and motivation. The aim of therapy should be discussed openly with the patient, that is, an improvement in the quality of life and the possibility to overcome the situation. In general, the various intervention programmes have proved to be beneficial for patients with cancer. These include relaxation therapy and stress management as well as behavioural therapy and supportive psychotherapy. Patients have high expectations of the therapy offered and this should be taken into careful consideration by all physicians, psychologists and others responsible for administering treatment. The aim of this work is mainly to present the clinical experience gained in a breast centre.

Schlüsselwörter

Brustkrebs · Psychoonkologie · Psychosoziale Intervention

Zusammenfassung

Nach einer Brustkrebserkrankung sowie im Krankheitsverlauf zeigen sich bei einem Drittel der Patientinnen Belastungsreaktionen und Anpassungsstörungen, die sich mit dem klinischen Bild von Angst und Depressivität äußern. Eine Unterstützung im Sinne psychoedukativer Gruppenangebote zur Informationsvermittlung und Unterstützung der Krankheitsbewältigung sollte allen Patientinnen zugänglich gemacht werden. Die Indikation zu einer umfangreichen Behandlung, z.B. einer Psychotherapie, ergibt sich aus den somatopsychischen Störungen. Dabei wird die Indikation zur Einzel- oder Gruppenpsychotherapie entsprechend der individuellen Diagnostik und der Motivation der Patientin gestellt. Die Therapieziele sollten mit der Patientin auf einer realistischen Grundlage gemeinsam abgeklärt werden; diese sind eine Verbesserung der Lebensqualität und des Bewältigungsverhaltens. Insgesamt haben sich verschiedene Interventionsprogramme als nachweislich hilfreich für Tumorpatientinnen erwiesen. Dazu gehören neben Entspannungsverfahren und Stressmanagement die Verhaltenstherapie und die supportive Psychotherapie. Die Hoffnung gebende Funktion aller Behandelnden wird vonseiten der Patientin immer erwartet, und dem sollte von Ärzten, Psychologen und weiteren Behandelnden sensibel begegnet werden. Ziel dieses Beitrags ist in erster Linie die Darstellung der klinischen Erfahrung aus der Arbeit in einem Brustzentrum.

Introduction

Over the past 20 years psychooncology has established itself as a specialist field of medicine. In Germany, this development has evolved from the field of psychosomatics as well as from medical psychology. Increasing interest towards the psychic aspects of cancer contributed to the changes brought about in medicine and influenced also the attitude of the physician towards the patient presenting with a grave and often chronic illness. Furthermore, the patients, in particular the self-help groups, have called for more involvement when drawing up a decision together with extensive measures corresponding to their psychic situation [1]. Medical treatment has become a challenging and often an overtaxing assignment. Especially the approach to a principally life-threatening illness which demands the necessity of intervening therapeutic measures, sometimes offering only a minimal chance of success, can bring about psychic instability [2]. Psychooncologic treatment has become an integrated feature in the concepts of breast centres and disease management programmes (DMPs). Despite the fact that this job is often taken up by qualified colleagues such as physicians, psychotherapists, psychologists and social workers, it must be emphasised that the diagnostics of psychic stress as well as the psychosomatic fundamental treatment remains primarily the task of the gynaecologists specialising in oncology.

Stress Experienced by Women with Breast Cancer

The diagnosis of cancer leads to intense emotional stress as well as physical changes. The life of those affected by this condition becomes a turmoil of confusion. The patient has to come to terms with the uncertainty brought about by a potentially life-threatening illness, even if the prognosis holds some hope for recovery [3]. The breasts play a significant role for a woman both in an emotional and a sexual way and present a feature of attractiveness for the woman herself as well as for others. The impairments associated with the intervening cancer treatment are brought about by surgery, radiotherapy, anti-hormonal therapy and/or chemotherapy. There is also the external clinical picture of the impairments; this includes loss of the breast or, more frequently, prosthesis, scarring or reconstructions. The sensitivity of the skin changes as a result of radiotherapy and the patient often suffers from loss of hair under chemotherapy. Persistent disruption of ovarian function during and following chemotherapy is another stress factor together with the loss of self-confidence, diminished participation in social activities as well as the psychic impairments regarding the future. All these factors greatly affect the close contact person or the entire family.

