EFFECT OF STRESS AND SOCIAL SUPPORT IN CERVIX CANCER PATIENTS

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ABSTRACT
Cancer of the cervix is a significant public health problem globally, especially in developing countries where it is the most common cancer in women. The psychological impact of cervical cancer is also significant. Each patient experiences a range of practical, psychological, and emotional challenges as a result of their diagnosis and treatment-related adverse effects. In early stages, it may be treatment that causes most stress, rather than the effects of the disease itself. This may impair the individual's coping abilities. Women with cervix cancer pass through a period with significant life changes that require immense psychological and social support. The present theoretical paper is an attempt to understand the effects of stress and social support in cervix cancer patients.

Keywords: Cervix Cancer, Stress, Social Support.

INTRODUCTION
Cancer of the cervix is a significant public health problem globally, especially in developing countries where it is the most common cancer in women. Developing countries bear a disproportionate burden of the disease, experiencing age-standardised mortality rates that are twice those experienced in developing countries. Every year, approximately, half a million new cases of cancer of the cervix are reported globally, 80% of which occur in developing countries, where the disease is also the leading cause of cancer-related death among women (Sankaranarayanan, Budukh & Rajkumar, 2001). According to IARC estimates,

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mortality from cervical cancer is expected to witness a 79% increase from 74,118 deaths in 2002 to 132,745 deaths by 2025 (National Cancer Registry Programme, 2009, WHO 2004).

Cervical cancer is caused by the sexually transmitted HPV, which is the most common viral infection of the reproductive tract. Almost all sexually active individuals will be infected with HPV at some point in their lives and some may be repeatedly infected. Although, there is no clear relationship between HPV & mental problems, there may be associated psychological problems such as feelings of fear, guilt, shame and anxiety. Also intrusive thoughts have been described in relation to the human immunodeficiency virus (HIV), depressive symptoms and lowered quality of life in the psychosexual fields and in sleep quality (Rose, Peake, Ennis, Pereira & Antoni; 2005).

The psychological impact of cervical cancer is also significant. Each patient experience a range of practical, psychological and emotional challenges as a result of their diagnosis and treatment related adverse effects. Each patient’s life may be further disrupted by changes in role and family functioning, occupational or employment status, and financial status. Shock, fear, self-blame, powerlessness and anger are the most common emotions experienced by women diagnosed with cervical cancer (Perrin, Daley, Naoom, et.al., 2006).

A role for psychology in cancer was first suggested by Galen in AD 200-300, who argued for an association between melancholia and cancer, and also by Gedman in 1701, who suggested that cancer might be related to life disasters. 85% of cancers are thought to be potentially avoidable. Psychology therefore plays a role in terms, attitudes and beliefs about cancer and predicting behaviour, such as smoking, diet and screening which are implicated in its initiation. In addition, suffers of cancer report psychological consequences, which have implications for their quality of life. Some evidence suggests that how well patients adapt to having cancer can affect the progression of the disease. Those who have high levels of hopelessness, depression and other psychological vulnerabilities have been found to survive for shorter periods after diagnosis than others do (Brown et al., 2003; Chida et al., 2008; Watson et al., 1999) perhaps because of the effects of stress and negative emotions on immunity and other processes (Antoni et al., 2006).

The persistent activation of the hypothalamic-pituitary-adrenal (HPA) axis in the chronic stress response and in depression probably impairs the immune response and contributes to the development and progression of some types of cancer.

In the early stages it may be treatment that causes most stress, rather than the effects of the disease itself. However, once treatment decisions and choices have been made, stress may still be important. The general process of hospitalization and surgery is known to be stressful and this may affect adversely
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the quality of the experience for some (Mathews and Rietgeway, 1981; Mumford, Schlesinger and Glass, 1982). However, over and above this, some treatments for cancer have their own problems. Surgery is often tolerated as a necessary evil because it is seen as a treatment that will root cancer out, but subsequent chemotherapy and radiotherapy can be more difficult to deal with. Agitations, withdrawal, non-engagement with treatment and unrealistic expectations of treatment have been cited as predictors of poor outcome in radiotherapy (Schmat et al. 1982).

In a recent study Montgomery et al.,(1999) reported that 30% of patients receiving radiotherapy suffered from adjustment disorder and/or stress/anxiety/depression. Chemotherapy is also associated with high levels of anxiety and depression (Middelboe et al., 1995). Chemotherapy is often accompanied by side-effects which may include nausea and vomiting. There is some evidence to suggest that these may be influenced by psychosocial factors. Some people develop the symptoms prior to the actual treatment (anticipatory nausea and vomiting-ANV) and for some, the unpleasant side-effects are exacerbated by anxiety (Andrykwoski and Redd, 1987; Burish and Carey, 1986). Psychologically oriented stress management techniques have been shown to be effective in reducing both ANV and the frequency and intensity of nausea and vomiting during the chemotherapy itself (Burish, Carey, Krozely and Greco, 1987; Lyles, Burish, Krozely and Oldham, 1982; Morrow and Morrell, 1982).

