Psychological Aspects of Cancer Pain Patients

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ABSTRACT

People suffering from a life threatening disease like cancer come across different physical and psychological stressful experiences. More so cancer pain patients are the most vulnerable group to psychopathological complication. Present paper is an attempt to took into these psychopathologies and their management as well.

INTRODUCTION

A patient suffering from cancer faces various stresses like fear of death, physical disability, disfigurement and growing dependency on others. These fears may vary between individuals depending on the patient’s personality, coping abilities, social support and medical factors. A multi-disciplinary approach, recognising the importance of psychological symptoms and psychiatric complications such as anxiety, depression, delirium (Massive & Holland, 1987) is presently the best option for management.

Psychological Impact of Cancer

After an initial period of shock when the patient learns about the disease, denial and disbelief, follows a period of anxiety and depression leading to disturbed sleep, diminished appetite, irritability and pervasive thoughts about cancer. These stress responses generally occur temporarily for a few weeks at specific points in the course of cancer e.g., after diagnosis, with relapse, prior to diagnostic tests, surgery, radiotherapy and chemotherapy. Psychiatric intervention at this stage is generally not necessary, although anxiolytic sedation and relaxation techniques along with support of family, social workers and hospital staff help the patient.
Pain is the most feared consequence of cancer. Pain is a psychological process involving nociception, perception and expression and requires addressing both physical and psychological issues. Apart from pain physicians, it requires services of the specialists from neurology, neurosurgery, anaesthesiology, rehabilitation medicine, in addition to psychiatrists. Unfortunately, psychological variables which are a consequence of pain often propose to be the sole cause of pain without addressing to medical factors (Massive & Holland, 1990).

**Psychiatric Disorders in Cancer**

After an adequate control of pain, it is imperative to reassess the patient’s mental state for psychiatric disorders which may increase mood disturbances and thus affect morbidity and mortality. After a thorough assessment and diagnosis, the treatment of depression and delirium needs behavioural and psycho-pharmacological management.

**Depression**

Depression occurs in nearly 20–25% of all cancer patients and prevalence increases with higher levels of disability, advanced illness and pain. The somatic symptoms of depression (anorexia, insomnia, fatigue, weight loss) are unreliable and lack specificity. Thus psychological symptoms of depression *e.g.*, hopelessness, guilt, suicidal tendencies are of greater diagnostic value. A family history of past episodes of similar nature and organic causes like administration of corticosteroids, chemotherapy, amphotericin and whole brain radiation, etc., further support the diagnosis of depression. Patients suffering from carcinoma of pancreas are associated with higher rate of depression than that of other intra-abdominal malignancies (Plumb & Holland, 1997). Depressed cancer pain patients are treated with a combination of antidepressant medication, psychotherapy and cognitive, behavioural techniques. Psychopharmacological treatment, however, is the mainstay of symptom management. Electroconvulsive therapy is considered for severely depressed patients, or when the antidepressant drugs pose unacceptable side effects.

**Anxiety in Cancer Pain Patients**

Anxiety syndromes in cancer patients are due to:

2. Manifestation of a medical or physiological problem *e.g.*, uncontrolled pain (organic anxiety disorder).
3. Phobias, panic and chronic anxiety disorders.
Reactive Anxiety

Anxiety at critical time points like waiting for diagnosis, surgery, interventional procedures can disrupt the ability to function normally, interfere with relationships and ability to understand and comply cancer treatments. Drugs like benzodiazepines, complimented with behavioural techniques, relaxation can reduce the distress.

Organic Anxiety

Uncontrolled pain, infection, metabolic derangements can be treated with analgesics, antibiotics and antihistamines. Anxiety related to the long term use of steroids can be treated with benzodiazepines or low dose antipsychotics (Stiefel, Breitbart & Holland, 2004). Encephalopathy, hyperthyroidism, carcinoid tumours, primary and metastatic brain malignancy also can lead to anxiety. These conditions also respond to benzodiazepines.

Phobias and Panic

Panic attacks, needle phobia or claustrophobia follow a critical moment and can complicate treatment of cancer. Relaxation training, systematic desensitisation and antipsychotic drugs often help control the patient’s fear.

Organic disorders: Delirium and dementia incidence may vary from 15–75% depending upon the progress of disease. Other organic disorders are dementia, amnesia, delusion, hallucinations, intoxications, personality and withdrawal disorders.

