

## review

# Psychosocial coping strategies in cancer patients

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**Background.** The aim of this review is to present common psychosocial problems in cancer patients and their possible coping strategies. Cancer patients are occupied with many psychosocial problems, which are only partially related to their health state and medical treatments. They are faced with a high social pressure, based on prejudices and stereotypes of this illness. The review presents the process of confrontation with the cancer diagnosis and of managing the psychological consequences of cancer. The effects of specific coping styles, psychosocial interventions and a social support on initiation, progression and recurrence of cancer are also described.

**Conclusions.** Although some recent meta-analysis could not provide scientific evidence for the association between coping strategies and the cancer initiation, the progression or the recurrence (neither have studies rejected the thesis of association), the therapeutic window for the psychosocial intervention is still wide and shows an important effect on the quality of lives of many cancer patients.

*Key words:* neoplasms-psychology; social support; cancer patients, coping strategies psychosocial problems, psychosocial support

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## Introduction

Coping is a complex mental process by which a person deals with stress, solves problems, and makes decisions. It is an emotional, cognitive and behavioural response of a patient to an illness. Coping process involves at least two stages: confronting («Is this something to bother about?») and managing («What can I do about it?») with different aspects of illness or

disability. Since every patient is a unique person, an emotional, cognitive and behavioural response can vary a lot and can occasionally be quite unpredictable in the same patient.

Despite striking differences in the progress of different cancers and the increasing effectiveness of medical treatments, cancer continues to be the most widely feared group of diseases. Undoubtedly, cancer causes considerable psychological distress in patients, families, and often those health professionals who care for them. Some socially determined problems often augment distress in patients as well. Besides unpleasant symptoms such as pain, nausea, fatigue and the distress, financial problems and problems concerning employment, housing, childcare, family worries and existential doubts also oc-

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cur. Only a well-planned care that fully involves patients and their families can minimize these problems.

How do patients adapt to cancer? The number of studies aimed at answering this question has grown rapidly over the past twenty years. Consequently, much more is known today about the patient's psychological functioning during the course of cancer and about the strategies they use in order to deal with this disease.<sup>1</sup>

It is commonly believed that a person's mental attitude in response to the cancer diagnosis affects his or her chances of the survival. Although different coping strategies in cancer patients are predominantly designed in order to diminish the distress and to improve their quality of life, all studies did not prove convincing evidence that some psychological coping styles like acceptance, fatalism, denial, helplessness, hopelessness can play a clinically important part in the survival or recurrence of cancer.<sup>2,3</sup> At the same time, many studies lay great stress on psychological and social factors that could be involved in the aetiology and response to cancer and its treatment.<sup>4-6</sup>

### Confrontation with cancer diagnosis

The topic of cancer is associated with many social and clinical taboos. In popular language and in medical settings, euphemisms such as »growth«, »tumour«, »lump«, »shadow« are used to avoid the word »cancer«.<sup>7</sup> Communications and reticence from communicating about cancer reflect numerous negative attitudes widespread among patients, their families, health professionals (including doctors and nurses), other hospital personnel and the wider lay community as well.<sup>8,9</sup> These kinds of communications may arise from the fears and misconceptions surrounding cancer and using them and may give rise to their rootedness. Doctors may refrain from using

the word »cancer«, because they believe patients prefer not to be given a potentially terminal diagnosis. However, research studies show that members of the general public were more likely to say that they wish to be informed of a terminal diagnosis than doctors estimated they would be, nevertheless they may not take these opportunities when offered.<sup>10,11</sup>

Some researchers pointed out that every patient searches for the information about the identity, consequences and causes of an illness, time line and the cure. These components of common sense representations tend to be reasonably stable over time and across different illness episodes.<sup>12</sup> Illness cognitions also tend to affect changes in health-locus-of-control-belief, different propensities to visit a doctor, changing attributions of getting sick and taking personal responsibilities over the treatment. Since the effectiveness of therapy not always depends on the medical treatment but also on patient's representations of the illness, the medical staffs have to recognize them and re-establish an effective communication.<sup>13</sup> Cancer specialists are beginning to acknowledge the value of improving communication skills via training models, residential workshops and educational programs and thus reducing the risk of patient's maladaptations to an improperly delivered diagnosis.<sup>14</sup>