It has also been argued that stressful life events may impair the individual’s coping ability (Newell, 1999). Further analysis showed that criticism and overprotection by spouse leads to negative mood and stress (Cooley, 1999; Thotis, 1999). Hence, family and social support are necessary for the individual to acquire personal resources, the motivation to enhance, and promote development of the individual. Social support is the number of social contacts maintained by a person, or the cohesiveness of a social network (Kaplan et al., 1993). Cobb also defines social support as the perceived belonging to a social network of communication, mutual obligation where one can rely on others, and to be cared for and loved (in Day, 1999). Hence social support is present to the extent that people perceive themselves as belonging to a particular network.

Often patients face either isolation, or undesired increase in social contact at their homes. The support can be much or too little, and therefore fail to meet the patient’s needs. Patients may experience too little or incorrect support because the family tends to misconceive their needs and priorities. (Tempelaar, De Haes, De Brutter, Bakker, Heuvel & van Niewenhuijsen, 1989) crowding causes tension and prevents people from experiencing needed states of privacy whereas, social isolation equally produces tension, and it is psychologically threatening (Proshansky, Nelson-Shulman & Kaminoff, 1979). Kaplan et al., (1993) suggested that chronic illness such as cancer can cause modifications in the support

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environment, or family interactions. Moreover, the patient becomes a victim as
the family may not know how to behave in the presence of patient, spouses may
be overly concerned, or the family may shy away from emotional involvement
with someone who may not be likely to survive. (Tempelaar et al., 1989).

Summers (1998) indicated that women with positive pap smears said their
partners were very upset, and this perpetuated the guilt and distress that they
already had. Bergmark and others (1999) also observed that women who had
cervical cancer were often single, suggesting that some relationships end as a
consequence of the illness. According to Corney et al., (1992) the sexual problems
in patients’ marriages resulted in marked difficulties.

According to Day (1999), families with a chronically ill patient are structurally
like psychosomatic families. These families, according to Meissner (in Day,
1999), tend to be rigid and repressive. The family gets to be characterised by
weak ego boundaries between members, over-protectiveness, rigidity of roles
and rules, as well as lack of conflict resolution. Hudgens (in Day, 1999) also
observed that the patient with chronic pain becomes dependent on the spouse or
significant other. Communication between the family members also becomes
indirect, social contacts are narrowed, and family members show an inability to
handle anger effectively.

For married persons, it is highly likely that the spouse will be the primary
source of both physical and emotional support in long-term illness. Social
support is a critical resource for persons who face serious illness. Longitudinal
studies of cancer patient show that social support at the time of diagnosis
predicts not only better emotional outcomes but longer survival times as well
(Funch & Marshall, 1983; Vachon, 1979; Weisman & Worden, 1980). A number
of studies have documented that women show better emotional adjustment after
diagnosis of breast cancer if their husbands are highly supportive (Jamison,
Among chronic pain patients, pain is less likely to lead to depression if the
patient’s spouse provides support (Kerns & Turk, 1984). For rheumatoid arthritis
patients, support from the spouse is associated with better adjustment and the
use of adaptive coping strategies (Manne & Zautra, 1989). It is important to
discover the conditions that promote and interfere with the maintenance of a
supportive marital relationship throughout the course of chronic illness.

The well spouse is not always a source of comfort. Marital partners of
seriously ill patients can at times contribute to the patient’s distress, exacerbate
problems, or reduce the patient’s motivation to recover or regain important
functions. Spouses are sometimes quite critical of their ill partners. As a result
the ill partners engages in less adaptive coping behaviours and are less well-
adjusted emotionally than those whose spouses rarely engage in criticism (Pape,
Taylor & Doughrty, 1999).

Illness such as cancer generates feelings of fear and aversion, especially in
those who have no previous experience with or exposure to serious illness. At
the same time, many people believe that the most appropriate behaviour toward a cancer patient is to maintain a cheerful optimistic façade. The conflict between these two reactions may lead to ambivalence and anxiety over interacting with the patient. Contradictory verbal and non-verbal behaviour may be confusing or hurtful to the patient, who correctly detects a lack of genuineness (Wortman & Dunkel-Schetter, 1979).

At worst, fear or discomfort may cause people to avoid the patient altogether. Another source of “misfired” support may be differences in how the patient and the spouse think about the patient’s disease. The patient’s preoccupation with her illness may be deeply unsettling to the spouse because it threatens his more benign assessment of the threat posed by her disease (Lichtman et al., 1986). For an effective working relationship, both partners need to understand the other’s way of thinking about the disease and the emotional ramification of the partner’s viewpoint. Without this understanding, a continuing spiral of well-intentioned but unappreciated attempts at support and mutually increasing feelings of resentment and emotional isolation can easily result.