Delirium is a global cerebral dysfunction characterised by concurrent disturbance of consciousness level, attention, thinking, perception, emotion, memory and sleep awake cycle. Aetiology of delirium is unknown and there is waxing and waning of above symptoms, often reversible except in terminal multiple organ failure. Haloperidol can control delirium, but it can produce extrapyramidal symptoms, dystonia, hyperthermia, confusion and high CPK level. In the terminal days of the patient’s life, methrimeprazine, or midazolam can be used as an alternative to neuroleptics.

Confusional state (Helig, 1998) in cancer is not inevitable and can often be treated completely or at least managed to a considerable extent. It may present as disorientation, misinterpretation, short-term memory loss and include drugs (sedative, opioids, steroids), infection, metabolic disturbances, cardiac or respiratory failure and in susceptible patients, a full bladder or bowel. When trying to understand a confused patient, a useful concept is that confusion reduces the number of messages from the environment and increase those
from the body and memory stores, while making difficult to differentiate the
source of the messages. The implication is that self-awareness is at least
partly intact. While this may cause some patients to be very frightened by the
confusion, it does provide a means of managing confusion. A further implication
is that, sedative drugs should not be used routinely in order to preserve
awareness. Haloperidol 10 mg per hour can be given until agitation settles.

**Guidelines for Managing Confusion** (Kumar, 2005)

- Diagnose cause: drugs? - treat if possible
- Provide - company, constant routine
- Look for clues - to understand confusion (ask relatives)
- Explain the cause - makes confusion less frightening
- Reassure - the patient is sane
- Reorientate - provide ‘hooks’ on to which they can hang their ‘reality’

**Cancer Pain and Suicide**

Inadequately controlled pain or poorly tolerated pain can lead to suicidal
tendencies. In addition, mood disturbances, hopelessness, depression, delirium
in advanced stage of cancer, pre-existing psychopathology, suicidal history
and inadequate social support.

**Euthanasia**

Unremitting pain and terminal illness generally are the primary reasons
for those patients who request for physician-assisted suicide. From a medical
perspective, uses of suicide as an end-point of psychiatric disturbance should
be prevented. However, philosophically, many in our society view suicide in
those who face the distress of a fatal and painful disease like cancer as
‘rational’ and a means to regain control and maintain the ‘dignity’ in death.
This subject is often discussed as active euthanasia and passive euthanasia.
Active euthanasia is often accepted under condition that (i) the patient’s
consent is free, conscious explicit and persistent (ii) the patient and physician
agree that suffering is intolerable (iii) other measures of relief have been
exhausted (iv) another physician must concur (v) the facts that the patient is
in the terminal stage should be documented. Incidence is 1.8% of deaths in
Netherlands. Common reasons for requesting euthanasia is loss of dignity—57%,
pain—46%, unworthy dying—46%, dependence on others—33%, tired
of life—23%.
Cancer Pain and Family (Second Order Patients)

Family members are called upon to provide emotional support, basic care taking, share responsibility for medical decision-making, bearing financial and social cost. A programme for family members in pain management should include issues like assessment, administration of medicines, emotional support and stress management. In addition to the family, staff nurses are also intensively involved in the palliative care and face treatment failures and psychological burnouts.

Cognitive-Behavioural Interventions in Cancer Pain

Hypnosis, biofeed back and multifunctional behavioural interventions are used as adjuncts in cancer pain management. Behavioural interventions include self-monitoring, anticipating anxiety and avoiding it.

Relaxation Technique—Achieve a physical and mental state of relaxation. This includes (1) Passive relaxation (2) Progressive muscle relaxation (3) Medication (4) Focused breathing. Once relaxed, the patient can use imagination to manipulate or distract pain. Patient imagery includes (1) Pleasant distraction (2) Transformational (3) Dissociative imagery. The patient can imagine pleasant, pain-free experience, a pain-free walk and breaking pain cycle.

Hypnosis—A stage of heightened focus concentration can manipulate pain perception. Three principles of hypnosis are self-hypnosis, relax, not fighting the pain and use a mental filter to ease the hurt in pain.

Biofeedback—Includes electromyographic and electroencephalographic assisted relaxation. However, pain relief is not maintained after the treatment stops.

Music Therapy—Can capture focus of attention away from pain while aroma therapy can have relaxing and stimulating qualities.

In conclusion, patients suffering from cancer pain are most vulnerable to psychiatric complications. Besides medical management with analgesics and antipsychotic drugs, psychological interventions, psychotherapy and cognitive behavioural therapy play an important role in their well-being.

REFERENCES


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