Although most of the patients have already constructed their own representations of their illnesses while waiting for the diagnosis, the final diagnosis is mainly a stressful event. Patients have varied ways of copings with a cancer diagnosis. The response to a poor prognosis is ranging from shock and denial through anger, depression and finally acceptance.<sup>15</sup> While there is considerable doubt about the actual sequence of stages, this range of responses is commonly observed in patients with cancer. Researchers tempt to reveal whether the application of some of the coping strategies may result in a better adjustment prognosis. In general, coping strate-

gies that focus on emotional aspects of the response are associated with a poorer emotional adjustment. By contrast, patients whose strategies also focus on thinking about the issue in a different way, e.g. by acceptance of the condition, or on seeking solutions to problems, show a better subsequent adjustment.<sup>16,17</sup> Some coping strategies may also influence the prognosis. Patients that predominantly show »denial«, »fighting spirit« or »stoic acceptance« were found to have better survival chances than patients whose coping responses reflected »helplessness / hopelessness«.<sup>18-20</sup>

### Managing the psychological consequences of cancer

The acknowledged psychological model of coping processes with the illness in general, is derived from the presumption that managing with the illness is usually a long graduate process, accompanied with many ego-defence patterns (e.g. denial, repression, projection, compensation, fatalism, dissimulation, etc.) and consecutively with a cognitive, emotional and behavioural consolidation.<sup>21,22</sup> Heim<sup>21</sup> described the coping process in a four step integrative model with alternating coping phases. The start point of the patient's perception phase is the moment, when the patient identifies some changes in his/her physiological condition and well-being and begins to analyze them. During the cognitive phase the patient is preoccupied with the disease and tries to find the right definitions and estimations about his/her illness. Adjusted by numerous defence mechanisms (repression, withdrawal, escapism, focusing, projection, dissimulation, aggravation, isolation, rationalization, reactive formation, regression, sublimation, symbolization), the patient's coping process finally ends with a cognitive, emotional and behavioural consolidation. It should be pointed out that coping is a very

delicate process, primary orientated on patient's needs and therefore often aggravating for the medical staff, patient's family and other patients as well. Conformed patients are socially more accepted than aggravating ones but in many occasions this condition can be a disadvantage that obstructs the coping process.

After facing with the cancer diagnosis and the first abrupt reaction of a shock, which is a normal response to a stressful event, patients often show signs of negation, disbelief and despair. This first step of the personal crisis usually lasts about a week. During the following step patients slowly recognize the reality and become anxious, frightened, panic, depressed, having problems with cognitive functioning, sexual life, appetite, and sleeping and with managing daily routine.<sup>22-24</sup> Some of the mentioned psychological adjustment problems may occur only in a smaller number of patients, while a range of psychological responses (denial, anxiety and depression) that accompany the cancer diagnosis, have been seen in the majority of cancer patients.<sup>25</sup>

*Denial* is a mechanism of denying the presence of illness and medical diagnosis. It is normally activated after the first stages of a shock, and usually disappears after a short time.<sup>26,27</sup> The denial may have a favourable effect when it appears in the first phase of coping, after the diagnosis has been established because it reduces anxiety. However, some negative effects of the denial have been observed, for example: it may interfere with the getting treatment (e.g., a delay in going to the doctor, not showing up for follow-ups, non-compliance) or it may disrupt the process of assimilating the stressful event. Furthermore, it may, adversely, affect interpersonal relations and constitute a cumulative stress depression - even immunocompetence.<sup>26</sup> Some researches revealed that a tendency toward denial could be one of the important risk factors for cancer.<sup>28</sup>