A psychic morbidity as a result of these stress factors has been recorded as 50% in cancer patients. Following cancer, the most frequent psychic disorders have been registered as

Table 1. Psychological co-morbidity following diagnosis of breast cancer stadium I and II [4]

Criteria of depression	36.6%
	9.6% major depression
	27.1% minor depression
	24.7% adjustment disorder and depressed mood
Criteria of anxiety disorder	2.3% dysthymic disorder
	10.6%
	5.9% adjustment disorder and anxious mood
	1.6% generalised anxiety disorder
	1.3% panic disorder
	1.6% post-traumatic disorder

depression and anxiety disorders (table 1). The prevalence data show marked differences according to the investigation group and depending on the setting and the diagnostic methods; these findings have been documented in detail in the literature [4, 5]. A number of reviews assessing the occurrence of co-morbid depression in cancer patients found that the incidence of depression ranged from as high as 58% to as low as 4.5% [6]. In the German-speaking countries there are to date only few investigations featuring this topic. The prevalence figures also vary in a broad range between 5% depression, 20% anxiety and 37% symptoms of distress [7]. About 10% of all patients suffer from severe depression during the first years after diagnosis [8]. Inconstant prevalence figures for meta-analyses in breast cancer patients have also been revealed. In a number of studies, the clinical symptoms have been recorded as significantly high; for example, depressive symptoms at 42% and anxiety symptoms at 30% [9]. Peak prevalence for depression, anxiety, or both was 33% in the year of diagnosis and falling to 15% after 1 year [10]. There are some groups of women who demonstrate an exceptional vulnerability to psychic disorders. These include women without a partner, younger women and women with more severe gynaecological symptoms. Those women living together with a partner presented with fewer complaints depending on the length of the relationship.

Needs for Assistance

Only few studies have reported on the needs for psychosocial assistance by cancer patients [11, 12]. Although the desire for assistance was generally high, both on the side of the patients [13] and on those persons administering the therapy, the investigation carried out by Söllner et al. [14] showed that there was only a moderate concurrence recorded between the requirement of the patient and the estimation of the requirement by the referring physician. The oncologists acknowledged in this investigation the presence of grave psychic problems in only 11 of the 30 affected patients. The recommenda-

Table 2. Influence of clarification on the patient and her relationship to the physician

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- Attention and interest of physician is of great support to patient.
 - Information diminishes fear of the unknown and excessive feelings of panic.
 - Clarification enables the patient to trust in the competence of the physician. The patient learns that one can talk about the illness, one can treat the illness and one can learn to cope with the illness.
 - The process of learning to overcome the illness creates a counter-balance towards passivity and regression.
 - The collaboration of physician and patient is brought about by clarification by the physician and cooperation of the patient.
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tion of the oncologists to undertake supportive counselling did not correlate with the problems of the patients. These results underline the requirement of further training for the oncologists in order to improve their knowledge when diagnosing patients with psychosocial stress.

Even fewer data are available referring to the consent to psychosocial therapy. One German study reported that 28% consented to participate in a group programme. This featured mainly women with breast cancer. This corresponds approximately to the figures presented by the working groups of Bruns and Plass [15, 16].

Particularly low are the figures at 2–8% in a US American investigation relating to a random sample of insured patients. Consent is low, despite extensive knowledge covering the various assistance possibilities. At the same time, it can be said that consent to psychosocial assistance as regards the needs of the patients is estimated to be higher by the professionals [17, 18].

Assistance through the Various Stages of Illness

Diagnosis Report

The determination of a diagnosis and the ensuing treatment constitute the most difficult phase during the course of cancer. During this phase, the physicians are often the most important contact persons of the patients, together with other cancer patients, family and close friends. From the perspective of the patient, the physician-patient interaction presents a particularly stressful situation: with often inappropriate setting, lack of empathy, sometimes findings related over the telephone and inconsistent information [19]. In the last decade, a positive outcome for the physician-patient relationship was achieved concerning the clarification and information obligation using the catch phrases ‘patient autonomy’ and ‘joint decisive factor’. There are a number of significant aspects associated with the disclosure of bad news, since for the patient this situation is always connected with shock and there are certain ways of helping the patient to deal with this. Firstly, it is important to make sure that the environment is suitable for an undisturbed discussion, also that enough time is given to impart the neces-

sary information and that close contact persons are in the vicinity. The next step is to clarify for the patient her position as it stands and, according to the requirements of the patient, the extent and details of the information to be imparted. For the disclosure of the diagnosis, it is of great help to the patient if the referring physician shows some element of empathy, e.g. ‘I am so sorry to have to inform you of the following diagnosis.’ The emotional reaction of the patient must meet with empathy and be allowed to be freely expressed. Depending on the condition of the patient, further offers of assistance must be made. In each case, the counselling should conform to the wishes of the patient [20]. The process of clarification always greatly influences the relationship between the patient and the physician (table 2).