The spouse is frequently the first person from whom support is sought during crisis and evidence suggests that support from other sources cannot compensate for lack of intimate or marital support (Brown & Harris, 1978; Coyne & DeLongis, 1986; Lieberman, 1982; O, Hara, 1986).

Much of the research with women suffering from life threatening chronic illness like cervix cancer shows that they pass through a period of significant life changes that require immense psychological and social support. Lack of support during this phase interferes with their psychological and physical functioning. A beneficial role of social support in psychological and physical wellbeing of patients of heart surgery (Oxman & Hull, 1997), cancer (Ell, Nishimoto, Mediansky, Mantell & Hamovitch, 1992) and dialyses (Elal & Krespi, 1999) indicates a strong association between social support and improved psychological adjustments.

Charmas (in Day, 1999) argues that despite disruptions and alterations caused by setbacks, complications, disability and impaired functioning, people with chronic conditions also struggle to have valued lives. Loss of status resulting from job loss, diminished income and loss of social support can have a profound effect on the patient’s identity, as she is challenged to adapt to these losses. In adjusting her identity, she tries to come to terms with the constraints and limitations of the illness.

Greimel & Freidl (2000) indicated that patients undergoing radiotherapy report a high level of anxiety, emotional distress and treatment side-effects, as well as sexual dysfunction. The comparative studies showed that this emotional distress is higher in cervical cancer patients than in patients facing other threatening disease such as heart disease (Greimel & Freidl, 2000). Again, cervical and
ovarian cancer patients became more distressed after surgery than endometrial cancer patients.

Cervical cancer has proven to be one of the illnesses that affect the sufferer most severely and negatively. However, some patients can cope effectively with resilience while others may be devastated and worn out by the illness. Stavkary (in Rosch 1984) observed that the cancer patients with a favourable outlook on life are those that are able to express strong emotions under severe stress without loss of emotional control.

It has been observed that social support mitigates the effects of stressful life events (Kaplan, Sallis & Patterson, 1993). Social relationships influence behaviours, and in turn promote desirable health outcomes. It is argued that individuals who experience significant life stress and yet have strong social support will be protected from developing psychosomatic illness associated with stress (Kaplan et al., 1993). Deprivation of social resources on the other hand results in continuing, distressful, self- rejecting feelings. Supportive social networks may thus be expected to moderate the severity of the distress associated with stressful life events like cancer through the promotion of emotional and physical support (Day, 1999). A study done by Bloom (in Day, 1999) on breast cancer indicates that social support was found to be the strongest predictor of healthy adjustment. It had an effect on coping, sense of power and diminished psychological distress, which in turn resulted in positive self-concept.

Self esteem is another factor that contributes to stress in cervix cancer patients. Self- esteem is the desire to be worthy, to love, and to be appreciated, strong, secure and loved (Samuels, 1977). The self-esteem theory asserts that individuals have a need to increase and maintain their feelings of worth, effectiveness and self- satisfaction. According to Samuels (1977), these feelings may be manifested either in a particular aspect of self- evaluation, or in global feelings. For instance, it may mean evaluating the self in terms of vaginal abnormalities or evaluating the self in terms of the overall abilities and strengths that one has. Looking at the physical abnormalities and behavioural deficits faced by cervical cancer patients, it is evident that they may have a very low self-esteem as their parts of self show discrepancy or incongruity.

The problem can however be avoided by giving what Rogers calls unconditional positive regard, which is a need every human has. Maddy (1996) argues that when a person receives unconditional positive regard from important others, she in turn regards herself positively and once this positive self regard is established it becomes autonomous and self- perpetuating. The person then becomes in a way her own significant social other (Feist & Feist, 1998). Positive self regard includes feelings of self confidence and self- worth, which results from social approval. Gender studies have indicated that women tend to be more sensitive to other people’s approval. Andersen and Cyranowsky (1994)
argue that gender differences in self esteem suggest that women are more dependent on others for self worth than men are. Cervical cancer patients need a supportive environment that shows acceptance. They need to feel important, regardless of their illness. They also need people who respect their sexuality and individuality. In most cases, instead of getting support from their loved ones, they suffer rejection by intimate partners. Consequently, they are faced with feelings of worthlessness. The end result is incongruence that manifests itself in anxiety and threat. Thotis (in Day, 1999) suggests that the social environment provides identity and sources of positive self-evaluation, thereby improving self-esteem. Thus according to Cooley (in Day, 1999) social support should be given in the form of positive regard from significant others, as the approval and disapproval from others becomes incorporated into one’s own esteem for self and an affection giving network is a positive basis for self evaluation and self acceptance.

Most researches on benefits of social support has focused on advantages acquired by individuals who receive support from others – better mental health, fewer physical health problems, even lower rates of mortality.

Looking at all these challenges facing the patients and their respective families, it is evident that there is a need for supportive care and psychosocial intervention.

REFERENCES


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