*Anxiety* is the response to a perceived threat. It is manifested as apprehension, uncontrollable worry, restlessness, panic attacks, and avoidance of people and of reminders of cancer, together with the signs of the autonomic arousal.<sup>29</sup> In certain circumstances anxious patients may overestimate the risks associated with the treatment and the likelihood of a poor outcome. The anxiety may also exacerbate perceptions of physical symptoms (such as breathlessness in lung cancer), and post-traumatic stress symptoms (with intrusive thoughts and the avoidance of reminders of cancer). Certain cancers and treatments are associated with specific fears. Thus, patients with head and neck cancers may worry about being able to breathe and swallow. Some patients may also develop phobias and conditioned vomiting in relation to unpleasant treatments such as chemotherapy.<sup>30,31</sup>

Insecurity, the outer locus of control over the situation, learned helplessness and perceived loss often result in *depression*. In contrast to anxiety, which arises immediately after the offspring of the disease and accompanies the clinical screenings, the *depression* is progressing more slowly. A diagnosis of cancer and the awareness of associated losses may precipitate feelings similar to the bereavement. The loss may be linked with lost parts of the body (such as a breast or hair), the role in family or society, or the impending loss of life. A severe and persistent depressive disorder is up to four times more common in cancer patients than in the general population, occurring in 10-20 % during the disease.<sup>31</sup> There is evidence that the depression predicts the cancer progression and the mortality, although disentangling the deleterious effects of disease progression on the mood complicates this research, as does the fact that some symptoms of cancer and its treatment mimic the depression. Obviously clinical signs of depression are often difficult to distinguish from the signs, which develop

due to the chronic illness and side-effects of chemotherapeutic and radiological treatment (e.g. vomiting, weight loss, insomnia, tiredness, etc).<sup>32,33</sup> The depression in chronic patients frequently leads to the high morbidity and suicide, especially in old patients, patients with the psychiatric diagnosis and patients without partners.<sup>34,35</sup>

### Managing the psychosocial problems of cancer

Cancer patients are occupied with many psychosocial problems, which are only partially related to their state of health and medical treatments. They are faced with a high social pressure, based on prejudices and stereotypes of this illness (e.g. suffering, dying, loneliness, dependence, no cure, loss of hair, mastectomy, etc).<sup>22</sup> Only a few diseases are associated with as many negative connotations as cancer. Nonverbal signs, absence of spontaneous speech and reactions, embarrassment, avoidance of interpersonal contacts or eye-contacts, poor communication and deficient concealing information are only a few signs of the prejudiced behaviour of medical staff, family members, friends and colleagues towards the cancer patient. Without doubt, these are representative behavioural patterns that reflect social perceptions of patients with cancer.<sup>36</sup> Although psycho-oncology literature concerned with coping strategies indicates that the coping style »thinking positive« is correlated with the cancer patient's overall level of mental health and mortality rates, the mentioned coping style could also represent a stress factor for cancer patients. In this case, »thinking positive« does not represent an accurate report of internal cognitive state, but rather a conversational idiom, summarizing a socially normative moral requirement.<sup>37</sup>

A social environment has an important impact on the patient's crises; together with the

disease it can affect different aspects of the patient's life quality and discomfort. In such a manner some patients can transform from dominant to passive persons during hospitalisations, suffer from the social isolation and existential fears, concern about family relationships and childcare and are anxious about their working career and financial situation and have lower self-esteem and poor interpersonal relationships.<sup>38</sup>

Since the social support was found to be a preventive factor against stress and diseases and a curative factor by chronic diseases, it might serve as a significant cue in cancer patients. The social support involves a social net, an important system of social relationships within the family, relatives, friends and colleagues. In most cases it is found to be useful but on some occasions it might have a distressed effect. For instance, when the patient prefers to be alone because he/she feels that other people feel pity for him/her or in case when someone has taken control over the patient and has broken the balance between support and control. It was also found that a continuous verbal communication about problems often leads to the depression in cancer patients.<sup>39,40</sup>