On disclosure of the diagnosis, it is important to divulge to the patient only the details she needs to know referring to the therapeutic possibilities. The reactions at the time of disclosing the diagnosis show a broad spectrum of shock reactions, ranging from a spontaneous expression of intense despair to a distant acknowledgement of the diagnosis revealing hardly any noticeable reaction. Independently of how the information is imparted, it will come as unexpected for many patients, resulting in shock and, for some, like a sentence of death. Since in this phase several important decisions will have to be made regarding further treatment, many women continue to function without exactly perceiving what is happening. The frequent reaction of denial may represent a safety mechanism, in particular when feelings appear to be unbearable. This may be expressed in such a way that the patient, despite detailed clarification and her knowledge of the illness, refuses to acknowledge a tumour or cancer. This denial should be respected and in no way confronted or denounced. Confrontation with the illness may be resumed once the primary treatment has been finalised and the transition to private and professional day-to-day routine has been achieved.

Postoperative Care

The transition from inpatient therapy to postoperative care and thus back into the daily routine of life is always an extremely stressful time for the cancer patient. Despite all impairments while being an inpatient, the patient feels reassured that she is in the hands of competent physicians and nurses. She is released from the burdens of day-to-day life; as one patient described it: ‘She feels she is inside a bell jar.’ With the return to familiar surroundings, she is now responsible for her own health and well-being. It is at this particular point in time that the cancer patient becomes fully aware of the extent of her illness and what effect this will have on her life style in the future. She feels uncertain of how her illness will progress; hence the term *Damocles Syndrome*. This refers to the latent stress and fear of a relapse of the illness which will accompany the patient for the rest of her life, especially prior to the post-

operative follow-ups. This fear may result in sleep disturbances and nightmares. One patient reported that she dreamt constantly of her own funeral although she had been cured for over 5 years. The fact that the patient feels she is not fully recovered despite reassurance by the physicians can lead to an ambivalent conflict between physician and patient. On the one hand, the patient may experience subjugation and wariness towards the supposedly patronising manner of the physicians; on the other hand, she may surrender completely to them. This psychic alarm reaction often leads to behavioural patterns that diminish all feelings of fear and strengthen the hope of recovery. In the positive sense, the need for information to compensate for feelings of helplessness may indeed constitute to regaining control over life once more [21]. This may result in changes in nutrition and to general well-being. During this phase, many patients express the wish to join self-help groups so that they can share their experiences. Besides, they gain a feeling of self-assurance to be able to transmit their experiences to others. Often during this phase, the patients wish for additional therapy, be it nutrition supplements or established treatment by natural remedies or alternative medicine. All these factors serve to ensure that the outcome of therapy is successful for the patient. It is important for the physician-patient relationship to discuss all these methods, and even if the physician is not in full accordance with the patient's wishes and decisions, these must not in any way be denounced or rebuked.

Postoperative follow-ups often place the patients under psychic strain: on the one hand, fear that the illness could recur and, on the other hand, hope that the follow-up is not associated with early detection but purely a routine medical check-up. In the case that recovery is confirmed, this at least offers the patient hope for the future and appeases the fear of any relapse. Seen from this angle, the follow-up must be viewed as a medical and humane pact of mutual professionalism and assistance. The cancer patient will only be able to overcome her fear once she is aware that denial of the condition will not serve to alleviate the situation. Far more helpful are distraction, projection, optimism and other, similar strategies. It is the task of the physician to accept and to respect the defensive reaction of the patient and, at the same time, to allow the patient to speak of her fears. One patient reported: 'I wish I had a physician with whom I could discuss my fears and that he would be prepared to give me an ultrasound even if he considered this unnecessary.'

Stage of Progress

In this phase, the patient must be informed of her chance of recovery, and the limitations of her life must be explained clearly. This may lead again to feelings of isolation, fear of separation or loss, and to mistrust in the treatment received so far. This phase places new demands on the physician-patient

Table 3. Spectrum of conditions of group counselling corresponding to treatment programme

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- Compliance with the individual psychosocial situation of the patient
 - Determining the requirement of a psychotherapeutic diagnostics/treatment
 - In the case of a discrepancy in the mammography findings, the patient is assured of a second opinion
 - Determining the requirement of pain therapy
 - Counselling should – if possible – be carried out together with partner/family members/close contact person
 - The patient should be given the possibility of writing down the important points of counselling
 - The patient should be permitted at any time to peruse her documents
 - Consideration of information status of patient
 - Advice on the certain specifications of the individual health services, if known
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relationship. It is the responsibility of the physician to relate frankly and truthfully to the patient in order to maintain a sound basis for the physician-patient relationship. The patient may show signs of disinterest concerning certain details. This defensive mechanism should be tolerated and respected by the physician. It would, however, be counterproductive on the part of the physician to refrain from imparting these details. It could well lead to a breakdown in the relations should medical assistance be refused even if the situation does become extremely distressing and difficult. Fear and despair would result if the patient was no longer able to discuss her problems with her physician. At the stage of the formation of metastases, the patient becomes more dependent on the physician since it is imperative for her to seek support and assistance. This dependence brings about several differing expectations: on the one hand, that the physician shows an interest in the patient's condition and imparts positive information, on the other hand, the fear of receiving bad news and then withdrawal from the situation. The physician should show sympathy towards this behaviour and should be available for the patient throughout the course of the illness. During this phase, it is imperative to convey to the patient a realistic approach towards the hope of recovery.

Palliative Care

Assistance and moral support from the nursing and medical staff is of utmost priority for the gravely ill and dying patients. They are engaged in an area that is mostly ignored and considered as taboo in our society. An increase of publications based on the individual experiences of illness and deaths, both biographically and scientifically, has been documented and demonstrates to the society that this is a subject to be faced and not denied. A significant pioneer in this area was Kübler-Ross [22]. During this phase, it is of immense support and help for the patients to know that there are people around who are available for them and who offer a reliable source of assis-

tance. For those no longer in the position to carry out day-to-day functions, it is necessary to rely on others for assistance. It is also important to enquire after the needs of the patients since they are often no longer able to express their complaints or problems. In this phase, contact with family members is of great importance. The physician-patient relationship is always determined by the fears and wishes of both parties. Details on the progressive illness can offer an impetus regarding the current position of the patient and physician. During this phase, the relationship with the physician should be one in which the patient can be assured that she will not suffer a premature or communal death.

Psychosocial Intervention Possibilities

Counselling and Group Discussions

At present there are several different methods of intervention offered to the patients following cancer diagnosis, such as possibilities to seek advice in order to come to terms with the illness and also for information concerning the illness. Emotional support is also imparted in self-help groups. In the postoperative phase, psycho-educative group sessions have been established and, in addition, also individual and group psychotherapy. These different methods of intervention serve to reassure the patients and help them to overcome their fears, despair, depression and stress. Several studies have reported on brief interventions lasting a few hours, and also on long-term interventions with a duration of up to 1 year. A meta-analysis covering different investigations concerning psychosocial interventions with cancer patients came to the conclusion that positive changes could be observed in conjunction with the emotional and functional adaptability as well as with the treatment and symptoms associated with the illness. The results suggested that there is sufficient evidence to conclude that cognitive-behavioural interventions are effective in reducing and managing psychological distress in cancer patients and are accepted by these patients [23]. Since the success of psychosocial intervention lies mainly in the motivation of the patients themselves, participation in such interventions can only be recommended but not prescribed as obligatory. It is therefore of great importance to provide a low-threshold service of group therapy in which the patient can participate after inpatient treatment. Significant topics and information include questions concerning the disease, therapy and further diagnostic procedures, and also the psychic effects of the illness. In view of this point, it must be emphasised that relevant and detailed information must be given in answer to the questions that are repeatedly asked. In a more physical approach, the women were able to learn relaxation therapies. Information about rehabilitation was communicated and, additionally, the women received information about dietetic aspects and physical exercise. An investigation by Fallowfield et al. [24] re-