An effective social support increases self-esteem and decreases depression, but not all forms of support are necessary appropriate for cancer patients. For example, a marriage was found to have mixed effects. It was discovered that some spouses who had been very concerned about the partner's health provoked depression and suffering in them.<sup>41</sup>

### **Psychosocial coping styles and their relevance to survival / recurrence of cancer**

Until recently there has been a common belief that psychosocial factors have a great influence on the initiation and the survival from cancer. An association between psychosocial factors and the initiation or the sur-

vival from cancer are biologically plausible through some immunological and neuroendocrine mechanisms.<sup>42-45</sup> Surprisingly, some meta-analysis studies discovered a little evidence that psychological coping styles and psychosocial interventions are important in the survival or the recurrence of cancer. In addition, there is no evident association between stressful life events, amount of social support, personality, locus of control, coping styles, negative emotional states / psychiatric symptoms, psychiatric diagnoses on depression, initiation and progression of cancer.<sup>2,3,6</sup>

Although some studies indicated specific coping styles and psychosocial adjustments that influence the survival and the recurrence of cancer, the evidence of these discoveries is inconsistent, probably due to publication bias and methodological flaws (small samples, uncontrolled and confounding variables, lack of studies of interactive effects). Some authors emphasized that people with cancer should not feel pressured into adopting particular coping styles (e.g. »fighting spirit«, problem focused coping, emotion focused coping, etc.) to improve the survival or reduce the risk of the recurrence because there is no good proof that a particular psychological coping style prolongs the survival or is more effective than some other.<sup>2</sup>

These findings suggest that psychological interventions should not be focused only on enhancing a certain coping style in regard to prolong survival. Therapists should be rather orientated to widening of a therapeutic window and to helping cancer patients to achieve a better quality of life.<sup>46,47</sup> A group therapy should be used first of all for the psychological benefit of cancer patients, not in order to prolong their life. Establishing a new social support network, expressing emotions, confronting existential issues, improving relationships, enhancing communication, learning coping skills, reducing of distress and pain, confronting with the possibility of dying and destigmatising of cancer and cancer

patients are many of benefits that the psychotherapy offers to their users. A well-trained and supervised staff should be encouraged to achieve a notable and positive effect on the quality of life in cancer patients.<sup>14,47</sup>

### Conclusions

In spite of the lack of convincing evidence that psychological coping styles and psychosocial interventions are important in the survival or the recurrence of cancer, there is no doubt that during the confrontation and managing with cancer some psychosocial intervention should be employed in cancer patients in order to diminish their distress. Some subgroups of cancer patients are especially vulnerable and need to be recognized in order to prevent serious psychological complications.<sup>6,34,46,48,49</sup> Particularly attention is advised in groups of patients with the history of chronic depression, patients undergoing chemotherapy and radiotherapy, patients with breast and genitalia cancer, patients experiencing uncontrollable pain, patients with terminal illness, patients who practice unhealthy behaviours, patients without social support, children patients and elderly patients. These patients are found to drive particular benefit from psychosocial interventions. Their quality of life was improved by reducing psychological symptoms and distress, by enhancing psychological and functional adjustment and by improving rehabilitation. Furthermore subtle benefits are predicted to correlate with psychosocial programs.

People with cancer benefit from care if psychological and medical cares are coordinated. Apart from the obvious benefits to quality of life, there is some evidence that encouraging an active approach to living with cancer can improve the survival. As for all chronic illnesses, a multidisciplinary ap-

proach and management protocols that include psychological as well as medical assessment and intervention are required also for cancer. These protocols need not be specific for cancer as the issues are common to many medical conditions. The danger is that psychological care can be neglected by the medical focus on the cancer treatment. A case manager, whether nurse or doctor, who can coordinate the often diverse agencies involved in cancer patient's care can ensure that the treatment is delivered efficiently.<sup>31</sup>

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