Table 4. Dimensions of psychotherapy for those with organ diseases [27]

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- The case history of a patient with her specific experiences, that is, her inner thoughts and memories of her childhood
 - The configuration of the basic outlook and values in the life history prior to illness
 - The aims in life and the question as to how close one is to achieving these aims
 - The current social situation of the patient regarding her professional, domestic and especially her personal life
 - The discontinuation of day-to-day life as a result of illness
 - The significance of the commencement and progress of the illness in connection with the patient's own life history
 - Further possible theoretical concepts formed by the patient, as perceived subjectively, relating to commencement and progress of her illness
 - The perspectives as perceived by the patient in her present condition pertaining to the future and whether or not they are viewed with hope or resignation
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vealed that the patients who did not receive adequate clarification as to the serious side effects of an oncological treatment showed more insecure and anxious tendencies and were of the opinion that their allocated therapy was ineffective due to the side effects experienced. In order to avoid the development of such insecurities, it was aimed to establish a modest choice of limited and constructed intervention programmes [25]. The contents of the discussions were based on the structured treatment programme (DMP) (table 3).

Besides the group discussions, individual counselling sessions were also established. These are supportive and are geared to suit the individual needs. The contents are focused on the frequent problems and stress situations at the start of the illness and take into account the needs of several patients according to concrete orientation guidelines and specifications. All the listed programmes cover the positive aspects of social activities, the psychic well-being, and physical functions such as fear and depression, and also the strategies to overcome the drawbacks [3]. Development of serious psychic disorders can be avoided with the help of psychosocial discussions. Focusing on the psychosocial dimension of the progress of the illness can offer emotional relief to the cancer patient. Moreover, in some cases, early introduction to an alternative form of psychotherapeutic treatment can be recommended. The patient's involvement in her treatment for cancer will thus be restored and the quality of her life greatly improved.

Individual and Group Psychotherapy

Psychotherapeutic interventions in an individual or group setting are reserved for risk patient groups. This refers especially to the psychic co-morbidity of an illness-related disorder. Around 10–30% of all cancer patients suffer from this disorder during the course of the illness. The impairments present as stress reactions and adaptation difficulties, which manifest

themselves clinically as fear and depression. Evaluation of both individual and group therapy shows that the patients generally benefit from this therapy, independently of the tumour localisation, their age and gender. The effect was also independent of the procedure, in general, expressive-supportive or cognitive-behavioural. In most of the cases, fear and depression were alleviated, and the patients were better able to cope with their illness and therefore improved their psychic well-being and social relations [3, 26]. The more specific the problems of a patient, the more likely is the success of an intervention geared to the individual situation. The constructed methods of intervention have the advantage of being more easily evaluated; however, they may not always be suited to the individual needs of the patients. It is still to be investigated in the future which patients benefit more and which patients less from the various forms of psychotherapeutic intervention offered. It is important to receive as much information as possible on those patients who decide against the intervention method of therapy. The objectives of psychotherapy include the stabilisation of self-esteem, help in the orientation in life as well as restoration of social competence and perseverance. Psychotherapeutic measures can be referred to as crisis intervention, that is, a short-term assistance to overcome the acute stressful situation triggered off by the illness. Moreover, there are supportive therapies aimed to consistently assist the patient over a longer

period of time. Psychotherapy with patients following a grave physical illness is oriented according to the dimensions listed in table 4. This refers to the so-called discontinuation of normal life experienced by the patient as a result of her illness and the way the patient views her illness from a subjective point of view, her objectives in life and how she is able to continue her life according to her objectives.

Outlook

To date there are still no routine psychooncologic services offered in many of the acute clinics. Deficits exist also in the research of the influence of such services on the quality of life and the battle to overcome the illness. At present there is, however, a broad spectrum of psycho-educative group therapy and counselling sessions, in particular in the established breast centres. It should be made possible for all patients to participate in these sessions. The identification of risk patients still presents a challenge, e.g. genetic counselling for patients following breast cancer. More specific forms of therapy should be offered to this particular group of patients since they require a longer motivation phase before they can be allocated further treatment. It should be stressed that the importance of the impartment of hope to the patients by the medical or the psychological-psychotherapeutic staff should never be underestimated.

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